Employe Benefits

'80s benefit forecast

Benefit plan changes in the 1980s could blow the top off employers' efforts to cap benefit plan costs. **Page 17.** The *BI* Benefit Board gauges the pressures that will force benefit plan changes. **Page 17.**

NHI lineup

There are so many proposed national health insurance plans, it's hard to keep the contenders straight without a roster. *BI* charts the six leading NHI proposals: the sponsors and the mandates. **Pages 22-23.**

Hospice care

Special care for the terminally ill is being added to group health plans. **Page 46.**

Small business blues

Health insurers neglect small firms, inviting national health insurance, a benefit manager warns. **Pages 61-62.**

Future planning

Benefit consultants are preaching future planning now that ERISA-compliance fires are out. **Page 68.** A directory of consultants' specialties and rates begins on **Page 71.**



business insurance

Week of December 10, 1979

the national newsmagazine of loss prevention, risk financing and employe benefit management

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Retro ban in Calif. alerts other states' work comp officials

By RHONDA L. RUNDLE

LOS ANGELES—California's attack on paid-loss retrospectively rated insurance plans for workers compensation could spur action in other states after officials talk shop at the National Assn. of Insurance Commissioners meeting in Los Angeles this month.

Two insurers have agreed to stop issuing paid-loss retro plans for workers compensation here until the California insurance department rules on their legality (*BI*, Nov. 26).

Although brokers, insurers and risk managers say these plans are commonly written for workers compensation risks in other states, officials of several other state insurance department rating bureaus were reluctant to admit the use of paid-loss retros in their states.

In Texas, where hundreds of these plans are believed to be written, the retro plan specialist in the department of insurance said, "There is no 'paid-loss' written that I am aware of. According to my manual, such plans would be illegal." An agent recently called to ask about such plans, said the official, who told the inquirer they had not been approved.

"Nothing in our retro plan authorizes 'paid-loss' arrangements," said Jack Piercy, vp at the New York Compensation Rating Board. "We've heard no flak or complaints about such plans being used."

In Pennsylvania however, "paid-loss"—sometimes called "claims-paid"—plans are perfectly legal, says Bruce Hoehman of the rating bureau. Most large accounts prefer to self-insure he said. A study conducted for the department by an independent research firm showed less than one-half of 1% of Pennsylvania companies would consider paid-loss retros, he reports.

State officials may not be formally aware of the existence of paid-loss retros because the payment mechanism is not reviewed by them, some industry observers suggest.

Since the insurance departments maintain close lines of communication, however, it's possible that California's ruling may create a ripple effect in other states.

"When there's a development in one state, the others look at it," Mr. Piercy says. "Mutual problems are discussed at meetings and ideas taken home for study."

Meanwhile, agents and brokers in California are 'ringing the phone off the hook" with questions

Continued on page 96

Health plan charges to climb 8% to 15%

BI Roundup

CHICAGO—Though everyone is throwing cost containment punches at mounting benefit costs, only group life insurance seems to be going down for the count.

An informal survey of brokers and group insurers revealed continuing cost increases for group health insurance ranging from 8% to 15%. Group life prices, however, are expected to drop steadily as mortality, health care and competition improve.

"Life insurance prices are going down and underwriters are becoming more liberal," remarked Ross Bond, vp at Safeco Insurance Co. "So buyers are getting a better value.

"Disability insurance premiums are staying about the same," he noted.

Safeco's group health insurance premiums, however, are increasing an estimated 11%. "Like everyone else, we're waiting to see what's going to happen," Mr. Bond said. "Are we going to have stagflation with the election coming up? The whole national situation is so volatile that you can't really say."

Inflation is cost containment's chief opponent, insurers say, but increasing use of medical services packs a wallop, too.

"Generally speaking, the cost to provide most benefits is going to spiral upward. There's no way to get away from it anymore," said

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Nuclear industry girds for liability battle

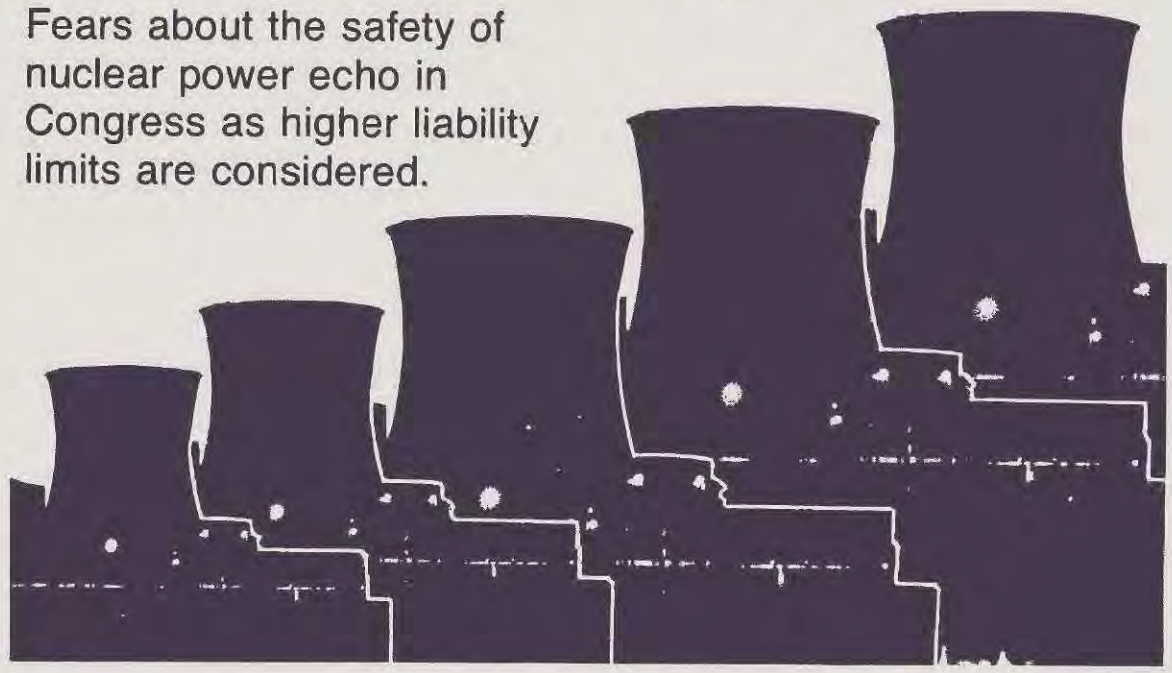
By STUART EMMRICH

NEW YORK—Almost nine months after the accident at Three Mile Island, the nuclear industry is readying for an onslaught by Washington regulators that could radically change the way it runs, inspects, builds and—perhaps most devastatingly—insures its nuclear power plants.

Proposals being studied in Congress and scheduled for public hearings within the next few months could increase by as much as 10 times the amount of liability borne by a utility company in the event of a nuclear accident. The proposals also call for much tougher safety programs and more sophisticated training sessions for nuclear plant operators.

Insurers and utility company officials are vehemently fighting a proposal in the Senate and House that would lift all liability limits for damages caused by a nuclear accident, removing the $560 million cap that has been on the industry since 1957. The staff of Sen. Gary Hart (D-Colo.), in charge of the committee studying Three Mile Island, has proposed a lesser in-

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Rock concert deaths

page 3

Harvester asks second trial in $15 million liability case

By JACK THORNTON

BELLEVILLE, Ill.—In the aftermath of a $15.7 million product liability jury award here against International Harvester Co., the giant farm equipment manufacturer is accusing the plaintiff's attorney with improper courtroom conduct and the judge with mishandling the trial.

Prejudicial pretrial publicity, inflammatory statements to the jury and the possibility the jurors saw inadmissable evidence such as insurance policies stacked the odds against Harvester, the company argues. It is requesting a new trial or an overturn of the Oct. 29 verdict.

A jury here awarded $15 million in punitive damages and $650,000 in compensatory damages to Merlin C. Stambaugh, a Versailles, Ill., farmer burned over much of his body in a May 1975 tractor fuel fire (a 1963 IH Farmall Model 706). It's the fifth such case against IH to be tried or settled in Illinois and the costliest so far. Harvester lost three cases and won one.

Mr. Cook also filed a third lawsuit last week against Harvester seeking damages for Melvin Holtz, an Ada, Mich., farmer burned in a similar tractor fire May 7, 1978.

Like the other cases, it was filed in Belleville, but Illinois law allows the defendant to choose the trial site.

Elsewhere around the country IH is defending 40 to 50 similar suits, says a plaintiffs' attorney.

Harvester is accused of designing and selling a tractor fuel system prone to overheating and to fuel "geysering" out. The company finds its reputation at stake both for its tractors and in accusations of so-called "document fraud."

It is unclear from whose pocket the damages, if any, will be paid.

Until two years ago, IH's product liability coverage was underwritten by Royal Globe Insurance Co. But IH is now mainly self-insured for product liability, as are many other large U.S. manufacturers.

"They couldn't even afford the premiums on that kind of product liability coverage," said a source in Royal Globe's New York City office.

IH's excess insurance arrangements are unknown. The company refuses to discuss its policies on the advice of its attorneys. The source at Royal Globe said he knew of no excess insurance through his firm's London office.

Royal Globe only handles Harvester's claims paperwork now, the source continued, and claims payment is further confused because of several policies. Some tied liability to when the tractor was made, some to when the accident occurred, some to when the suit was filed.

Without stating so directly, Harvester is also attacking some court practices routinely permitted in Belleville, Ill., that would raise eyebrows in other Illinois jurisdictions. One is a failure to sequester the jury during deliberations.

These practices combine to make Belleville, St. Clair County and East St. Louis a "haven" for plaintiffs' attorneys, Harvester sources say, adding that the area is notably unsympathetic to defenses by railroads, large machinery builders and other corporations. Both sides agree there is a disproportionately large number of product liability trials here.

The county harbors a large contingent of plaintiffs' attorneys who specialize in suing corporations. They usually win.

"There are more plaintiffs' lawyers here (in Belleville) than in Chicago," observes a local newspaperman.

"That's because we are successful," says Bruce N. Cook, Harvester's chief adversary here and Mr. Stambaugh's attorney. Mr. Cook has beaten Harvester twice this year, including a $3.5 million out-of-court settlement for tractor fire burns suffered by an Alsey, Ill., farmer, Stephen Gauges.

Harvester's post-trial motions here in the Stambaugh case have fueled the controversy. Robert D. Owen of Decatur, Ill., Harvester's chief trial lawyer, declined to discuss his views on the Stambaugh case—unlike Mr. Cook.

Instead, Mr. Owen had his say in a 28-page brief filed after Thanksgiving. Demanding that the case be retried or that the verdict be thrown out, he raised more than 130 objections. About 20 were related to law or to fact, 30-plus to Mr. Cook's conduct before and during the trial and another 80 relating to Judge Richard Goldenhersh's handling of procedural matters.

Harvester and Mr. Owen charge:

- Inadmissible evidence about Harvester's insurance coverage was available for the jurors to see during their unsequestered deliberations.

Continued on page 95

Coming up

What risk assumption techniques will dominate the decade of the 1980s? Captives? Pure self-funding? Novel cash-flow plans underwritten by insurers?

Business Insurance is zeroing in on captives and self-insurance questions for its Jan. 7 issue, the first of 52 issues in 1980 as a weekly newsmagazine. A special report on self-assumption of risk will also look at how small and medium sized businesses incorporate self-funding techniques in their risk management planning, how competitive insurance markets affect corporate risk management programs and more.

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The status of tort reform around the country will be summarized in the *Business Insurance* Product Liability Scorecard to be published Dec. 24.

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for your information

Management consultants to unveil proposals to reorganize NCCI

CHICAGO—A management consulting firm is expected to unveil proposals this month for reorganizing the National Council on Compensation Insurance.

The consultant was hired because NCCI member insurance companies were dissatisfied with NCCI's inability to get what they consider adequate workers compensation rate increases in most states, admitted vps from three major workers compensation underwriters.

If NCCI's board of directors approves the reorganization recommended by consultants Booz, Allen & Hamilton, decentralization efforts and coordination of activities between the central office and the rest of the states will proceed immediately, said George Reall, retiring president of NCCI. NCCI requests workers compensation rates for insurers in 31 states and acts as a consultant in half of the remaining states.

News of the possible reorganization and the announcement of Mr. Reall's retirement came as a surprise to most of the employes in NCCI's main office in New York, said an NCCI staffer. "Most people here were totally unaware of what was going on," he said.

Ill. revokes broker's license

CHICAGO—The Illinois insurance department has revoked the brokers license of Richard Kinst, principal of Kinst Insurance Inc. here and Atlanta, Ga., pending his response to the department's audit of his firm.

Mr. Kinst allegedly owes commercial and personal lines insurers more than $850,000, according to the unreleased insurance department report, and he has not yet responded to the insurance department's charges (*BI*, Nov. 12).

The broker's lawyer, however, told *Business Insurance* Mr. Kinst has not yet asked him to fight the revocation. Mr. Kinst, hospitalized three weeks ago for an unknown ailment, is not likely to respond to the charges until he is released from the hospital, his lawyer added. Mr. Kinst was hospitalized three weeks ago for an unknown ailment.

American Home Insurance Co. is thought to be Mr. Kinst's largest creditor, missing about $750,000 in premiums for an insurance package program for gasoline service stations. Underwriters Insurance Co., one of the largest homeowners insurers in the Chicago area, has charged the Kinst agency owes it more than $100,000.

Model bill introduced in House

WASHINGTON—Rep. John LaFalce (D.-N.Y.) this month introduced the Commerce Department's model product liability bill (*BI*, Oct. 15).

The model bill gives manufacturers a tougher defense against product liability suits 10 years after a product is sold and offers more protection to companies if their products are altered or modified without their consent.

The model law (H.R. 5976) "is most equitable to both product users and manufacturers," Rep. LaFalce said.

P/C insurers suffer losses

NEW YORK—U.S. property and casualty insurers lost $1.45 billion on underwriting operations in the first nine months of 1979, according to the Insurance Information Institute. In the same period last year, insurers earned $778 million.

But investment income earned the first three quarters of this year was 36% more than last year and pulled the insurers' results ahead of last year. The $6.66 billion in investment income gave the insurers a net income after taxes of $4.89 billion for the first three quarters of 1979. In the same period in 1978, insurers' net income after taxes was $4.6 billion.

The $1.45 billion loss on underwriting operations in the first nine months of 1979 reflects a statutory underwriting loss of approximately $448 million and payments of approximately $997 million in policyholder dividends. In addition to direct payments to policyholders, these dividends include adjustments made under commercial insurance rating plans that take into account the insured's loss experience.

U.S., Germany revise tax

WASHINGTON—The U.S. and the Republic of West Germany have agreed to coordinate Social Security protection for workers spending part of their careers in either country.

Under the Dec. 1 agreement, a U.S. citizen working in Germany for an American firm will no longer pay Social Security taxes to both nations and will be covered under only one benefit plan. The same will hold true for Germans working in this country who, in the past, had found themselves subject to double taxation and coverage.

The agreement will also allow workers who could not otherwise qualify for benefits under either system to combine their work years as a single unit with both the U.S. and Germany paying a respective share of benefits due.

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Rock concert deaths may limit insurance for open-seat gigs

CINCINNATI—Fireman's Fund Insurance Co. wrote two spectators liability insurance policies for The Who concert here last week at which 11 rock music fans were killed.

The most tragic mob scene at any rock concert occurred when 7,000 general admission ticketholders stormed glass doors outside Riverside Coliseum. Insurers may now pull back from underwriting liability insurance for general admission concerts, one underwriter suggests.

But the next two stops of The Who's American tour are reserved-seat-only concerts, as are most rock concerts.

Electric Factory Concerts, promoters of The Who concert in Cincinnati, bought spectators liability insurance through the New York office of Albert G. Ruben Agency of Beverly Hills, a subsidiary of Alexander & Alexander.

Normally concert promoters buy a primary liability policy with limits of $500,000 to $1 million, said Don Cass, senior vp at Albert G. Ruben, and name the concert hall as an additional insured.

Neither the coliseum nor the concert promoters would discuss the specifics of their insurance policies.

Riverside Coliseum has a spectators liability insurance policy of its own, recently marketed to Fireman's Fund, *Business Insurance* learned.

National Union Fire Insurance Co., a member of the American International Group, was the previous underwriter, according to Sal F. Nociforo, vp American Home/National Union.

The Dec. 3 Who concert in Cincinnati was both reserved seating and open admission.

Concertgoers with reserved seats had been seated before the concert began without problem, but general admission ticketholders, many of whom got in line seven hours before the concert was to begin, panicked about getting the best seats remaining. They began smashing doors and surging forward after recorded music was heard from inside Riverside Coliseum.

Thirty-three Cincinnati police officers were stationed outside the Coliseum to control the crowd. Increased security personnel would not have been able to control the rush, said a spokesman for the Cincinnati Police Department. "Once you're in a push and shove situation, you have no choice but to move with the crowd," the spokesman added.

Lawsuits for damages are likely to take a "shotgun approach," naming everyone involved with the concert including the city and The Who, a British group whose off-stage antics have caused past problems for underwriters (*BI*, Oct. 29).

Cincinnati self-insures its liability risk, an official in the city's risk management department said. The Who is insured by Lloyd's of London through the Adams Brothers syndicate.

Insuring rock concerts has been good business when priced properly, said National Union's Mr. Nociforo.

However, underwriters have reduced prices in recent years, without taking into consideration the catastrophic exposure.

In many cities, crowd control has not been good, Mr. Nociforo noted. General admission seating aggravates the risk and is a negative underwriting factor for several reasons, including the uncertain number of people in attendance, he added.

As a result of the deaths at the Cincinnati concert, underwriters could become reluctant to write general admission concerts in the future, Mr. Nociforo added. •



Photo: Kathryn J. McIntyre

United Opera Co. manager Rutha Jessup (left) and Mary Ann Mozga are still rehearsing.

Broker's quick response fails to raise curtain on the opera

By LEN STRAZEWSKI

CHICAGO—"The show must not go on," the Auditorium Theater here told the United Opera Co., citing insurance regulations.

But, fancy footwork to snare the needed insurance policy almost saved the show.

"We just started too late," explained opera company manager Rutha Jessup. "It was 7 p.m. on the Wednesday before Thanksgiving and we realized we hadn't bought amusement insurance for our performance the following Sunday."

The company was scheduled to perform Verdi's "The Masked Ball," Nov. 25.

The opera troupe's broker was closed for the holiday weekend, forcing Ms. Jessup to postpone the performance until January 1980, but a patron almost saved the show.

Ms. Jessup was referred to Frank Marchant & Associates, a minority brokerage here merging with Beneficial Agency Inc.

"We're open practically around the clock," said principal Frank Marchant, "and I'm always here from 9 a.m. until midnight. So when we got Ms. Jessup's call, we just started calling underwriters."

The brokerage finally reached an underwriter for MGA American Amusement Underwriters Inc.—through his wife.

"We never actually talked to the underwriter," Mr. Marchant explained. "His wife managed to reach him and explain the risk and relay rates back to us. He agreed to come in on Saturday and bind the risk for the National Union Fire Insurance Co."

The broker had the coverage ready at 10 p.m. on Friday with the assurances of a Saturday binder, but couldn't reach Ms. Jessup before she announced the postponement. Frank Marchant & Associates will place the coverage with National Union for Jan. 6, 1980, performance, however. The $500,000/$1 million property and spectator liability policy, for an audience minimum of 4,000, will cost the troupe $351.

the benefit beat

Transit workers win drive for health plan

Two unions, Amalgamated Transit and United Public Employes, have won improved health, life and dental benefits in a recent strike settlement with Bay Area Rapid Transit in Oakland, Calif.

The new health plan, effective Dec. 1, increases hospital coverage through the employe's choice of Blue Cross or Kaiser-Permanente to 365 days from 70 days and major medical limits to $1 million from $250,000. Relative value schedule surgical fees were upped to $9 from $6. Also expanded was a supplemental inpatient accident benefit to $500 from $300 and outpatient lab and x-ray coverage of $100 per accident or $100 per calendar year for sickness was added.

Additional benefits will be phased in gradually during the lifetime of the three-year contract. Next year, employes will get a prescription drug plan which pays 100% of costs with a $1 deductible per prescription as well as a vision care benefit covering examinations, frames and lenses with a $10 deductible.

In July 1981, coverage for prosthodontics will increase to 90% from 50% of usual and customary charges and orthodontic benefits begin the following January to pay 50% of charges with a $50 deductible and $500 lifetime maximum.

BART pays the full premium for all employe benefits, including expanded life insurance equal to each employe's annual salary. Banker's Life of Iowa underwrites the life insurance and administers claims on BART's self-insured dental plan. A BART company spokesman said he expects Banker's Life to also underwrite the new drug and vision programs.

Pension revision

Pensions for salaried employes at Chicago-based Hart Schaffner & Marx will be based on their average pay for their last five years of employment instead of a career average, beginning in January. The change in the contributory plan will apply only to employes retiring in the future.

"The additional cost to the company will be about 50% higher than the current employer contribution," said Sherman Rosen, corporate director of compensation and benefits, but he declined to give dollar figures.

Hart Schaffner & Marx's pension changes follow other benefit increases earlier this year. Major medical benefits were raised to a lifetime maximum of $250,000 from $50,000; the maximum employe thrift plan contribution was raised to 6% of salary from 4%, and the company introduced a supplementary, optional employe paid life insurance policy equal to the employe's base salary.

About 55,000 employes participate in the health plan and about half that many take part in the pension and thrift plans, Mr. Rosen said.

PBGC boosts maximum

The Pension Benefit Guarantee Corp. next year will boost the maximum monthly pension benefit it will guarantee for participants of terminating pension plans.

For plans that terminate in 1980, the new monthly maximum guarantee will be $1,159.09, up from the current monthly maximum of $1,073.86.

Under the pension reform law, the PBGC pays out benefits to retirees whose pension plans terminate with insufficient assets to pay guaranteed vested benefits.

Currently, the PBGC is paying out a monthly average of $111 to participants of terminated pension plans.

$96,590 returned

Thirty-six former members of Local 23 of the International Typographical Union must receive a total of $96,590 docked from their profit sharing benefits after they went on strike at the Green Bay Press-Gazette, a federal judge has ruled.

The workers filed suit in federal court in 1975 after the Green Bay Newspaper Co. dropped them from its profit sharing plan and paid only 80% of the funds they had accumulated. The company said the workers were entitled to a reduced share of their funds because they had been "voluntarily terminated" and had gotten jobs at a strike paper.

Combined deductible

About 2,800 salaried employes of Purex Industries, headquartered in Lakewood, Calif., have received a combined, reduced deductible for major medical and dental care. A family now pays a single $50 deductible that can be applied to either medical or dental costs. Formerly, the plans had separate $100 deductibles. The policies are self-funded.

Another change in Purex's medical insurance plan is a $5,000 limit on out-of-pocket costs to a family. The company pays 80% of the bills up to that limit and 100% of further costs.

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Benefit Beat keeps risk managers and employe benefit managers abreast of changes in plans around the country as well as other important developments. We'd like to know if you've made any changes or know of any significant developments. Write Kathryn J. McIntyre, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611 or call (312) 649-5286.

High court reaffirms expanded longshore act

By JERRY GEISEL

WASHINGTON—Maritime workers who may never work on a ship or the water are still covered under the federal Longshoremen's and Harbor Workers Act, the Supreme Court ruled last month.

The unanimous decision upheld a U.S. Court of Appeals ruling that two Texas workers were covered under the federal act rather than under the state workers compensation program.

A huge new class of injured workers will now be eligible for the federal benefits, which are sharply higher than if the workers were covered under state programs.

For example, the maximum weekly workers compensation benefit in Texas is $105, about one-fourth of the $426.26 payable under the federal act.

The tendency of the court in recent years to extend the scope of the longshore act has begun to arouse some concern in Congress. A House Education and Labor subcommittee held a round of hearings last month on legislation introduced by Rep. John Erlenborn (R.-Ill.) that would limit the jurisdiction of the federal act to the point of rest—the spot where the cargo comes off the ship and is put down on the ground.

However, it remains unclear if Congress will take any steps this session to enact the Erlenborn legislation.

At issue before the court was whether the federal act applied to workers who engaged in "maritime employment" but never worked on ships or the water.

The injured men's employers argued the federal act did not have jurisdiction because the two men performed jobs that were based entirely on shore and didn't deal with docked vessels.

One of the injured workers tied down military vehicles on railroad flatcars for P.C. Pfeiffer Co. in Beaumont after they were unloaded from a ship. The other worker was injured while unloading a bale of cotton from a dray wagon onto a pier in Galveston for Ayers Steamship Co.

The court said that the federal act focuses on the nature of the work, not where the work is performed. Since the two men "were engaged in intermediate steps of moving cargo between ship and land transportation," they were engaged in maritime employment and thus covered under the federal act. ■

N.Y. may postpone safety regulations on boiler operation

ALBANY, N.Y.—New York state businesses using high pressure boilers may get a six-month break before hiring certified boiler operators to comply with a new state labor department safety regulation.

The regulation, scheduled to take effect Jan. 1, mandates the presence of certified boiler operators whenever high pressure boilers are operating, even when automatic systems are working. The rule affects single or tandem-operating boilers producing 40 horsepower or more.

The New York senate-assembly administrative regulations review commission is spearheading the delay plan in response to industry testimony presented at a Nov. 1 hearing.

Meanwhile, a task force of industry labor boiler experts is trying to achieve a compromise on the regulation.

Boiler and machinery experts in the insurance industry, however, lean in favor of the regulation in spite of the costs to firms that will have to hire operators.

Certification of boiler operators will improve safety used with automatic controls, said Donald J. Coelbel, assistant vp at Marsh & McLennan. "It will be a beneficial development, but it will have a definite financial impact upon corporations with boilers."

Many firms already have qualified, experienced operators on staff who can become certified upon their experience, Mr. Coelbel noted. But small and midsize companies are more likely to feel the regulation's impact than their larger competitors, he added.

William Schumacher, a boiler and machinery loss control engineer with the Kemper Group's Melville office, also supports the regulation. Although most firms with high pressure boilers have qualified operators, they do not employ them around the clock, he noted.

Typically, for the late night shift these firms employ a general maintenance person who is not always totally competent to run a boiler, Mr. Schumacher explained.

Many modern, large boilers are equipped with automatic controls, but those controls are good to a limited degree, pointed out Jack Lyon, director of risk management at Ingersoll-Rand. He previously was insurance manager for Babcock & Wilcox, one of the nation's largest boiler manufacturers.

"Automatic controls are like computers. They work fine, but they have their limits and they can malfunction," Mr. Lyon said. "When you have high pressure boilers, you need competent people manning the controls to shut them down in an emergency."

Certification and round-the-clock supervision of high-pressure boilers are presently required in eight states, the District of Columbia and the Panama Canal Zone. In at least 25 U.S. cities, including Buffalo, New York and White Plains, certification and supervision of boiler operators are incorporated into local ordinances.

Hartford Steam Boiler Inspection & Insurance Co., however, the nation's largest boiler and machinery underwriter, says its records do not show whether or not certification is beneficial, says John R. Eklund, director of marketing development.

"If our records could show (certification) being beneficial we'd be right there," he said.

Hartford Steam Boiler has taken no formal position on the labor department regulation, but James Stevens of Hartford Steam Boiler's engineering/claims department has said, "From my viewpoint, those regulations won't make boilers any safer than they are today."

Kemper has no rules for considering boiler operators in rating, Mr. Schumacher said. But if there are incompetent operators or no operators present during an inspection, underwriters probably would take this into consideration. ■

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10 experts to judge risk exec competition

What makes a winner?

The nine criteria to be used in selecting the winner of the 1980 award broadly indicate that an outstanding risk manager will have accomplished one or more of the following tasks:

- Established and implemented an effective risk management program.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applied the diverse tools of risk management and insurance.
- Established a workable intelligence system inside and outside the organization, culminating in access to information about events and activities affecting the organization's risk management and insurance programs.
- Skillfully applied the principles of management in the overall organization and within the risk management/insurance department.
- Achieved the most effective program at the optimum cost over the long term.
- Demonstrated technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operational aspects of the job. These categories include insurance, safety, law, industrial hygiene, claims control/administration, underwriting, communications and information systems.
- Demonstrated an attitude and participated in activities fostering the advancement of the risk management profession.

CHICAGO—*Business Insurance's* third annual Risk Manager of the Year competition will draw on the talents of last year's winner plus nine other industry experts.

Edward L. Erickson, director of insurance for ABC Inc. in New York and winner of the 1979 award for his outstanding performance at ABC, will join the team of judges this year.

Returning to judge the 1980 competition are John R. Cox, president of INA Corp. in Philadelphia, and Hal B. O'Connor, senior vp-operations for American Mutual Insurance Co. in Wakefield, Mass.

Edward D. Hansen, risk manager-attorney for Trans Union Corp. in Lincolnshire, Ill., and Ralph E. Gentry, insurance manager for Times-Mirror Co. in Los Angeles, are other prominent risk managers who have agreed to judge the 1980 nominations that close Dec. 31.

Representing the insurance brokerage community on the panel are John F. McCaffrey, executive vp of Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y., and William C. Cohen Jr., president of Insurance Management Associates in Wichita, Kan.

Dr. Thomas B. Morehart, associate professor of insurance in the college of business at Arizona State University in Tempe, will look at the nominees from an academic standpoint.

The risk management consulting profession is represented by Leonard J. Silver, principal, First Risk Management Co. in Wyncote, Pa., who has worked with corporate clients on insurance and risk management problems.

And looking at the nominees through senior management's eyes will be Kenneth F. Reimer, executive vp-operations at Dallas-based Lehndorff Group of Cos., a real estate holding and development company. Mr. Reimer has long been a leading proponent and practitioner of progressive corporate risk management at his former job with Austin Industries Inc. and at Lehndorff.

The award will be presented and announced in the pages of *Business Insurance* April 1, 1980. Forms to use in nominating a corporate practitioner of risk management may be obtained from the editorial headquarters of *Business Insurance*. The form lists the criteria and procedure to follow for entering a nomination.

Individuals eligible for nomination may be full-time or part-time insurance or risk managers or executives handling insurance and risk management as part of their overall duties. These managers may be employed by corporations, institutions or governments and are not restricted as to job title.

The competition is meant to foster the qualities of courage, innovation and upgraded general management and administrative skills among the men and women practicing corporate risk management.

Nominations may be submitted to *Business Insurance* by anyone in the insurance industry or the field of risk management. Names of those who nominate a candidate or the nominees themselves are not revealed.

To request a nominating form, call 312-649-5278 or write to the Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611. ■

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LOUISVILLE—Local insurance agents in Assurex International have beefed up their risk management services capabilities.

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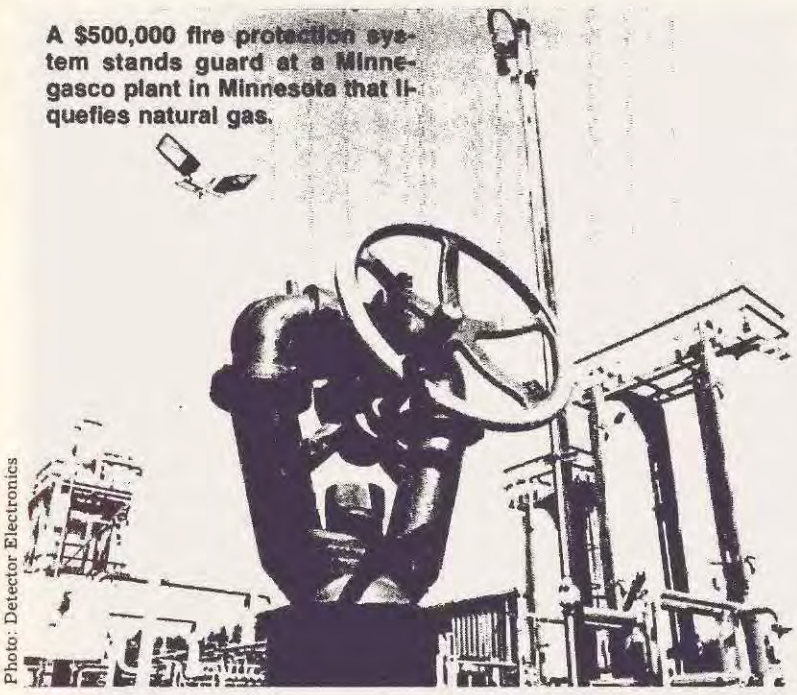
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BI-4



A $500,000 fire protection system stands guard at a Minnegasco plant in Minnesota that liquefies natural gas.

Photo: Detector Electronics

Gas plant spreads sensors to defuse explosive problem

BURNSVILLE, MINN.—Product flammability is a potentially explosive problem for liquefiers of natural gas, but one company—Minnegasco in suburban Minneapolis—couples careful plant design with a $500,000 fire protection system to tip the safety scale in its favor.

The Minnegasco plant here is capable of liquefying five million cubic feet or vaporizing 70 million cubic feet of natural gas daily.

"There are hazards anytime you handle flammable hydrocarbons, but I wouldn't say it's a high risk," said John Somrock, manager of gas control at Minnegasco.

Although Minnegasco has handled natural gas for 10 years, it has never had a fire.

But the $500,000 protection system at the company's only liquefication plant "makes good, plain common sense," Mr. Somrock said.

The investment is only about 2% of the replacement cost of the facility, estimated at $25 million to $30 million. And when thinking in terms of the product value, "half a million dollars is very cheap protection," he said.

The plant has been liquefying gas for about 18 months, although designing of the fire protection system began about a year earlier. The sophisticated system, now fully operational, consists of a network of 18 ultraviolet flame detectors, five low-temperature sensors to detect liquid spills and 15 flammable gas sensors to detect gas vapors. All are linked to an integrated alarm system within the plant.

Hazardous areas of the plant are monitored by one or more of these sensors. If the ultraviolet or low temperature detectors are triggered, dry chemicals or high expansion foam is automatically released.

However, since the gas vapor detector sounds at low levels, Mr. Somrock said "it gives sufficient time for operator intervention." The system, he said, usually detects minor problems such as small pipe leaks, which are easily corrected.

"It's very easy to have a fire anywhere when dealing with flammable liquids. We don't want a small fire to go into a big involvement," Mr. Somrock said.

This type of sensor system came into vogue following the energy crisis of 1973, said Alan Peterson, vp of Detector Electronics, Minneapolis, marketers of the sensors.

The cost of hardware alone for the Minnegasco system could be about $35,000, Mr. Peterson said, but price ranges depend on the company and the protection system requested.

Fire protection at Minnegasco doesn't end with sensors that operate at the speed of light. Backup systems include automatic shutoff valves for the gas and a water sprinkler system to douse all adjacent buildings in the event of a fire.

The company also requires all operators, supervisors and management personnel to attend its own fire training school. At a training site, Mr. Somrock said, all types of fires are simulated so operators can learn to deal with them.

This "gives (employes) confidence to go in and put out a small fire," he said. It also reduces the fear factor which often compels a person to run from the scene of a fire, Mr. Somrock said.

The company has never had any problems obtaining property or liability insurance for this or other facilities, Mr. Somrock said. However, since the fire protection system became operational, the company's insurance rates have gone down, said John Slogan, coordinator of claims and insurance for the gas company.

"Rates are lower now than a year ago, but the system wasn't installed with that in mind," he added.

Industrial Risk Insurers underwrites the firm's property insurance with a nominal deductible.

However, for liability risks, Minnegasco has a substantial self-insured layer and policies are underwritten by Associated Electric Gas Insurances Services Ltd., the gas industry's mutual insurer in Bermuda, and Lloyd's of London. ■

Malpractice cover

INA Special Risk Facilities has formed INAPRO, an underwriting company that will specialize in medical malpractice coverage for large groups and associations. Peter H. Foley has been named president of the new subsidiary, which will be based in New York. INAPRO has underwriting supervision over insurance programs for several large medical associations, including the American Assn. of Nurse Anesthetists, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.



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editorial opinions

Exercising clout

COMPANIES SHOULDN'T necessarily believe they have to be part of a group to exercise some influence over the health care bills they pay.

There has been lots of talk for several years but relatively slow progress by employers who believe they should be involved in the health care business in order to hold down the rate of inflation in hospital costs.

Companies joining together to exert collective clout, of course, may have quicker success in making their influence felt. But individual employers, too, can do their part. Anybody employing more than a couple of hundred people in one location can walk into the local hospital administrator's office, wave some figures in his/her face and force the administrator to recognize that the bill-payer is upset.

One person who believes individual employers have a lot more power than they ever use, ironically enough, is Wanda Jones, a hospital consultant in San Francisco. She thinks health care providers would respond right quickly to employers who make noise. "Right now, providers are responding primarily to Medicare and Medicaid because they are the most active purchasers of health care," she says.

As a story in this issue points out, employers have banded to assert their collective influence in such cities as San Diego, Los Angeles, Stamford, Philadelphia and Toledo. Ms. Jones says she has helped such groups, particularly in Portland, Ore., create organizations designed to enable employers to sit across the table from health care providers to discuss medical care. Topics have included the nature of reimbursement in the region, the need for and the cost of outpatient services, the applications and opportunities for the hospital in providing on-site testing and treatment for employes in the area of industrial medicine, the need and cost for rehabilitation services, hospital and employer involvement in local HMOs and diagnostic services.

Even an individual employer can do this, by writing down the number of employes in a given hospital's area and waving the figures in an administrator's face. "In a 'down market' for the hospital, or in an area where the hospital depends on that employer's workers for revenues, the administrator will do almost anything an employer wants him to do to keep the employer happy and using the hospital," Ms. Jones contends. It's perfectly proper to ask an administrator to discuss the local hospital's capital budget, she adds.

The key to the whole process is using purchasing leverage to get hospitals to "bargain" over these issues with the employer or employers in an area. Though employers have generally not recognized their power or used it, they are important determinants of local and national health care delivery.

A few unions along with several large employers like IBM, General Tire & Rubber Co., Sybrom and Rockwell International first began paying for second opinions on surgery, participating in local planning agencies and on hospital boards and using internal data systems to scrutinize hospital admissions, costs and length-of-stay statistics to pinpoint areas where costs were out of control.

It is high time more companies—even the smaller ones—caught on to what they can do, individually and collectively, to manage hospital costs and health care bills. Instead of a few dozen companies involved in this, there should be hundreds.

The coalition of employers and health care providers can be productive in other ways, too, forging a consensus about the most efficient system. If anything, that should stave off more government regulation of hospitals and more health insurance legislation for employers.

letters

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible and we reserve the right to edit or shorten letters for clarity or space. Please send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Drug programs

To the editor: Your article of Nov. 12 on drug programs listed the two methods for administering drug programs, but failed to list the major differences: Reimbursement plans cost one-third to one-half less than ID card plans, cover over 1,600 non-prescription items not covered by ID plans and a mail order option is standard with most reimbursement plan administrators.

The cost differences are appreciable. The auto industry program in California has an approximate claims cost of $9 per month with a $3 deductible per prescription with insulin the only non-prescription item covered.

The cannery workers plan in California has a claims cost of $6.18 per month for reimbursing 100% of the reasonable cost and covers over 1,600 non-prescription items.

Samuel X. Kaplan
President, Prepaid Prescription Plans Inc., Los Angeles

Words of praise

To the editor: Just a brief note to let you know that the Oct. 29 issue of *Business Insurance* was one fine job! Considering that I've always thought highly of *Business Insurance*, please consider that a real compliment.

In-depth reporting (pardon the cliche, but it's entirely appropriate here), a most interesting and varied group of topics and, of course, your usual first-class writing.

Congratulations!

David M. Monfried, CLU
The Equitable Life Assurance Society of the U.S., New York

Basic fallacy

To the editor: In response to your editorial "Health care economy" (Nov. 12), I believe there is a basic fallacy to your suggestion that the health care consumers have price comparison information on various hospitals. In spite of your observation that more patients are accessing the health system through ambulatory care facilities, the physician still predominantly determines the facility to be used.

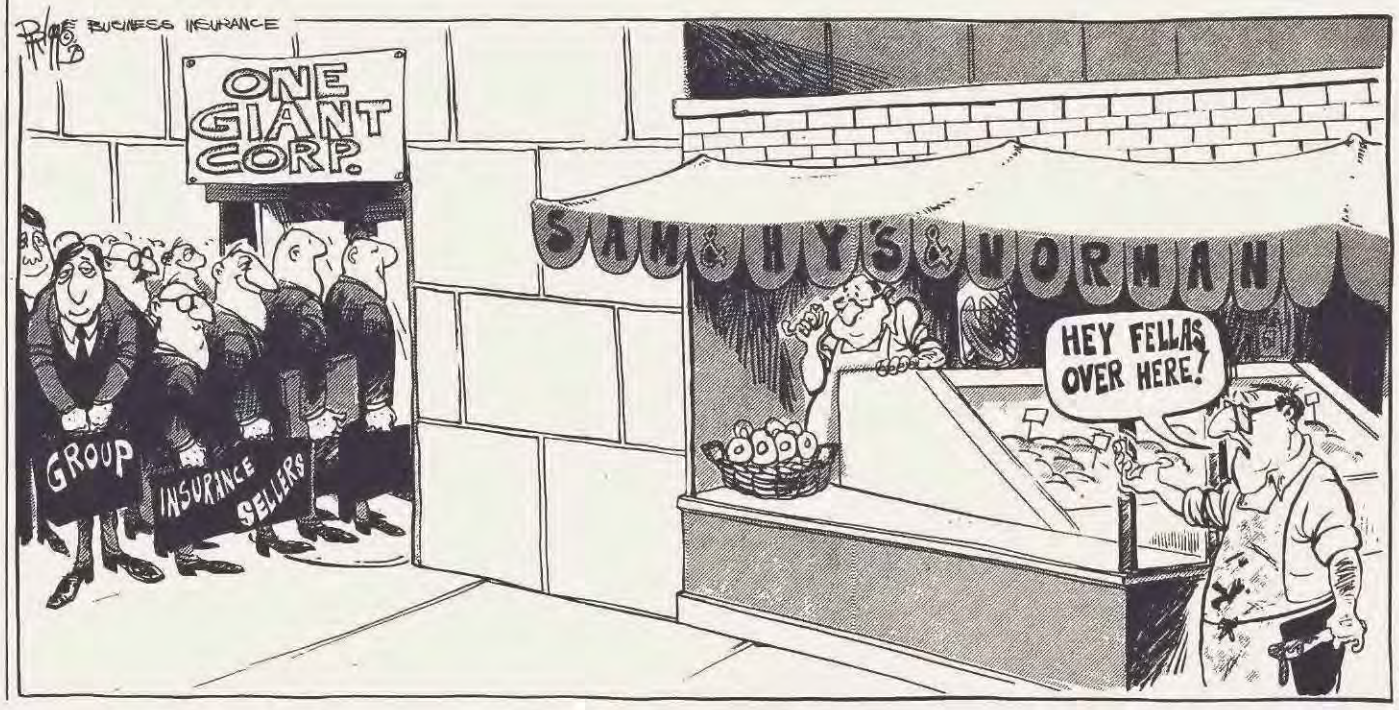
Even patients who originally are seen in an ambulatory care setting have come there primarily due to geography, not price comparison. A private physician is usually assigned who may or may not keep the patient in that facility.

Multi-staff privileges provide for selective admissions by physicians. A consumer will not make the same objective choices concerning health care facilities that will be made in buying an automobile or home appliance. Why not? His personal health is at stake and he must trust his physician's judgment. Cost is secondary.

Incentives must be established to have the physician select the cost-efficient hospital, not the consumer. Presently, those hospitals providing the broadest range of services to all areas of medical specialization may be the least cost efficient.

Larry Hicks
Director of industrial relations, Lindberg Corp., Chicago

Continued on page 94



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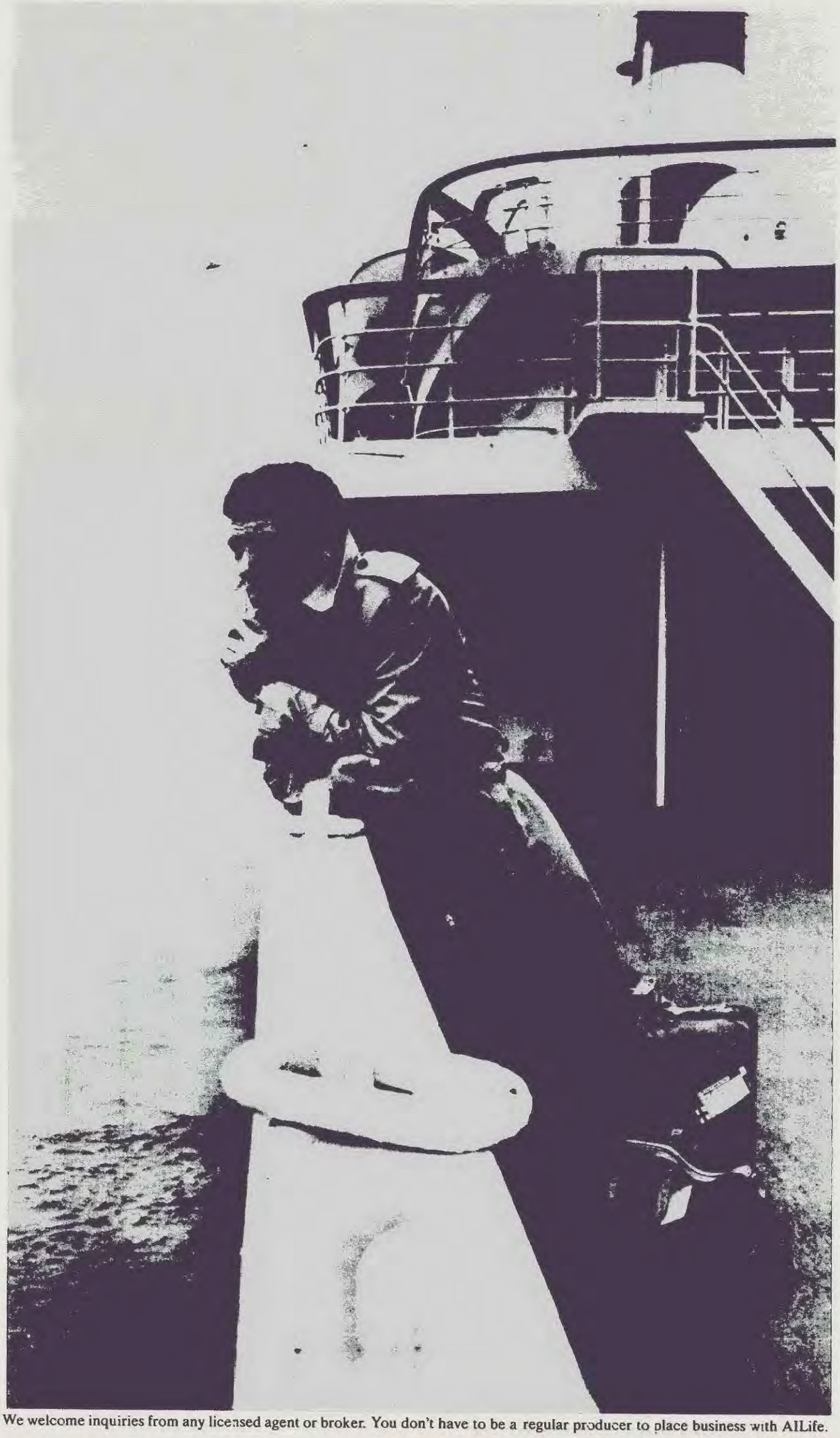
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A Member Company of American International Group

AIG dominates the N.Y. Free Trade Zone

By ELLIS SIMON

NEW YORK—American International Group could become the gatekeeper for the New York Insurance Exchange if it continues to dominate underwriting in the Free Trade Zone.

AIG companies have reaped 83.2% of the $3.7 million in premiums from business placed with Free Trade Zone companies during its first full year as an alternative insurance market.

As an alternative market, however, most insurers agree the Free Trade Zone is a flop—superfluous in the current competitive standard insurance markets.

Although 82 companies are licensed in the Free Trade Zone, only seven have utilized it; three of them are part of AIG. Others writing free zone business were Agway Insurance Co., $338,461; Greater New York Mutual Insurance Co., $237,049, and Insurance Co. of New York, $29,885. Prudential Reinsurance Co. wrote $68,000 in credited free zone reinsurance.

"I don't think there is much real need for the Free Trade Zone," said Jack Morrison, president of INA Special Risk Facilities Inc., one of AIG's major competitors. "For most of the things companies are willing to do, they could have found a way to do it prior to (the Free Trade Zone's) creation."

But as principal underwriter in the Free Trade Zone, AIG is setting itself up in the advantageous position of being able to take first crack at domestic risks heading for the New York Insurance Exchange.

Before direct, domestic risks can be looked at by exchange syndicates, they must be rejected by the Free Trade Zone companies. The exact number of rejections and the mechanics of the rejection system have yet to be established. The insurance department is waiting for the opinions of the exchange's board of governors before issuing a proposed regulation outlining the procedures.

AIG was one of the main champions of the Free Trade Zone, created by the same law that authorized creation of the New York Insurance Exchange. An insurance Free Trade Zone could give domestic insurers the edge to better compete with Lloyd's of London, AIG argued.

An insurer licensed by the New York Free Trade Zone is permitted to underwrite high premium and exotic business risks without prior approval on rate and form from the insurance department.

Some insurers and brokers see the Free Trade Zone primarily as an impediment to access to the New York Insurance Exchange. The exchange can write direct domestic business only after it has been rejected by the Free Trade Zone.

L. Patton Kline, chairman of Marsh & McLennan Inc., has called for dismantling of the Free Trade Zone for just that reason.

However, Lee Barnes, executive vp of The Continental Insurance Cos., points out that the Free Trade Zone was never expected to "take off" until the insurance exchange started writing business.

"The underwriters on the New York Insurance Exchange will be different people from those in the Free Trade Zone," he noted. Underwriters on the exchange could be very interested in quoting on certain risks and, as a result, brokers would be willing to run business through the Free Trade Zone first.

Some of this business will be written by the Free Trade Zone companies if they are competitive, Mr. Barnes said. But there is a lot of business these companies cannot write in or out of the free zone and those risks could eventually wind up on the insurance exchange.

Analyzing the business written in the Free Trade Zone in its first full year, Mr. Barnes said traditional insurance markets can adequately handle any business eligible for the Free Trade Zone. The surplus lines market and admitted facilities are being fully utilized and Lloyd's is as competitive as ever, he added.

Bruce Ebert, AIG vp-marketing, countered that the Free Trade Zone has enabled AIG to develop innovative combinations of coverages and special programs in the financial services areas—directors and officers liability and fiduciary liability—that it might not have been able to have done otherwise.

"We've taken better advantage of the Free Trade Zone than our competitors," Mr. Ebert said. "Other companies have been more traditional and their underwriters might not have wanted to take advantage of it."

Free zone companies can write more than 300 kinds of exotic risks normally underwritten by surplus lines companies, but few have chosen to compete, noted Gerard J. Nolan, president of the New York State Excess & Surplus Lines Assn.

Any business lost by surplus insurers to standard markets would have been lost regardless of the free zone's existence, he said.

Few admitted companies have the talent and are willing to write the exotic classes open to them as free zone insurers, one underwriter said.

Officials at the Atlantic Cos. said they declined to write their only Free Trade Zone inquiry, for roofing contractors liability, because they did not write the class. ■



"I don't think there is much real need for the Free Trade Zone," says Jack Morrison of INA.

Chem Spec plan sees 12 claims

WASHINGTON—Chem Spec Ltd., the product liability insurance program of the Chemical Specialties Manufacturers Assn., has seen only 12 claims filed in its first year, the trade group reports. Only two of the claims may possibly exceed deductibles.

Chem Spec issued 72 policies covering 78 firms, including parent companies with subsidiaries. ■



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Two sides meet

Exchange disputes being solved: Exec

NEW YORK—Regulatory disagreements between the New York Insurance Exchange and the state insurance department are being "ironed out," says exchange president Donald Reutershan.

"The insurance department always has overall regulatory responsibility over the syndicates and they won't give that up," he said. "But department officials said they will do whatever they can to make the exchange a useful, viable marketing system."

Mr. Reutershan, exchange attorneys and insurance department officials met Nov. 29 to work out disputes over the language in proposed Regulation 89, which would govern exchange operations. Sources on both sides described the session as "fruitful."

Two days earlier, exchange chairman T. Vincent Learson testified at a hearing that the regulation ran counter to the intent of the drafters of the exchange constitution and bylaws that the exchange regulate its members and the insurance department regulate the exchange.

The exchange's board of governors objects to several reporting requirements, reinsurance transaction rule requirements and a provision requiring syndicates writing risks rejected by the Free Trade Zone to comply with applicable provisions of state insurance law, testified Mr. Learson, the only witness at the hearing.

The exchange's attorneys recognize the necessity of the record-keeping requirements as being in line with good business practices, Mr. Reutershan said. The exchange's reinsurance transaction rules for domestic business will probably be neither more nor less onerous than those for other reinsurers, he added.

"Reinsurance markets already have a great deal of flexibility," Mr. Reutershan pointed out. "While the exchange offers a market presence, one of its advantages won't be because of rule changes." Reinsurance transaction rules incorporated into state insurance law are in line with good accounting practice, he noted.

There will be even less regulation applying to exchange syndicates' foreign business since foreign insurers usually compete in a freer environment than domestic companies, Mr. Reutershan said. Mandatory policy wording is not required on forms used to cover foreign risks, he noted.

Yet to be discussed by the two sides is the Free Trade Zone issue. The Free Trade Zone is a provision in state insurance law permitting especially licensed insurers to write high premium and exotic risks without prior approval on rate and form.

In its critique, the exchange board said requiring syndicates writing Free Trade Zone business to comply with applicable insurance law provisions would discourage syndicates from writing this business since they would, in effect, be treated like licensed companies.

The Free Trade Zone issue was of lower priority since exchange governors have not yet agreed on what should constitute rejection of a risk by the Free Trade Zone to be eligible for the insurance exchange, Mr. Reutershan said.

That issue, which has been highly debated by insurers and brokers, will be dealt with in an insurance department regulation yet to be released. ■

Ill. Lloyd's seeks rules by Jan. 15

SPRINGFIELD, Ill.—The Illinois Insurance Exchange will have draft bylaws available for interim governing board review by Jan. 15, 1980.

A legal committee charged with drafting the exchange plan was announced last week along with a financial/audit committee that will study exchange funding and an electronics systems committee to study communications systems for the project.

Peter Van Cleave, vice chairman and secretary of James S. Kemper Agency Inc., sits on both the legal and the electronic systems committees. Investment broker Richard A. Podesta of Altorfer, Podesta, Wollard & Co. is also doubling up on the financial/audit committee and the electronic systems group.

Donald Kramer, president of Kramer Capital Consultants, one of the key forces behind the New York Insurance Exchange, is also on the legal constitution committee. ■



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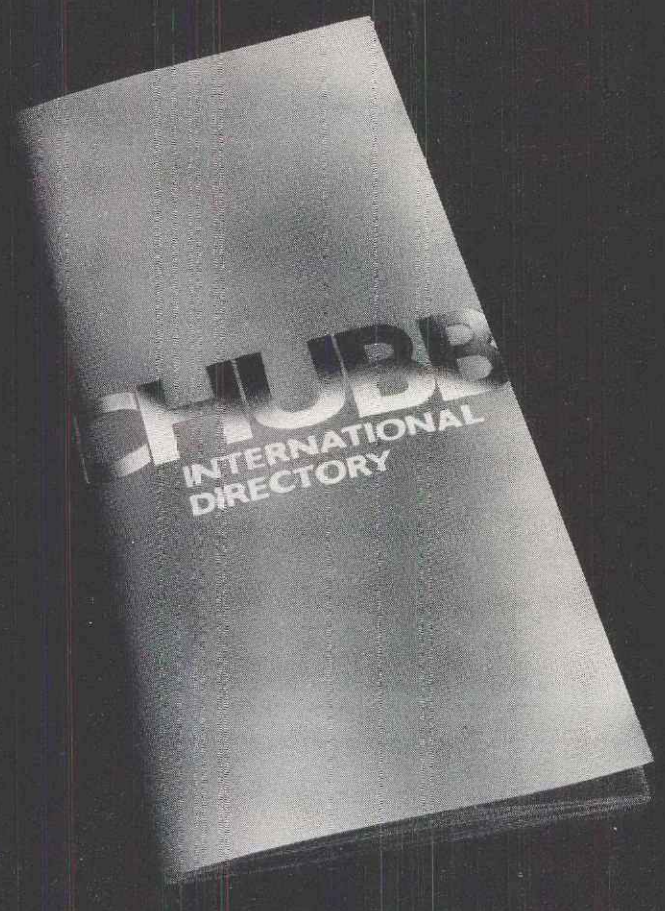
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Employe Benefits



Experts fear a benefit cost explosion as social pressures heat up demands

CHICAGO—Inflation, legislation, powerful unions and the needs of a changing workforce threaten to blow the top off employers' efforts to cap employe benefit cost increases in the 1980s, benefit experts say.

These forces will pressure employers to improve existing programs, add new benefits and offer employes more chances to shape their benefit packages, predict insurers, consultants and benefit managers.

"Benefit costs will keep going sky-high till we get something that works to control them," laments David C. Wineland, manager of compensation and benefits at Armco Inc. in Middletown, Ohio.

Increasingly concerned about higher benefit costs as the '70s shift into the '80s, employers aren't about to just cave in to the pressures.

Based on reporting by Stuart Emmrich, Jerry Geisel, Margaret LeRoux, John Maes, Mary Ann Matlock, Kathryn McIntyre, Mary Ellen McKee, Rhonda Rundle, Ellis Simon and Len Strazewski, this story was written by Ms. McIntyre.

They are forming coalitions, committees and task forces around the country to work with health care providers on holding down increasing costs. There's more talk of cost sharing with employes and attempts to teach thrifty benefit consumption.

More self-funding of benefit programs, especially by small and medium sized employers, is expected as firms try to tap the advantages of holding their dollars at least until the bills roll in.

But cost control efforts in the '80s won't preclude the addition of new programs to employe benefit packages.

Dental insurance, prized by employes, will spread from the West Coast and major unionized companies to other large and smaller employers, concurred 22 benefit underwriters, consultants and managers interviewed. Variations on thrift, savings and profit sharing plans will be added to supplement defined benefit pension plans whose value to retirees is dwindling and cost to employer is growing under the squeeze of inflation.

Prescription drug and vision care plans will be pushed onto the benefit roster by unions and possibly folded into more major medical plans.

Group auto and homeowners plans, which insurers promise to promote in the '80s, probably won't catch on among employers or employes until Congress grants them the tax-free status of group life and health insurance, it's agreed.

And group legal plans, perennially predicted to be just around the corner, still aren't in sight, say both insurers and consultants.

Of existing benefits, only disability income plans may be scaled back because they are so expensive, it's suggested.

Inflation is most often mentioned as a driving and molding force of benefit changes in the coming 10 years.

Union leaders are so concerned about the weakened buying power of their members that they list wages as their number one priority in the '80s. "But assuming we moderate inflation, we will concentrate on fringes that tend to improve job security," says John Zalusky in the research department of the AFL-CIO, namely improved early retirement benefits, more holidays and better supplemental unemployment benefits.

Retirement plans are seen as the most susceptible to changes forced by inflation, which Prudential Insurance Co. predicts will be less than the current 13% in 1980 but still double digit until midyear,

Continued on next page

Regulations, health costs worry execs: Poll

By SUSAN ALT

CHICAGO—The need to rein in runaway employe benefit costs that are prodded by inflation in the health care sector is the leading concern for the next decade among members of *Business Insurance*'s Employe Benefit Board.

Almost as worrisome to the benefit executives is a fear that the 1980s will see expanding federal and state regulation of employe benefits, already one of the biggest problems facing corporate managers handling benefit plans.

Growing regulation is contributing to a deluge of paperwork and escalating administrative costs, making managers ever-mindful of proposed legislation and regulation at all levels. This pressure alone apparently is prompting a great many benefit managers to visit state legislatures and Congress as expert witnesses trying to shape or reshape the form of benefit legislation and to participate actively in associations influencing legislative efforts.

The prospect of more regulation, legislation and inflation during the 1980s makes benefit managers worry the money won't be available to pay for already-established benefits, new benefits or mandated benefits.

A half-dozen of the 36 Benefit Board members responding to a survey said a current problem they have is competing with other corporate programs for the funds to administer present plans or upgrade benefit programs. They predict this will be even more difficult in the future as even more demands are made upon corporate cash. Three managers for very large corporations mentioned this as a real threat in the next decade.

Already inflation-related problems are far and away the biggest headaches of benefit managers, prompting at least half of the 36 benefit managers surveyed to take specific actions to lighten the economic burdens hitting employers, including:

- Joining with other employers to deal with health care providers.
- Exploring better or different benefit financing arrangements.
- Modifying plan design and/or instituting cost-sharing and coordination-of-benefit provisions.
- Investigating and/or instituting claims controls and other cost controls in benefit plans.
- Using fee schedules.
- Forming cost containment committees.
- Teaching employes about preventive medicine and how to be intelligent health care consumers.

Inflation not only forces up benefit costs but also creates exceedingly high expectations in the workforce as pay scales quickly rise year by year, the managers noted. Several benefit managers expressed concern about their companies' ability to meet expectations with better benefits and bigger compensation packages.

Of all the social, political, economic and regulatory forces buffeting benefit programs throughout the 1970s, this group of highly influential executives from many of the nation's largest corporations says legislation/regulation has been the most importance force. The com-

Continued on page 28

Forces Shaping Benefits

	Now	1980s
Economic factors/inflation	26	22
Regulation/legislation (state and federal)	22	30
Competition in the employers' industry	20	17
Corporate benefit manager	20	18
Employes of the company	17	18
Competition in region/locale	16	15
Political factors	14	10
Tax laws/tax reform	6	4
Social Security funding/benefits	4	5
Social pressures/demographics	4	5
National health insurance	3	6
Collective bargaining/labor pressure	2	2

Benefits don't draw recruits

The answer to "And what are your benefits like?" probably won't convince a job applicant to work for your firm, but it could drive the applicant away.

"It's gotten to the point where companies without comprehensive benefit packages stand out," observes David Skovron, a partner with consultants Kwasha Lipton. "People won't take a job because of a good benefit plan, but they will stay away from companies that don't have one."

A recent survey by Interviewing Dynamics in Chicago confirms that employes seldom choose an employer for the benefits package offered.

Less than 10% of the professional or executive employes switching jobs in Chicago recently said they did it for better employe benefit programs. Clerical or administrative personnel are lured a little more by the benefit package: 13% of these workers said they switched jobs for better benefits or working hours.

Among both groups, however, the generosity of the benefits package played fourth to other reasons for changing jobs: higher income, advancement potential and greater work satisfaction.

Experts fear cost explosion

Employe Benefits

Continued from previous page

when it could slow if credit tightening policies work.

"I can't see plan sponsors voluntarily adopting automatic cost-of-living adjustments to benefits," says R. David Parsons, chairman of Atlanta-based consultants Hazelhurst & Associates. "Plan sponsors will continue to grant ad hoc increases in benefits but they won't improve the pension benefit. There will be an improved role for savings plans."

The addition of defined contribution plans is suggested as a way for employers to supplement retirees' income from defined benefit plans without being forced into costly indexed pensions. Defined contribution plans offer a more cost-controllable and less government-regulated program that easily incorporates employe contributions.

"Most profit sharing plans today are non-contributory, but we think you'll see sponsoring organizations considering if not adopting employe contributions to help defray the terribly heavy costs," says Frank Peabody III, president of consultants Meidinger & Associates in Louisville.

Contribution plans

Defined contribution plans that permit early withdrawals are appreciated and used during inflationary times, notes Larry Fisher, president of consultants A.S. Hansen.

But inflationary pressures shrinking disposable income could also stem the flow of new benefits if employe contributions are demanded, suggests B.T. Hurley, vp of industry and government relations at Provident Life & Accident Insurance Co. "Dental is moving fast and is popular, but it may not move as fast unless the employer pays for it," he said.

Inflation-fighting wage and price controls that recognize the value of employe benefits could be part of more legislation and regulation of benefit plans expected to change the flow of benefits in the coming decade.

Benefit managers expect mandatory retirement will be outlawed, sending ripples of changes through benefit programs. More preretirement counseling plans and more incentives to early retirement will be created lest the workforce hang around forever, benefit executives say. Life and health insurance cost increases for older workers will be offset by savings on pension benefits, they add.

At the same time, more regulation of pension plans is anticipated as the President's Commission on Pension Policy and other groups probe the system for weak spots. If the private sector doesn't provide what is considered to be adequate retirement benefits, the public sector will intervene, warns Melvin Glasser, Social Security director for the United Auto Workers.

National health

National health insurance is expected in some form by nearly everyone. But benefit managers are crossing their fingers that existing plans provide the benefits that will be mandated.

One consultant, however, warns NHI will shower managers with paper work reminiscent of ERISA. "Employers are suddenly going to be faced with a deluge of paperwork and problems," says consultant Thomas E. Wahlrobe of The Wyatt Co. in Washington, D.C.

Taking health insurance off the list of benefits to be bargained for will set off new union demands for other benefits, predicts Robert Ostrander, second vp at Unionmutual Insurance Co. of Portland, Me.

"We have just about everything now; there's not much left but vision care and group legal," observes Richard Kroczyncki, manager of employe benefits for the unionized Uniroyal Inc. in Middlebury, Conn.

Unions are emphasizing job security, the need for full employment and better income protection for retirees. But they also admit to wanting to maintain benefit levels in this inflationary period—meaning higher benefit levels will be sought—as well as harboring some desire for new benefits.

A Teamsters spokesman noted that the workers would like to have more group auto and homeowners insurance plans, although the few plans negotiated to date didn't last long "because the premiums went out of sight."

Having nearly exhausted the list of insured benefits they can bargain for, the unions may go after sabbaticals and perks like group travel plans, the Teamsters spokesman added.

But the powerful unions' ability to negotiate strong insured benefit plans is still shaking down through other corporations that now feel compelled to offer competitive packages to hold their employes. Insurers and consultants expect the most growth and improvement of insured benefit plans to occur in medium sized and smaller companies forced by competitive pressures to imitate the union contracts.

The needs of a new mixed workforce will also change the mix

Continued on page 20

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Costs may skyrocket

Continued from page 18

of benefit plans in the coming decade, consultants and benefit executives stress.

More women working outside the home, more two-income families, the declining birthrate, increasing life expectancy, a more educated workforce and later retirement will all affect benefit plans in the '80s, says Robert D. Paul, vice chairman of consultants Martin E. Segal Co. in New York.

"Currently more than 50% of American women are working or actively seeking work," he said, and companies must provide women with equal pensions and disability for pregnancies.

Women will want benefit equality and portability of pension benefits, Mr. Ostrander of Unionmutual said. This could lead to more interest in defined contribution plans.

Employe Benefits

"More two-person working families means more demand for protective benefits like dental and vision care plans, savings plans, group legal, group homeowners and group automobile insurance," Mr. Paul said.

The declining birthrate, he noted, will affect pension plans, because "as the ratio of active to retired workers drops, the per capita Social Security tax must go up in order to pay retirees the benefits due them. In turn, the recent raises in both employer and employe taxation and Social Security benefit payments are promoting wider use of more carefully designed private pension plans which are integrated or coordinated with Social Security."

Increased life expectancy, Mr. Paul said, will prompt actuaries to look more closely at pension plan mortality tables, increasing pension costs unless people postpone retirement beyond that age.

A more educated workforce, he said, "will have larger expectations which will be felt in demand for higher initial salary levels and more and better benefits. Most important, a better educated workforce will probably exhibit greater interest in how pension funds should be invested and what type of retirement programs are most beneficial," he added.

Retirement plans

"Later retirement has important effects on retirement programs," Mr. Paul said. "A demand for higher levels of benefits may be created because pensions will be paid out over a shorter span of retirement years, beginning from age 70 instead of age age 65."

The mobility of the American workforce will also create strong demand for more portable pension benefits and decreased vesting periods, mused Arnold Glassman, manager of benefits, planning and compliance for Los Angeles-based Atlantic Richfield Co.

These changing needs will convince more employers to adopt flexible benefit programs that allow employes to pick among benefits and choose those that fill their needs, predicts Mr. Parsons of Hazelhurst & Associates.

Employers concerned about rising costs will try to make the efficiency plans of the '70s work in the '80s.

Employers will increasingly turn to HMO's to help cut total health care bills, it's predicted. Frank Loeffler, supervisor of employe benefits at Gulf States Utilities Co. in Beaumont, Tex., is waiting for space to open in a Louisiana HMO to offer enrollment to the Louisiana utility employes. "It seems to lower the number of days employes stay in the hospital," he noted.

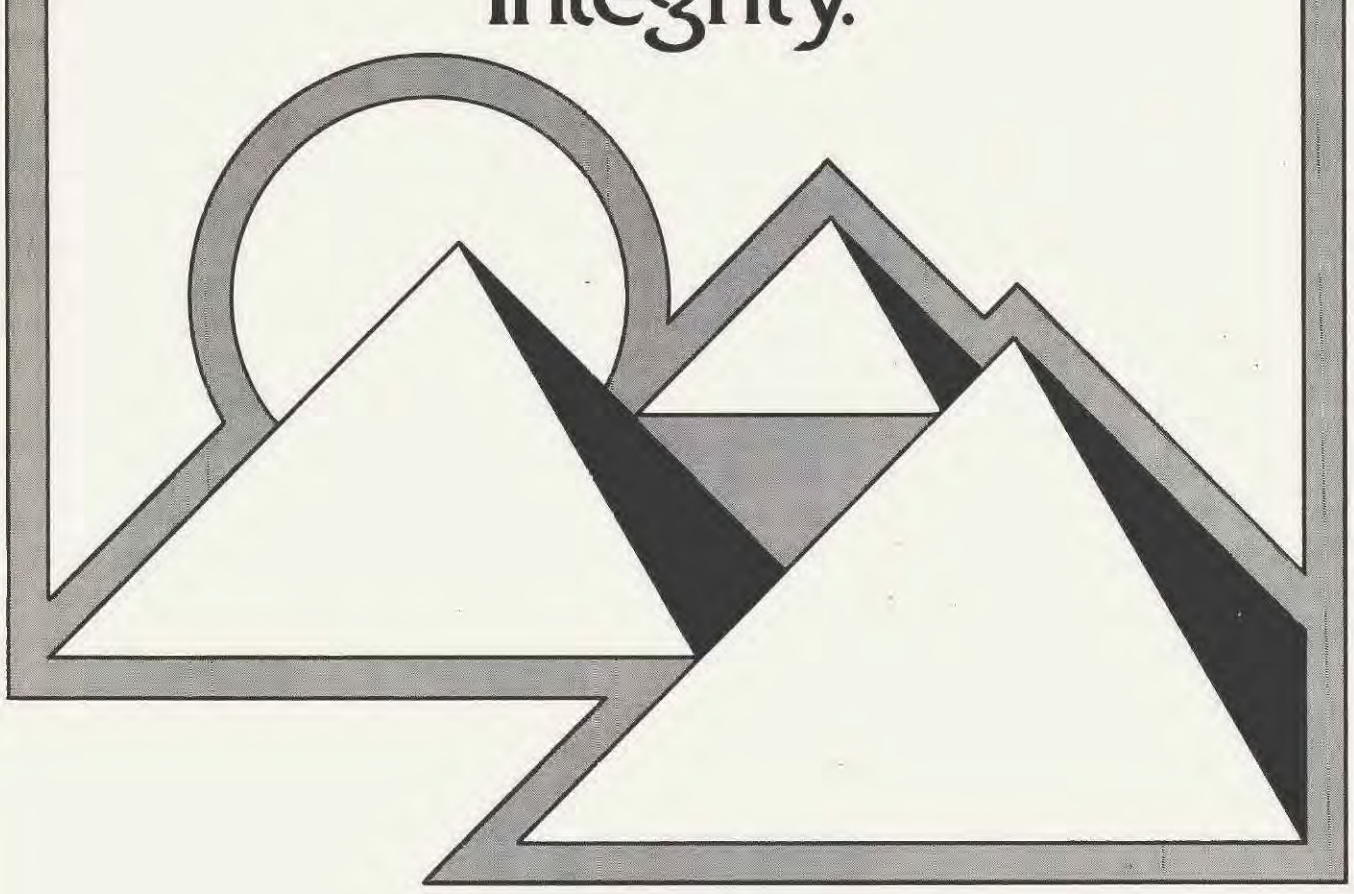
More second surgical opinion benefits, incentives for preadmission testing and outpatient surgery and health screening will be worked into more benefit plans to try to contain the cost of health care services, consultants and insurers predict.

Employers will also try to return to the health care cost-sharing practices of the 1950s and '60s, forecasts Mr. Wahlrobe of Wyatt, such as reintroducing limits on room and board charges for hospitalization.

Mr. Hurley predicts more deductibles will be reinstated.

Union representatives, however, vow to fight any new cost-sharing proposals like those or more deductibles and coinsurance. "We won't take a reduction in benefits," said Mr. Zalusky. ■

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New stance may swing NHI to first base

By JERRY GEISEL



A bill proposed by Sen. David Durenberger (D-Minn.) would give rebates to employes who opt for low cost, high coinsurance health care plans.

Employe Benefits

WASHINGTON—Advisers to President Franklin Roosevelt suggested in the early 1930s that a national health insurance plan be incorporated in a program to provide pensions to retirees.

But when Social Security was enacted into law in 1935, national health insurance had been dropped from the plan—a victim of intense opposition from medical and other groups.

In the 40 years since that first defeat, however, national health insurance has yet to step out of the batter's box.

Of the hundreds of national health insurance bills introduced in Congress since the New Deal, none has ever received full Senate or House approval. Sen. Edward Kennedy (D-Mass.), the leading advocate of national health insurance in the 1970s, has been unable to even move a bill out of committee.

National health insurance, though, is still swinging away. In 1965, the federal government began to provide comprehensive medical and hospital benefits to the growing over-65 population through the Medicare program.

In Congress today, national health insurance remains a priority issue with more than two dozen bills pending. **(See chart on facing page for the major proposals.)**

No longer is national health insurance a cause celebre of only the liberal members of Congress. Interest in national health insurance spans the entire political spectrum from ultra conservatives such as Sen. Robert Dole (R-Kan.) and Sen. Richard Schweiker (R-Pa.) to liberals like Sen. Kennedy and Rep. Al Ullman (D-Ore.).

Regardless of their political orientation, there has been a radical shift among members of Congress over the years in how a national health insurance plan should be structured and what it should accomplish.

"The largest single difference has been a moving away from a truly comprehensive government-run plan to a plan that closes the gaps with a focus on the existing private system," says Willis Goldbeck, director of the Washington Business Group on Health.

Sen. Kennedy, for example, in a remarkable shift from his earlier position in which he advocated a government takeover of health insurance similar to the British system, now would allow employers to continue to purchase benefit policies from private insurers. The government would continue to provide coverage for the elderly and those not covered under an employer plan.

The Kennedy shift away from a massive public program to one that fills in the cracks in existing coverage represents a recognition that government lacks the resources to pay for a huge public program, according to consultant Steve Schanes, president of Schanes Associates in San Diego, Calif. "There is just no room in the budget" for an all-encompassing program, Mr. Schanes says.

Although the latest Kennedy proposal is considerably scaled-back from his original plan, his bill still represents the most ambitious and expensive of the myriad proposals.

Under the Kennedy plan, employers would have to offer full coverage for hospital care, physician services in and out of the hospital, laboratory services, ambulance services and medical equipment. For expansive catastrophic coverage, an employer plan could not limit the number of covered hospital days or number of physician visits to patients.

The government would pay for coverage for the poor, the elderly and the unemployed under Sen. Kennedy's plan.

Although it is difficult to measure just how expensive Sen. Kennedy's latest proposal would be, the American Medical Assn. said enactment of the plan would result in "huge costs" and lead to "rationing of health care services" by inflating demand without increasing the supply of medical care.

The Carter Administration reportedly had considered championing a bill similar to Sen. Kennedy's. But a "womb to tomb" plan like Sen. Kennedy's was rejected because it had about as much chance of passage as an "elephant passing through a keyhole," former HEW secretary Joseph Califano remarked at the time the Administration unveiled its national health insurance plan.

Under the Carter plan employes could pay the first $2,500 of their family's health care services, unless an employer chose to provide a more liberal plan. Employers could continue to purchase this catastrophic protection from private insurers or they could buy health insurance from the federal government to cover employes' medical and hospital costs of more than $2,500. The premium for the federal insurance would be 5% of payroll.

President Carter also would pour more than $18 billion in federal funds into merging the state Medicaid program, which provides benefits to the disabled and the poor, with Medicare, which provides benefits to the elderly.

Benefits would be sharply improved for the elderly and disabled under the new program, to be called Healthcare. Healthcare would be structured in such a way that out-of-pocket expenses could not exceed $1,250 annually.

Because of the huge costs, informed observers say the Carter and Kennedy bills have no chance of passage. If a national health insurance proposal has a chance of passage, it will be legislation that deals only with catastrophic medical and hospital expenses, most agree.

A catastrophic bill would have the most support "because it would be least expensive and easiest to superimpose on the existing (health care) system," Mr. Schanes says.

Catastrophic legislation is backed by Sen. Russell Long (D-La.), the powerful chairman of the Senate Finance Committee. Mr. Long would give employers the option of purchasing catastrophic insurance from either private insurers or a public plan. The insurance would cover all medical and hospital expenses that exceed $2,000.

Meanwhile, Sen. Dole also favors the catastrophic approach, but he wants the deductible limit pushed higher—employers only would be obligated to cover medical and hospital expenses that exceed $5,000.

Trying to bridge the gap in the different deductibles sought by Sen. Long and Sen. Dole, the Senate Finance Committee staff last month recommended a family should not be required to pay more than $3,500 a year in medical and hospital bills.

Under this compromise, employers would purchase catastrophic insurance to cover health costs above $3,500. Employes could be required to pay up to 25% of the catastrophic insurance premium.

The latest major batch of national health insurance bills has been labeled the pro-competitive approach. Sen. Richard Schweiker, for example, wants to require employers to offer their employes a choice of at least three competing health insurance plans. He reasons that if insurers are forced to compete, lower premiums and better benefits will result.

To encourage cost-sharing, Sen. Schweiker wants one of the three employer health insurance plans to allow employes to pay the first 25% of their hospital bills out of their own pocket, up to 20% of family income. The employe would receive as a tax-free rebate the premium difference between the high coinsurance plan and the other plans the employer offers.

Similarly, Rep. Al Ullman, chairman of the House Ways and Means Committee, wants employers to offer a low cost health plan with coinsurance or an HMO as well as a traditional full benefit health insurance program. A low cost plan would have to be offered if the company's group health plan costs the firm more than $75 a month for family coverage. The company then would be required to rebate 90% of the difference in cost between the comprehensive plan and the low cost plan to the employe.

If a comprehensive corporate health plan costs $140 per month and a high coinsurance plan costs $70 per month for family coverage, under Rep. Ullman's plan the employe would get $63, with the company retaining $7 to compensate for the additional expense of maintaining two plans.

In addition, Sen. David Durenberger, the freshman Democrat from Minnesota, is set to introduce a new bill that also would give rebates to employes who opt for low-cost high coinsurance health plans.

Under the Durenberger bill, an employer with more than 100 employes would be required to offer three health insurance plans. An employe opting for a low cost plan would receive a cash rebate representing the difference in monthly premium cost between the regular high cost indemnity plan and the high coinsurance, low-cost plan.

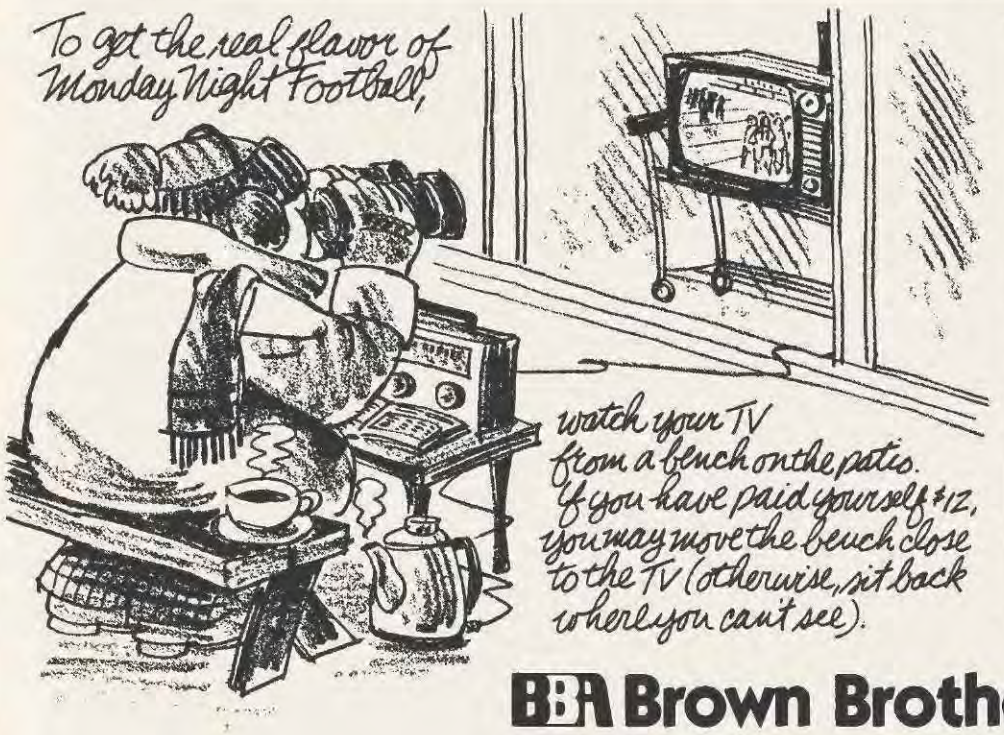
The Schweiker, Ullman and Durenberger bills recognize that national health insurance costs will zoom out of control unless employes are given a greater incentive to cool demand through cost sharing, one consultant says.

Most observers predict that if a national health insurance bill is to pass, it will be in the next six months. After that, Congress will be too preoccupied with campaigning for the upcoming national election.

If Congress misses the mid-1980 deadline, Mr. Goldbeck doesn't see any momentum developing for passage until 1982. ■

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National Health Insurance Bills

By JERRY GEISEL








Proponents & Proposals	Carter Administration S. 1812	Sen. Robert Dole (R-Kan.) S. 748	Sen. Edward Kennedy (D-Mass.) S. 1720	Sen. Russell Long (D-La.) S. 760	Sen. Richard Schweiker (R-Pa.) S. 1590	Rep. Al Ullman (D-Ore.) H.R. 5740
Coverage	Employers must pay annual health care costs of more than $2,500. Self-employed could buy coverage from the government.	Employer plans must pay annual employe health care costs that exceed $5,000 in a 15-month period.	Employers must offer a broad array of benefits in group health insurance plans. Full coverage for hospital care. Employes must be given the choice of joining an HMO.	Employers must cover employes who have been with the firm at least 30 days.	Companies with at least 200 employes must offer three plans, of which one must provide hospital coverage with employe coinsurance of 25%.	Employers whose family health insurance premiums exceed $75 a month must offer a low-cost group plan with coinsurance.
Catastrophic benefits	Annual expenses of more than $2,500 covered under employer plans.	Plan pays costs of more than $5,000.	No limit on the number of hospital days covered or physician care.	Employers pay annual health costs of more than $2,000.	Plans must pay medical expenses that exceed 20% of annual family income.	Plans to cover annual health care costs of more than $2,000.
Preventive benefits	Maternal care and childhood immunization. Employer pays for preventive benefits.	None mandated.	Basic immunization, pre- and postnatal maternal care and well-baby care.	Prenatal and well-baby care. Childhood checkups.	Employer plans must offer comprehensive maternal care, Pap smears, childhood immunization and well-baby care.	None mandated.
Medicare	Overhaul of Medicare into a new system called Healthcare for the poor and elderly. Healthcare would pay all bills above $1,250.	Expands medical and hospital benefits.	Removes deductibles and coinsurance for inpatient hospital services and post-hospital extended care services.	Expansion of medical benefits.	Eliminates 150-day limit on hospital benefits. No cap.	No change.
Penalties	Civil penalties for employers who fail to upgrade their plans.	Employes can sue companies that fail to provide catastrophic benefits.	Violations to be handled by state and federal boards.	Employers who fail to provide catastrophic benefits subject to tax of 150% of premium they would have paid.	No tax deductions for premiums unless employer offers choice of plans and provides catastrophic benefits.	Employes must pay tax on employer contributions that exceed $120 per month for family health insurance.
Premiums	Employer pays at least 75% of the premium.	Employer pays at least 75% of the premium.	Employers pay 65% to 75% of premium depending on firm's financial status.	No requirements on employer contributions.	No requirements on employer contributions.	Employer's contribution must be equal for high and low cost plans.
Extended benefits	Three months.	Three months.	Until new employment.	Six months.	Six months.	No mandate.
Remarks	This $24 billion bill is given no chance of passage.	The Dole measure is billed as the Republican alternative to national health insurance. Uncertain outlook.	The most expansive and expensive of the national health insurance bills. No chance of passage.	The Long measure has the best chance of all national health insurance bills that have been introduced. Senate Finance Committee is marking up measure.	Sen. Schweiker says the bill would save employers $3 billion because of cost containment features. Measure locked in Senate committee.	Rebates to employes who opt for low cost plans with high coinsurance. Bill backed by major hospital trade associations.

Chart: ©Business Insurance 1979

ERISA reform remains on the back burner

Employe Benefits

WASHINGTON—Comprehensive legislation to overhaul the pension reform law is in cold storage until a federal report examining the effectiveness of the government's 1978 reorganization of ERISA administration is published next year.

The report, being prepared by the Office of Management and Budget with assistance from the benefit community, not only will measure how effective an earlier reorganization was in cutting red tape, but also will examine whether ERISA administration would be significantly improved by a single agency—the cornerstone of Sen. Harrison Williams' (D-N.J.) and Sen. Jacob Javits' (R-N.Y.) ERISA Improvements Act.

Although Congress is not expected to act on major pension reform legislation until it has a chance to digest the OMB report, it is expected to approve legislation to limit federal guarantees of collapsing multiemployer pension plans.

The Pension Benefit Guaranty Corp. currently has discretionary authority to guarantee vested benefits of workers belonging to terminating multiemployer plans, subject to a monthly limit of $1,076.

This authority to guarantee multiemployer benefits would become mandatory, just as the agency guarantees benefits for participants in single employer plans, but the benefit guarantees would be slashed.

Under the proposed PBGC formula, participants of terminating multiemployer plans would be guaranteed 100% of the first $5 per month per year in vested benefits and 60% of the next $15 per month per year in vested benefits. The minimum benefit guarantee would be $100 per month and the monthly maximum would be $500.

The reduction in benefit guarantees is necessary to prevent the PBGC from going bust or raising termination insurance premiums tremendously as it covers a rash of multiemployer plans that are expected to collapse in the 1980s with insufficient assets to pay benefits promised to participants.

While Congress had devoted much attention to the problems of PBGC guarantees of pension benefits of multiemployer plans, a possible collapse of ailing Chrysler Corp., the nation's 10th largest corporation, could focus more attention on whether the PBGC has the means to guarantee unfunded pension liabilities of large single employers, says Steve Schanes, president of Schanes Associates, a San Diego, Calif., consulting firm.

The PBGC already has warned that if Chrysler collapses and the agency takes over the automaker's $1.1 billion pension debt, termination insurance premiums that all companies with defined benefit plans pay could more than triple from the current annual $2.60 per participant to $10.

Congress also is expected to closely consider legislation that would allow employes to take tax deductions for contributions to corporate pension plans. But the sheer number of bills—at least a dozen—makes it unclear if Congress will move quickly on any one piece of legislation, says Theresa Stuchiner, a partner at Kwasha Lipton, a national consulting firm in Englewood Cliffs, N.J.

Legislation allowing tax deductible employe contributions to corporate pension plans passed the Senate last year. But it died at the 11th hour, a victim of intense opposition from the Treasury Department.



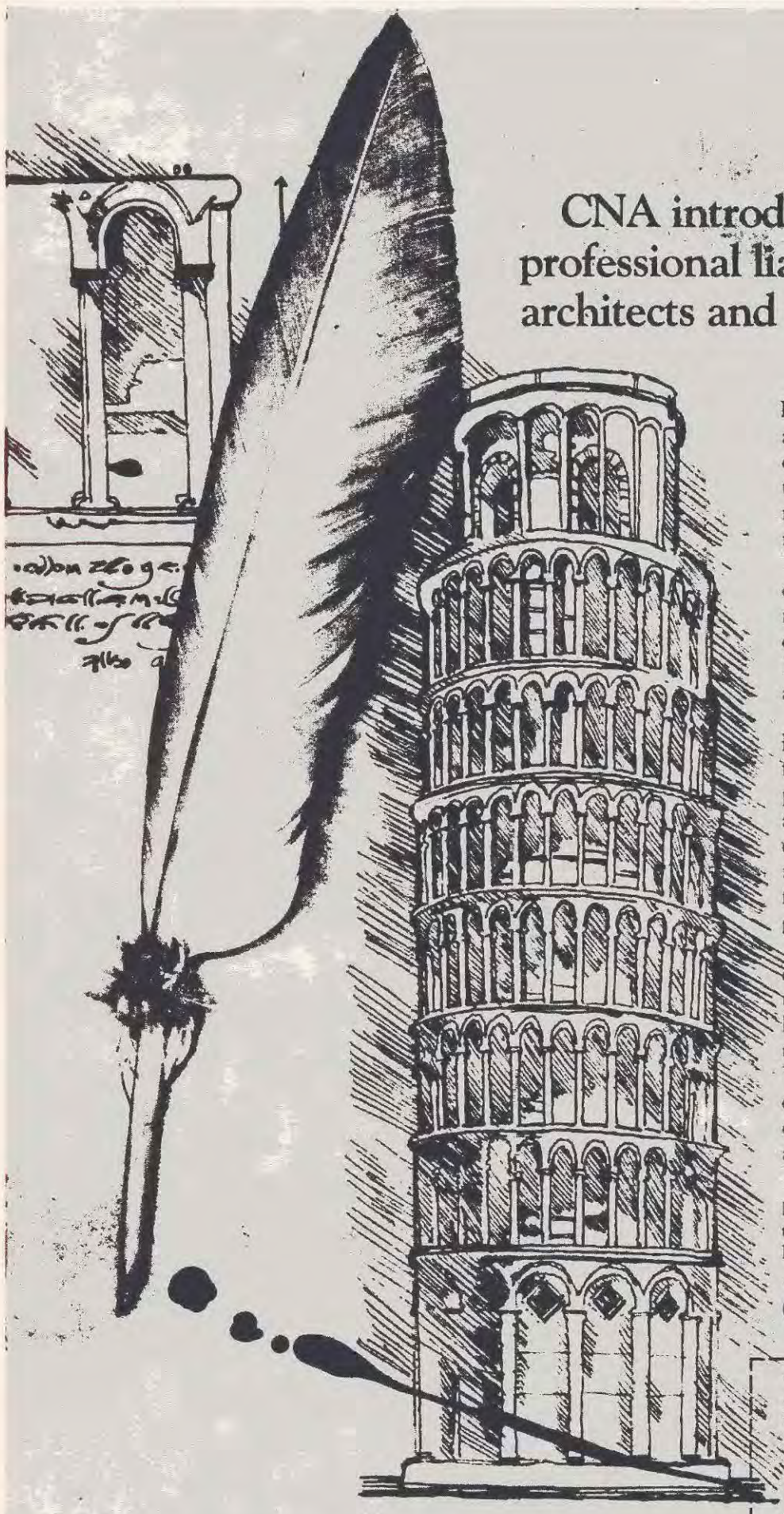
Sen. Jacob Javits's ERISA Improvements Act probably won't see action this year.

Rep. John Erlenborn (R-Ill.) is expected to introduce legislation to establish reporting, disclosure and fiduciary guidelines for the nation's 7,000 state and local pension plans.

Unlike ERISA, which only covers private plans, the public plans bill (PERISA) will not set vesting and participation standards. Instead, an advisory council most likely would be set up to hammer out voluntary guidelines for vesting and participation.

PERISA, though, will establish reporting and disclosure standards. Plans in states that adopt these federal standards only would be required to file their annual reports with the appropriate state agency. However, public plans in states that lack reporting and disclosure requirements would have to file annual reports with the federal government.

Elsewhere on the pension front, Mr. Schanes, an adviser to the National Employe Benefits Institute, foresees a large drive to simplify some of ERISA's reporting and disclosure requirements, with some chance of success. ■



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Legislators disagree on how to cut back Social Security tax

Employe Benefits

WASHINGTON—Congress and the Carter Administration want to hold the line or roll back recent increases in Social Security payroll taxes, but can't agree how to do it.

Rep. Al Ullman (D-Ore.), chairman of the House Ways and Means Committee, wants to impose a 10% tax on goods sold to slash employers' Social Security taxes by about one-third.

To offset further increases in Social Security taxes, Rep. Richard Gephardt (D-Mo.) has suggested granting employers and employes tax credits for their contributions to Social Security.

The Carter Administration, meanwhile, has proposed cutting back on benefits payable under the Social Security disability income program to save taxpayers more than $2 billion by 1982.

Employers and employes are paying substantially higher payroll taxes to pay for ever-increasing benefits to a growing pool of retirees.

This year, 115 million workers and their employers paid a 6.13% tax on each employe's first $22,900 of salary, up from a 6.05% tax on an individual's first $17,700 of earnings the previous year.

By 1981, the payroll tax rate will jump to 6.65% on an employe's first $29,700. Further increases are expected in the 1980s to keep up with the cost of benefits that are indexed to inflation.

Some members of Congress and the business community are concerned that as Social Security taxes rise, employers will lose the cash needed to create new jobs.

To prevent that from happening, Rep. Ullman has proposed a 10% value added tax (VAT) be imposed on the price of property or services sold. The tax revenues would cover a massive Social Security payroll tax reduction.

This 10% VAT, which would raise $130 billion annually, would allow a rollback in Social Security taxes to 4.50% for both employes and employers, Rep. Ullman suggests.

Action in Rep. Ullman's bill isn't expected until next year, at the earliest.

Taking a different tack, Rep. Gephardt's legislation (H.R. 4990) would permit employers and employes to claim a tax credit equal to 20% of their contributions to Social Security.

Arguing on behalf of the proposal, Ronald K. Shelp, vp-international relations at American International Group, told a recent House Ways and Means Committee meeting the Gephardt legislation could create as many as 70,000 jobs by stimulating the economy through the use of tax credits.

It's considered remote Rep. Gephardt's proposal will pass Congress.

The Carter Administration has been pushing its own plan to cut Social Security disability costs, which are partly financed by the payroll tax.

One part of the plan, already approved by the Senate, would cut disability benefits by 15%, saving more than $1 billion by 1984. For example, a disabled worker with two dependents whose previous annual earnings were $12,650 would receive $8,109 in disability benefits.

Currently, the disabled worker would receive $9,546 in benefits, a difference of about 15%.

Similar benefit cuts would apply to disabled workers in other income groups. These reductions in benefits are designed to give injured workers a greater incentive to return to their jobs as soon as they have recovered.

Other parts of the legislation, which have yet to receive congressional approval, include eliminating a mother's or father's benefit when the youngest child reaches age 16 instead of age 18 as under the current law. ■



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Benefit costs worry managers

Continued from page 17

bined influence of the HMO Act of 1973, ERISA in 1974, the Age Discrimination in Employment Act in 1978, the Pregnancy Discrimination Act in 1979, Equal Employment Opportunity Commission guidelines and revisions in the tax laws (affecting such things as TRASOPs) have superseded all other forces, even inflation, in pushing and pulling benefit programs and corporate benefit administration.

Other forces Benefit Board members said affected benefit programs during the 1970s were:

- Social Security funding and benefit levels.
- Collective bargaining/labor pressures.
- Wage and price guidelines.
- The proliferation of dental care plans.
- Threat of national health insurance.
- Competitive practices of other companies.

Same forces

Most benefit managers surveyed don't think the forces affecting benefits will change much during the 1980s, except that national health insurance, Social Security benefits/funding and tax reform (possible elimination of employer deductions to benefit plans) loom larger as major influences on corporate benefits.

The benefit chieftain for one large company was very specific about what he thinks will happen in the 1980s: "In the regulatory area, I expect the age 70 maximum mandatory retirement age to be discontinued; I expect more restrictions on pensions via ERISA, such as mandatory five-year vesting; I expect a modified compulsory health care program to be legislated. In the social realm, I expect the retirement age for Social Security to be changed to age 68."

From a list of nine things or people who influence decisions about benefits within a company, members of the Benefit Board said regulation and legislation are the most significant influences on employe benefits, followed by competition within an industry, employes themselves and the corporate benefit manager.

Least influential, in their opinions, are insurance brokers, employe benefit consultants and news/publications. Other corporate executives are only moderately influential on benefit decisions, they say.

But in the future, these benefit managers think regulation/legislation, employes, other corporate executives and benefit consultants will influence benefit plans more than they do now.

Immediate problems

Among immediate problems employe benefit managers say they face are:

- The enormous administrative burden of handling the paperwork and keeping the records, accompanied by the need for more EDP support.
- Monitoring wage-price guidelines.
- Maintaining good employe communications and, as one benefit manager said, "maximizing the selling opportunity" with proper use of benefit statements.

Not to be forgotten during these times of rising benefit costs, several pointedly noted, is the immediate problem of explaining to top management why costs are rising so quickly and why claims controls have only limited effectiveness in holding down the bills.

Employe Benefits

To offset some of the problems he sees ahead, one benefit manager for a conglomerate says he's designing benefit plan changes now to anticipate more regulation and legislation in the coming years.

Another is putting more money into administrative systems.

A third has devised a strategy of monitoring the competition to stay abreast of what benefits are being offered and keep up but not take the lead on benefit improvements. ■

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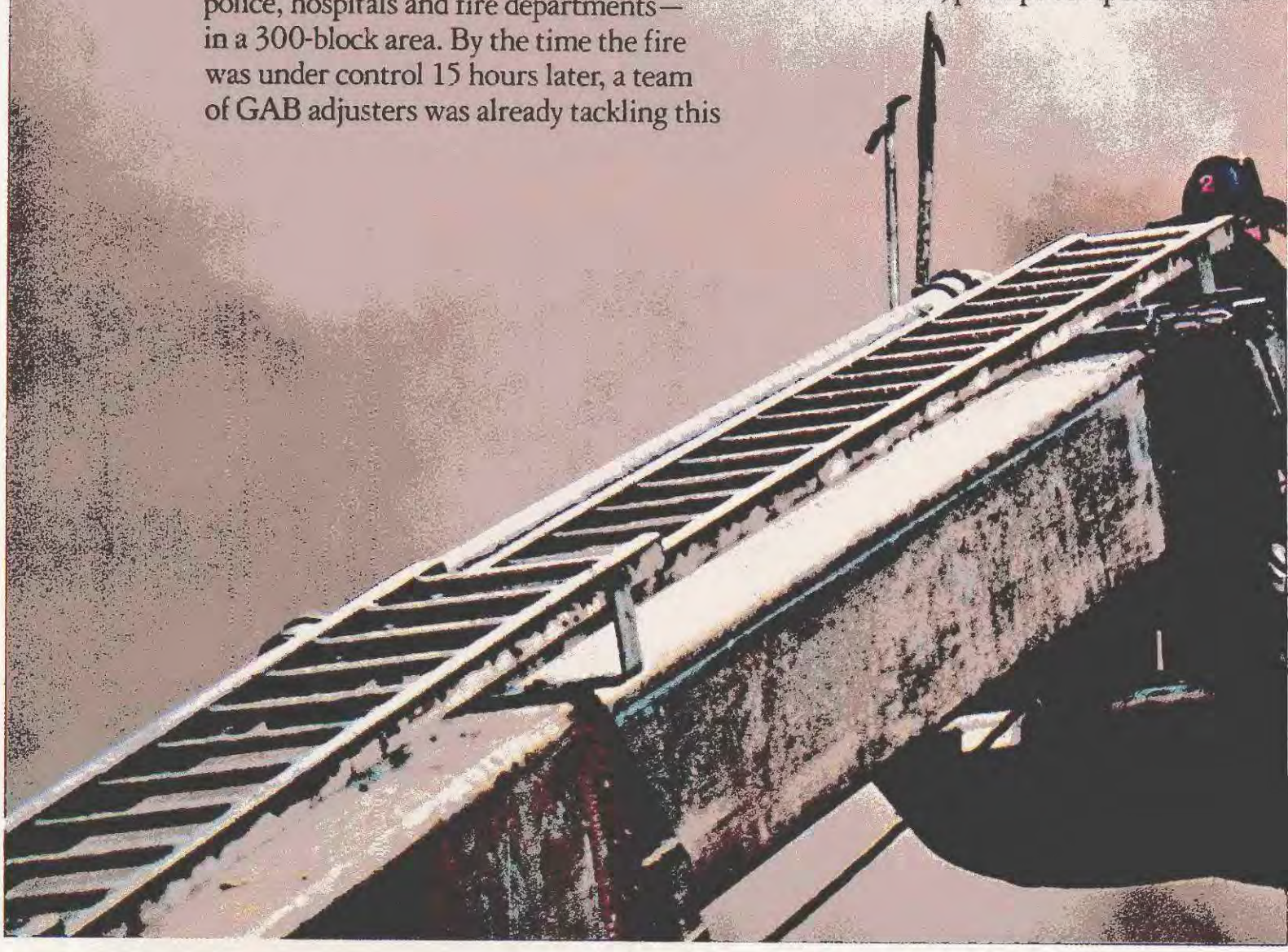
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Benefit managers report job satisfaction

CHICAGO—Most of the 36 members of *Business Insurance's* Employe Benefit Board report to a corporate personnel executive or the head of employe relations.

The overwhelming majority of these benefit managers say they have close to the ideal amount of influence over benefit decisions in their companies and operate relatively autonomously, which pleases them.

Nearly all benefit managers have direct responsibility for benefit planning, benefit communications, benefit claims handling and counseling of employes on benefit matters, but less frequently have the full authority to make decisions and take actions in those four key areas.

Of the 36 participants responding to the survey, three out of four benefit managers also are charged with handling benefit financing and/or group insurance buying. But in the financing area, less than half of the group has authority to make decisions governing benefit funding, while only two-thirds of those with responsibility for buying group insurance have the authority to make purchasing decisions. It appears, then, that managers mostly make recommendations on financing and insurance buying for superiors to act upon.

Employe Benefits

Fourteen of the respondents have responsibility for administering a 501(c)(9) trust for benefits, while 10 said they have authority to make all decisions related to the trust's operation.

Ten benefit managers said they are responsible for investing benefit funds, including pension and profit-sharing fund management. Most of these apparently are members of investment committees, since only two managers said they have authority to make decisions about investments.

Most Employe Benefit Board managers say they have adequate authority to do their jobs and carry out their responsibilities. Only five said their delegated authority is insufficient to perform well. Most complaints focused on lack of autonomy and too much decision-making red tape.

When asked to rank themselves on the amount of influence they have over benefit decision-making in their companies, based on a scale of 1 (almost total autonomy, making most benefit decisions on your own) to 5 (superiors make nearly all decisions except for minor administrative matters), half the group ranked themselves at a level of 2. Another nine said they think they are at level of 3 on the scale. Only two benefit managers in the group of 36 said they have nearly total autonomy, and only one manager in the group said he is at level 5.

The vast majority of Benefit Board participants said the ideal influence level would be at 2 on the scale, while 25 survey participants said they're pleased with the influence they now have.

Benefit managers most frequently present information and recommendations for benefit decision-making through formal proposals and memos to their superiors and senior executives. Slightly less frequently, they employ committee meetings and personal conversations to convey information and recommendations about what changes or modifications need to be made in benefit plans. Half of the benefit managers make formal recommendations to the boards of directors.

A couple of managers noted that in order to get changes approved, they negotiate with group executives or division heads in their companies.

In half of the companies represented by participating managers, the president or chairman makes the final decision about benefit program changes and things like financing techniques, while in another 11 companies the board of directors makes the final decisions.

In about two-thirds of the 36 companies, the approval process has several steps. In some companies, a retirement committee or benefit committee approves changes, additions, modifications or new insurance/financing programs, and then the board of directors has to give final approval. In others, a financial officer or personnel officer approves benefit changes followed by final approval of the corporation's executive committee.

It is still common for benefit managers to report to a vp or director of personnel; 15 participants in this survey do. Another five said they report to a vp or director of employe relations, while another two report to an industrial relations officer. Only two benefit managers out of 36 said they report to a financial officer or treasurer.■

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Insurance executive urges pension link to cost-of-living rate

Employe Benefits

WASHINGTON—Employers reaping greater returns on their pension fund investments with today's higher interest rates should pass some of those returns on to retirees, a top insurance executive says.

Harrison Givens, vp at The Equitable Life Assurance Society in New York, advocates a limited indexing of pension benefits to cost-of-living increases to redistribute higher investment income to pensioners whose benefits have been stripped away by inflation.

But indexing pension benefits to inflation can prove very expensive to employers. At Equitable, indexing has boosted pension costs by 30%. At Aetna Life & Casualty Co., indexing accounts for $10 million to $15 million of the Hartford-based insurer's $54 million in pension costs.

Aetna and Equitable are among the few U.S. companies that automatically index their pension benefits to increases in the cost of living. Executives at both companies predict more employers will adopt some form of pension indexing because inflation is continuing to eat away at retirees' income.

"We felt it was necessary to give protection to former employes who were really getting hit hard by inflation," said Bruce T. Wright, manager of compensation and benefits development at Aetna.

Both Aetna and Equitable adjust retirees' pension benefits each Jan. 1 based on the increase in the consumer price index the previous year, subject to a maximum adjustment of 3%.

For example, because the consumer price index increased 12.1% between September 1978 and September 1979, an Aetna or Equitable retiree receiving a monthly $1,000 pension will get $1,030 in January 1980.

These annual pension increases have struck a responsive chord among retirees, says Equitable's Mr. Givens. "Every year, we get unsolicited letters from people who write in and say: 'God bless you. Thank you for remembering us,'" he said.

At Aetna, there have been similar jubilant reactions, although some retirees now seem to take the annual cost-of-living adjustments for granted, Mr. Wright reports.

Undoubtedly, more companies would like to adjust retirees' pension benefits to compensate for inflation, but have been scared off by perceived enormous costs. Instead, more companies choose to periodically increase pension benefits.

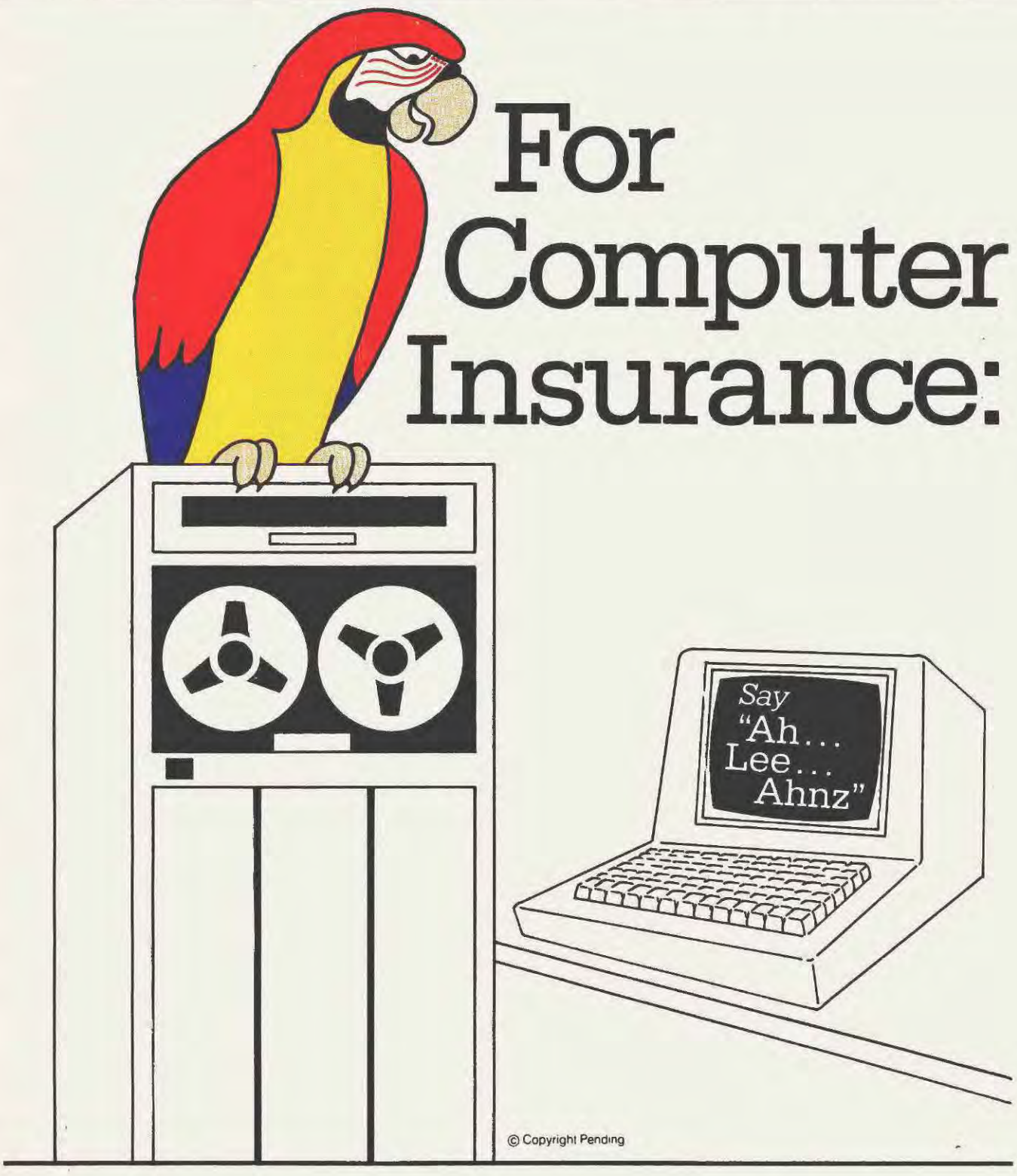
Although the costs of indexing are substantial, those costs are not as high as they might seem at first glance, Mr. Givens says.

While inflation pushes up pension costs, it also boosts investment return. Interest rates are much higher now than they would be in a non-inflationary economy, giving employers more money to pay indexed benefits. An inflationary economy is "why you can get 12% on Treasury notes," Mr. Givens says.

"If you don't index, what you are doing is pocketing the investment profits and letting the pensioner pocket the inflation losses. You ought to be spending the higher returns on indexing of benefits," Mr. Givens observes. ■

Fremont subsidiary

Fremont General Corp. of Los Angeles has formed a U.K. reinsurance subsidiary in London. The new company, Fremont Insurance Co. (U.K.) Ltd., will be capitalized at 2.5 million pounds sterling ($5.6 million). Underwriting for the subsidiary will be handled by Fremont Underwriting Management Co. Ltd., which is 50% owned by Fremont and 50% owned by British interests.



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Health care execs promote HMO use to cut down costs

Employe Benefits

NEW YORK—Two corporate executives assigned strictly to evaluating health care costs at two different firms are supporting health maintenance organizations to compete with standing health plans.

Ronald Hurst, named health care director 18 months ago at Caterpillar Tractor Co. in Peoria, Ill., and M.S. Plunkett, named director of the health care department at Deere & Co. in Moline, Ill., in the fall of 1977, both work to increase HMO use among employes.

Developing an HMO program and increasing dialogue between the company and local hospitals and physicians have been Mr. Hurst's projects. He has worked to offer six HMOs at four company plant locations: two in Denver, two in San Leandro, Calif., one in Peoria and one in Mintor, Ohio. Twelve other locations are being considered for future HMOs.

"We believe HMOs are a sound approach for introducing competition into health services and providing care at competitive prices. Nationwide, enrollment is increasing significantly because HMOs can deliver cost-effective, high quality health care," he said.

Meanwhile, Mr. Plunkett at Deere has helped plan an HMO for Moline which will begin operating in 1980. "I do believe that HMOs are a positive step. They bring the patient, provider and physician together in a form that didn't exist before," he said.

Though corporate self-evaluation of health care costs is new and unproved as a cost containment measure, Mr. Plunkett sees the concept growing. In addition to Caterpillar and Deere, Chrysler Corp. has established a committee to evaluate health care.

Employe benefit managers still handle ongoing benefit administration matters at both firms but the health care executives have a more investigative role: finding out what drives up costs.

"When you have any element standing out, such as health care costs, you have to start looking at why . . . then you can uncover basic problems," Mr. Plunkett said.

Though "it's still too soon to tell" what the results of the Deere self-review will indicate, Mr. Plunkett says he doesn't expect health care costs to go down.

The goal of the department is to see rates for health increase at a rate consistent with the cost of living, he noted.

At Caterpillar, the self-evaluation revealed direct payments for medical, dental, vision and drug benefits jumped to $96 million in 1978 from $35.5 million in 1973. The company is largely self-insured and totally self-administered.

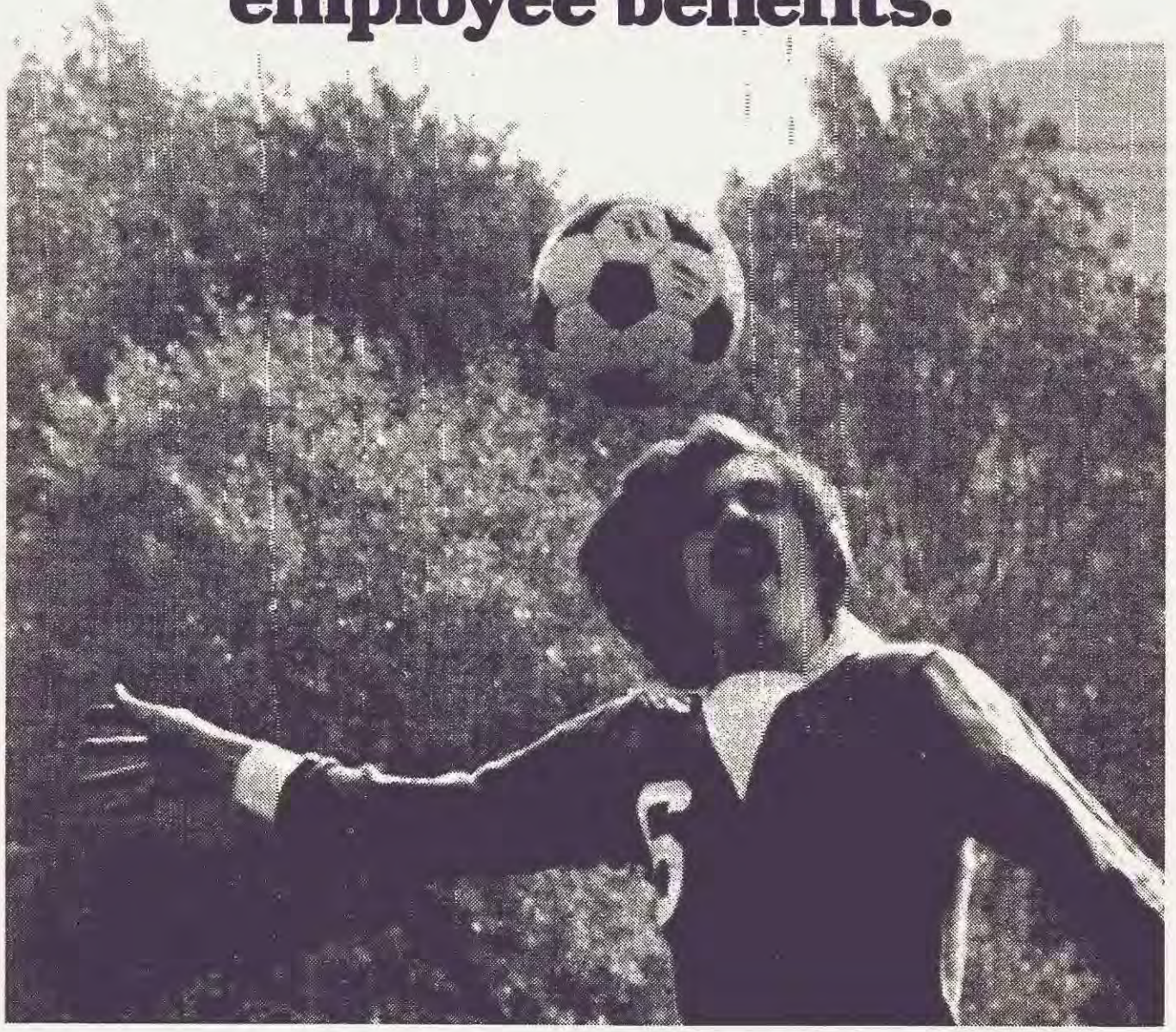
He said his job in view of these increased costs is "to strengthen efforts to contain costs while continuing to see that employes receive quality health care." The program has only one other full-time employe, a statistician, and is essentially a new function of the compensation department.

Persons from the benefits administration department, however, are used to offset the workload, he added.

"We avoid trying to put a dollar figure on the program," Mr. Hurst said, but added that the average length of hospital stay for Peoria plant employes is down .8 of a day for May 1978 to April 1979 from the previous year and that hospital admission rates are also down. Now, "We're just slightly above the national average in length of hospital stay," Mr. Hurst said.

He credits this reduction to the hiring of a professional standards review organization for the Peoria area some 18 months ago (*BI*, April 2). This peer review of hospitals in Central Illinois monitored hospital admissions, length of stays and made sure hospital confinements were medically necessary. ■

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HMOs will double, peak out in '80s: HEW predictions

By JOHN MAES

Employe Benefits

CHICAGO—The gush of health maintenance organizations will slow to a trickle by the end of the 1980s with only a fifth of the U.S. population in HMOs, the federal government admits.

The number of HMOs is expected to double in the coming decade to 430 from 216 now and enroll 15 million to 20 million people, compared with the eight million people who now receive health care under the prepaid system.

But despite a new federal program and funding to promote HMOs in the '80s and growing support from business, HMOs will ultimately serve only 20% of the population, estimates the Department of Health, Education and Welfare. The other 80% of Americans will want to stay with fee-for-service care.

There's still a lot of growth, though, before HMOs reach the estimated saturation point. Plans are popping up in areas of the country that never had them before, like Dallas, and are being planned elsewhere, like Moline, Ill.

In Southern California, the biggest and most successful HMO, Kaiser-Permanente, has closed



HEW will highly promote HMOs now, says Howard Veit, national HMO director.

new enrollments to avoid a membership overload. And in cities like Minneapolis and Los Angeles where HMOs already operate, competing HMOs are being set up to give the consumer more choices and promote price competition, prime methods in cutting spiraling health care costs.

The federal government is playing a part in promoting HMOs as the best way to combat the increasing cost of health care. Consistent with the Carter Administration's announcement of an all-out attack on rising health care costs, HEW is promoting the plans by supporting their use in the public and private sectors and will adopt a rather generous feasibility grant policy.

Howard Veit, national director of HEW's office of HMOs, said the government had assumed a passive position on HMOs, but with costs rising as rapidly as they are, "The department is taking a highly promotional posture," he said.

HEW said it will award nearly $48 million in grants for HMO feasibility studies next year, double the $23 million awarded this year.

Mr. Veit predicted business and labor will also assume a greater role in fostering HMOs, primarily because of the rising cost of health insurance premiums.

Employers say they see a definite cost saving in HMOs and generally like to offer employes the alternative to traditional health plans. But despite their support, corporations say they don't bang the drum when it comes time for their employes to make a choice.

"We're supportive of HMOs, but we take a neutral stand when it comes time for our workers to choose," said Jack Shelton, benefits manager for Ford Motor Co.

However, HMOs have saved Ford $3.6 million in insurance costs. Ford first offered a prepaid plan to its employes in 1953 and now offers 15 plans nationwide in which 14,600—or 5%—of its eligible workers are enrolled. Its Northern California employes have the highest enrollment, 45%, but other areas of the country have less than 1% membership.

Earlier this year, Ford, General Motors and Chrysler Corp., along with the United Auto Workers, joined together to sponsor a new, community-based plan in Detroit called Health Alliance Plan, which now has some 80,000 members.

There will be more of these types of ventures involving business and labor in the coming years, Mr. Shelton said, as both groups, acutely aware of the need for cost control, try to tackle the problem.

At other large corporations, HMO enrollment has been increasing year by year, but benefits managers say they believe membership will eventually level off as employe attitudes and lifestyles change. More working men and women are delaying marriage and putting off or foregoing child-rearing altogether and people from these groups may prefer conventional indemnity insurance to an HMO, they say.

"I don't see a point in time when we won't see a demand for traditional health insurance plans," said Martin Bael, benefits manager for Eastman Kodak Co. in Rochester, N.Y.

Sharon Collins, benefits manager for Control Data Corp. in Minneapolis, said enrollment in company-sponsored HMOs has risen 55% this year compared with last year. But she said she doubts enrollment will grow to 50% of eligible employes, despite the fact the company's Twin-Cities location is one of the hottest centers in the nation for HMO membership. Some 5,500 of the firm's 22,000 eligible workers are HMO members, she said.

One of the biggest challenges for HMOs will be the ability to procure able, professional management talent familiar enough with both the business and technical side of the operation to be competent administrators. "The key is for the HMO industry to develop enough technically competent managers to manage this growth and exercise the necessary controls to keep the organization solvent and to provide high-quality care," an HEW spokesman said.

To meet this need, Congress has appropriated more than $800,000 to HEW's office of HMOs to finance setting up the internship programs for young persons eyeing HMO management as a career.

Dr. Paul Ellwood, director of Interstudy in Minneapolis, a health care policy research organization, said he'd like to see large corporations enter the health care field, establishing HMOs to sell services to the general public as a profit making venture. ■



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HEW plots HMOs for 61 localities in new promo push

Employe Benefits

CHICAGO—The U.S. Department of Health, Education and Welfare, promoting health maintenance organizations as the best way to control the rising costs of health care, will work to increase the number of prepaid health plans and enrollees in the 1980s.

In a strategy report outlining its goals for promoting nationwide HMO growth, HEW has targeted 61 U.S. cities in which it will work to set up new plans, expand existing ones and bring the prepaid care to rural and inner-city areas that now lack it.

HEW will solicit the support of business, labor and private sponsors in each of the target areas. And while it will provide funding for start-up costs of nonprofit plans, HEW will continue to encourage private enterprise, the report says.

"The growth targets set up by HEW call for more than doubling the current number of HMOs nationwide and nearly tripling national enrollment by 1988," according to a document outlining the plan. There are currently 212 plans serving 8 million persons.

The HEW effort is an extension of the Carter Administration's avowed support for dealing with the health care field's chief nemesis: upwardly spiraling costs.

HMOs have proven themselves to be cost-effective, the report says. A recently completed review of all studies published since 1950 concluded that total health care costs of HMO users are 10% to 40% lower than those for comparable persons with traditional health insurance coverage. Research shows hospital days averaged less for HMO members than for those covered by indemnity plans.

HEW also says it hopes to improve access to HMOs in "medically underserved" areas such as poor and rural sectors by encouraging and assisting with the conversion of many community health centers to HMOs. It will also try to increase HMO enrollment by federal government employes and public beneficiaries.

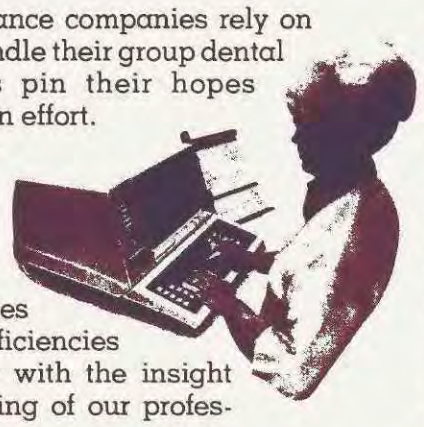
The report lists nine steps being taken by HEW to stimulate HMO expansion.

- Formulation of a market development plan to be used during 1980, outlining marketing objectives for targeted and non-targeted areas. Public education plans will be designed to increase consumer awareness about HMOs.
- Compilation of a marketing data base with current information on potential growth areas for use by private developers.
- Development of a pool of experienced HMO developers who could be called upon to assist community organizers in the 61 target cities.
- Mobilization of business and labor support through the National Industry Council for HMO Development. Participating organizations will be asked to teach their members about HMOs.
- Streamlining the eligibility process to speed review of grant applications. HEW will give priority to applications from target communities and the federal qualification process will be completed within 120 days.
- Improving procedures for monitoring compliance with federal regulations, financial health of the plan and whether quality care is being delivered.
- Coordinating management of regional offices of HEW's HMO bureau, including a geographically equitable workload distribution.
- Developing a comprehensive plan for training HMO managers and technical administrators.
- Requiring greater coordination and cooperation among federal programs such as the Health Care Financing Administration, the Health Services Administration and the Health Resources Administration. All three can affect HMO growth, HEW says. ■

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Africa, Mideast enter benefits sphere

By STUART EMMRICH

NEW YORK—Somewhere in darkest Africa, local employe benefit managers are attending seminars on group life, accident, health and pension plans.

That's because Africa and the Middle East are offering insurers a new market for the basic benefits that already saturate the Western Hemisphere and Europe.

"The potential for us is just enormous in these developing countries. The opportunity to provide leadership is just great," says George Abouzeid, senior vp of the American International Group.

"We don't say, 'These countries are 20 years behind the times, so we should put in these programs gradually.' We get them used to sophisticated programs right away. We establish a solid base which cannot really be attacked. In fact, the education process is almost the same as we would use in putting in any new programs here in the United States," Mr. Abouzeid said.

The AIG official, head of a group management division that oversees the company's foreign insurance dealings, should know what he is talking about.

AIG is considered by most to be far and away the leading U.S. insurer in these countries. Worldwide, AIG has boosted its annual premium income to $55 million last year from $22 million in 1977. The company expects to hit the $100 million mark in 1980.

"The education process is almost the same as we use here in the United States," says George Abouzeid, head of AIG's foreign division.

Much of that increased business is coming from companies in these countries starting employe benefit programs almost from scratch.

"Most of these countries have not refined even a social security program and most of the companies there have not thought about employe benefits as an important tool to retain people. The emerging middle class has forced the hand of the employer to provide a fully contributory program," he explained.

AIG has relied on local talent to staff its offices in 130 countries with 14,000 people—people who know the language and customs of the country they are working in, Mr. Abouzeid said.

History is important in African countries.

The former English colonies are used to the concept of insurance, but have no mechanism to provide it, while the former French colonies are used to being basically uninsured or given just the minimum standard of benefits.

As might be expected in these countries, the basic benefit programs are most in demand: major medical, group life, group accident, pension plans. Most state retirement programs, if any, provide some sort of financial assistance for retirees that "won't even buy them a package of cigarettes," Mr. Abouzeid said.

Retirement programs have gained less acceptance among African employers, even though they are among the most needed by the employes, Mr. Abouzeid said. The firms have been reluctant to make the long term commitment necessary to make the plar. work, he said, but seem to be more receptive to the idea in the past couple of years.

"There is generally a trend across the world for developing nations to catch up quickly to fill the void left by inadequate state plans," the AIG official said.

Among the countries most receptive to new employe benefit programs is Kenya.

Employe Benefits

"Kenya really started booming about two or three years ago. It is mushrooming very fast. Every few months we see a new opportunity there," Mr. Abouzeid said. "Group marketing plans have been especially successful; no one has ever tried them before."

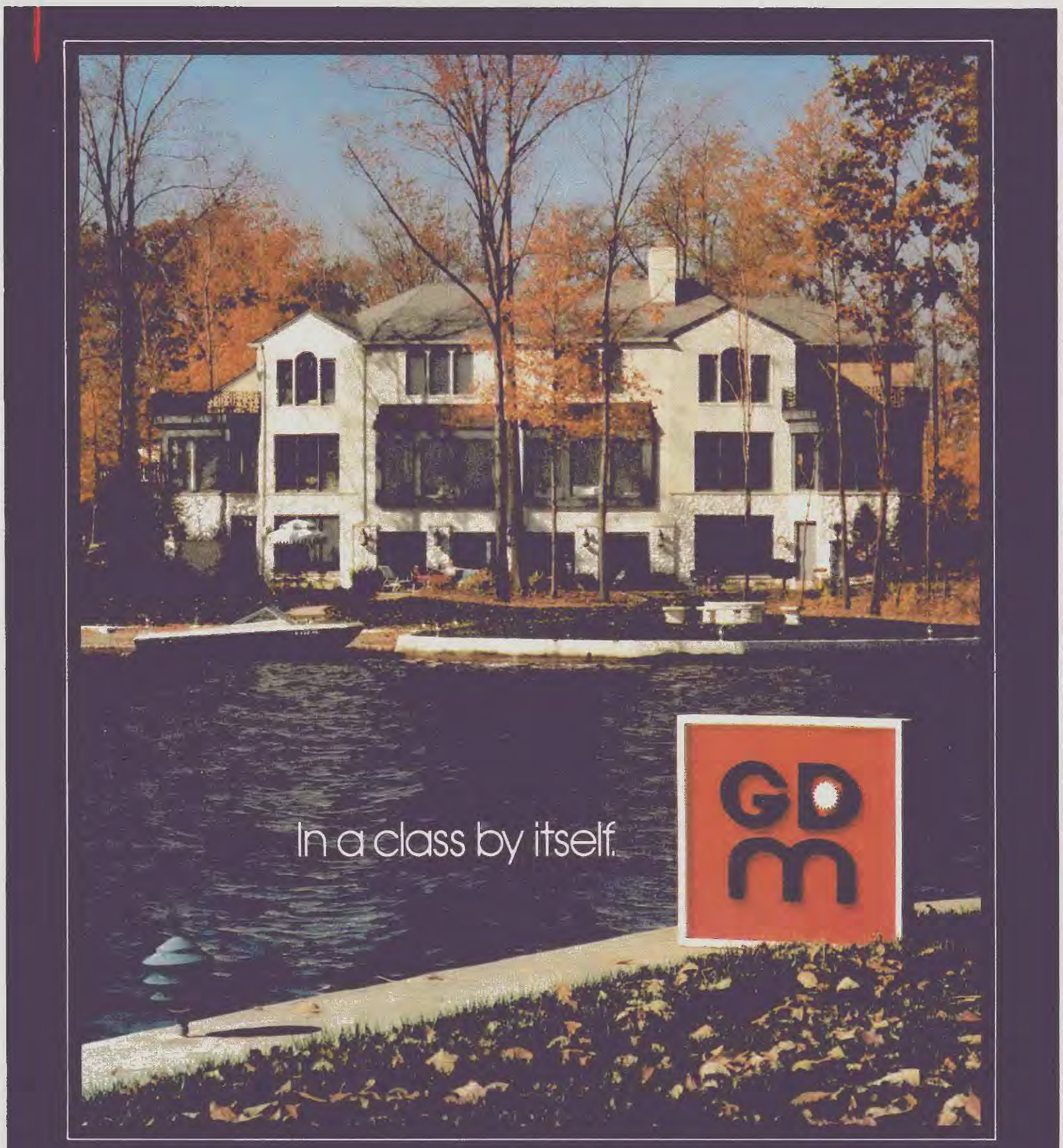
Like in other African countries, in Kenya the opportunity for new benefit plans is enhanced because laws covering employe benefits are not being changed; they are being created.

Nigeria is one of the area's more advanced countries in terms of employe benefits, Mr. Abouzeid said. "It is a big country growing richer every day. The benefit climate is very good. There is just a great attitude toward employe benefits there; no one thinks it all should be left up to the state," he said.

"Some employers even go so far as to provide transportation to and from work for their employes because the transit conditions in the country are so horrible."

There are some benefits, however, that have generated little enthusiasm in these developing countries of Africa and the Mideast.

Voluntary programs seem to generate almost no interest among employes. "Payroll deductions are a difficult thing to do because of the need for a sophisticated awareness of what benefits they can provide. Many of these countries don't think in terms of estate planning," Mr. Abouzeid said. ■



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Self-insurance spurt slashes cost of ASO contracts: Poll

Employe Benefits

CHICAGO—The growing number of self-insuring corporations is driving down the cost of administrative services only contracts, according to a *Business Insurance* survey of insurers and brokers.

In the last 18 months, every one of the major companies selling the services has reduced prices, reports Mansford Barnes, vp of employe benefits for Bayly, Martin & Fay International Inc.

"Competition will just toughen as more and more third-party administrators vie for business with insurance companies," he said.

The increasing cost of health care is also pushing down the percent of claims paid needed to cover administration, one insurer admits.

ASO contracts are riding the crest of booming self-insurance, Mr. Barnes emphasized, and low premium methods of self-funding are being offered by large underwriters including Prudential, Aetna Life & Casualty and John Hancock.

The underwriting giants, Mr. Barnes said, are more willing now to grant premium delays, release reserves to the policyholder or require minimum premiums under a retrospectively rated policy.

Other brokers, including Arthur J. Gallagher & Co., Corroon & Black, Fred S. James & Co. and Albert M. Bender & Co., report more client demand for self-insured services and more sources of ASO contracts.

As the concept of self-insuring grows, notes A. William Greenfield Jr., manager of employe benefits for Arthur J. Gallagher, corporations are staying with insurers for services and paying a percentage of paid claims for the help.

Prices, he said, average about 6% of claims. Other brokers agree, setting a range of fees for ASO contracts at about 4% to 6% of claims.

Corroon & Black, which also does claims administration for its clients, is anticipating a 35% increase in self-funding management, says Frank White, executive vp of C&B's benefit subsidiary.

"Seldom do we charge on percent of premium," he explained. "Usually we bill on a per employe or claims processed basis. Self-insurance is increasing dramatically, both full self-insurance and high deductible plans. We know our market will increase significantly."

Only one of the brokers predicted a price problem in the boom years for administrative services agreements: Daniel V. Malloy, executive vp of Fred S. James & Co. "ASOs will go up in price, certainly. But insurers are making major strides in cost control, so prices in the 1980s will quickly stabilize due to cost control technology," he remarked.

The insurers agree they are beginning to aggressively market ASO contracts as something other than a way to save premiums slipping away to self-insurance.

In the next year and a half, Massachusetts Mutual plans to significantly expand its offering of ASO contracts as it beefs up its computer capability. Until recently, ASO contracts only were offered as a "defensive" measure, noted vp Dick Cunningham.

In offering ASOs, insurers are making the best use of their abilities, explained David W. Grant, Aetna Life & Casualty assistant vp. "We're primarily administrators and operators regardless of whether clients insure or not," he said.

Minimum-premium type contracts, however, will be fastest growing. There won't be much growth in pure administrative services only contracts, he predicted.

"You can accomplish the same effect of an ASO contract through minimum premium contracts. Any corporate law department would rather have an intervening contract to avoid getting caught in the nitty-gritty," Mr. Grant explained.

Pure ASO contracts will most likely be the choice of large employers, said Ted Dunn, actuarial and underwriting vp at Provident Life & Accident Insurance Co. "I see more ASOs for medical plans for large employers," he said. "Provident looks at this as: 'We're in the service business—we can provide this service and we had better be prepared to do so or third-party administrators will'. They're a substantial competitive threat in the '80s."

Provident likes to charge a percent of claims paid under ASO contracts. Medical/dental plan charges are 3% to 5%, but for dental only, prices will go up 8% to 10% per claim paid.

Occidental Life has developed a special "flexible funding" package that is nearly the equivalent of an ASO contract with a layer of stop-loss insurance on top. This is Occidental's way of maintaining its presence in the face of growing self-insurance.

Gary McDonald, vp and group actuary, estimates that less than 10% of Occidental's total benefit business involves self-insured plans. But he expects it will grow because of the popularity of self-insurance. Brokers and consulting firms are "pushing" these types of arrangements, he said.

"Whether we like it or not, this seems to be the way the market is going," Mr. McDonald said. He was one of only a few, however, who predicted charges for ASO contracts will go up because the costs of providing the services are going to go up. Others note that the increasing cost of medical care allows insurers who charge a percent of claims paid to recoup increased administrative expenses.

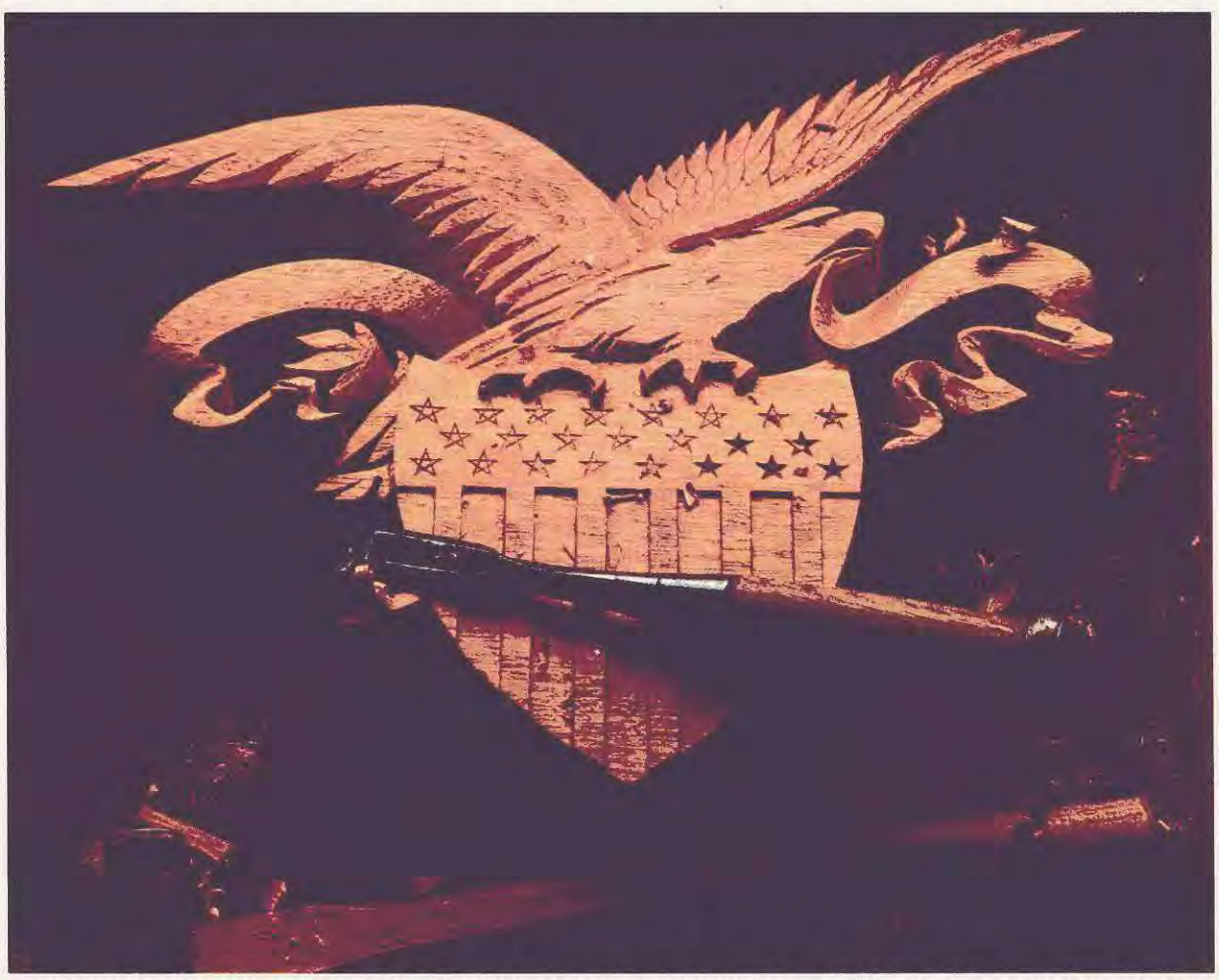
The combination of ASO contracts and minimum premium business makes up more than half of Metropolitan Life's business, with about 10% of it coming strictly from ASO contracts. But group vp Leon Muskowitz added that ASOs are gaining a larger and larger part of the overall share, especially among large employer clients.

Yet the competition could become stronger, holding off ASO contract price increases, as smaller companies look to save money through self-insurance like their big corporate counterparts.

"More and more employers are middle size companies thinking of self-insurance," concluded Robert Nossen, vp of William M. Mercer Inc., a consulting firm specializing in benefits and administrative services. "The big advantage is where there is big money, but the economic crunch makes middle-sized companies try to save money."

ASO prices should stabilize, responding to the added competition between life insurers trying to capture the growing market. "ASOs are very competitive. They should stay the same," he said. ■

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Claims contractors sell self-insurers more than adjusting

By MARGARET LeROUX

Employe Benefits

SAN FRANCISCO—For companies that self-fund group health benefits or assume a large deductible on individual plan members, there are myriad service firms eager to provide a wide range of administrative service only plans.

Typical of the spectrum of administrative services available are those provided by two Western U.S. firms, Smith-McMullin Employe Benefit Administrators in Salt Lake City and New Systems Inc. in San Francisco.

Smith-McMullin, a partnership of two former insurance industry executives, provides insurance as well as administrative services for approximately 350 commercial clients, most of them small businesses. Most of the firm's corporate clients have high deductible insurance plans, though some are self-insured with stop-loss coverage.

"About 70% of our business is $500 deductible (per employe)," said Richard Smith, former group insurance director for Tracy, Osborne & Dickson Insurance Co. in Salt Lake City.

"With such a high deductible, we're able to achieve a big decrease in average individual premiums," he explained. For one corporate client, the $500 deductible meant dropping the per employe premium from $130 to $50. The difference is put into a trust fund to pay claims that fall under the $500 deductible."

Smith-McMullin administers trust accounts for its clients, pays claims and acts as intermediary between clients and insurers. IDS Life Insurance Co., Republic National Life Insurance Co., Phoenix Mutual Life Insurance Co., Lafayette Life Insurance Co., and Occidental Life Insurance Co. are some of the insurers used by the three-year-old administrative firm.

Among corporate clients are Pepsi-Cola Bottling Co. in Denver and Sorenson Research and Wheeler Machinery Co., both of Salt Lake City.

Smith-McMullin recently took over group health coverage for the Utah Council of Small Businesses and has established a reciprocal insurer to underwrite and handle claims for the 2,300 companies the council represents.

Smith-McMullin charges between 6% and 9% of claims paid for its administrative services and realizes gross monthly fees of approximately $91,000.

Based on a different philosophy is the computerized claims administration offered by New Systems Inc., headed by Don Meyers, whose background includes hospital administration, employe benefit management and consulting.

Mr. Meyers argues that third-party claims administrators should have no ties to either insurers or brokers. "There are all sorts of problems involved with commissions and brokerage fees," he said.

New Systems is paid for claims administration on a fixed fee basis, between $2.10 and $3 per month per family unit. Gross fees are slightly more than $1 million per year, the president says.

Among New Systems clients are hospitals and clinics throughout California, including Mt. Zion Hospital in San Francisco, unions and single employer groups including Buttes Gas & Oil Co. in Oakland.

On-line computer processing includes a wide range of data available for benefit managers or insurers. For example, a run-out chart shows how much should be reserved each month to pay claims incurred; a reserve analysis pinpoints estimated costs of incurred but not reported claims.

The highlight of the New Systems services is an annual report of benefits that shows the total amount billed and paid and total usage of available benefits for each member of group plans. ■

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A dentist in the house answers employe's call

Employe Benefits

WINSTON-SALEM, N.C.—R.J. Reynolds Tobacco Co. employes here owe their teeth to a fellow employe: the corporate dentist.

A staff of 30 full-time dentists provides free dental care to 35,000 Reynolds employes. For $7 a month, employes' dependents can be treated, too. Emergency care, however, costs $24.

The dental program, begun in mid-1977, is part of the company's overall medical plan which includes a corporate health maintenance organization. The dentists work in a six-story dental building on the company grounds, treating employes all day.

"Cost was not a major consideration when one considers the time an employe might lose if he neglects his teeth," said a company spokesman, declining to reveal what Reynolds spends on the benefit.

Services include exams, cleanings, fillings, extractions, inlays, periodontics, orthodontics, dentures, oral surgery and crowns. Employes' appointments are usually scheduled during working hours and with such a large staff of dentists, there's seldom, if ever, a wait, the spokesman said. An employe can choose his or her own dentist.

The emphasis is on preventive care and there is no limit to the number of checkups a worker can have, but each is advised by the dentist how many he or she should have each year, he said.

Instead of seeing a staff dentist, a worker may continue to visit a private dentist and be reimbursed for charges up to $1,000 per year over a $50 annual deductible. The option is provided because some employes prefer to choose their own dentist or to remain with a family dentist.

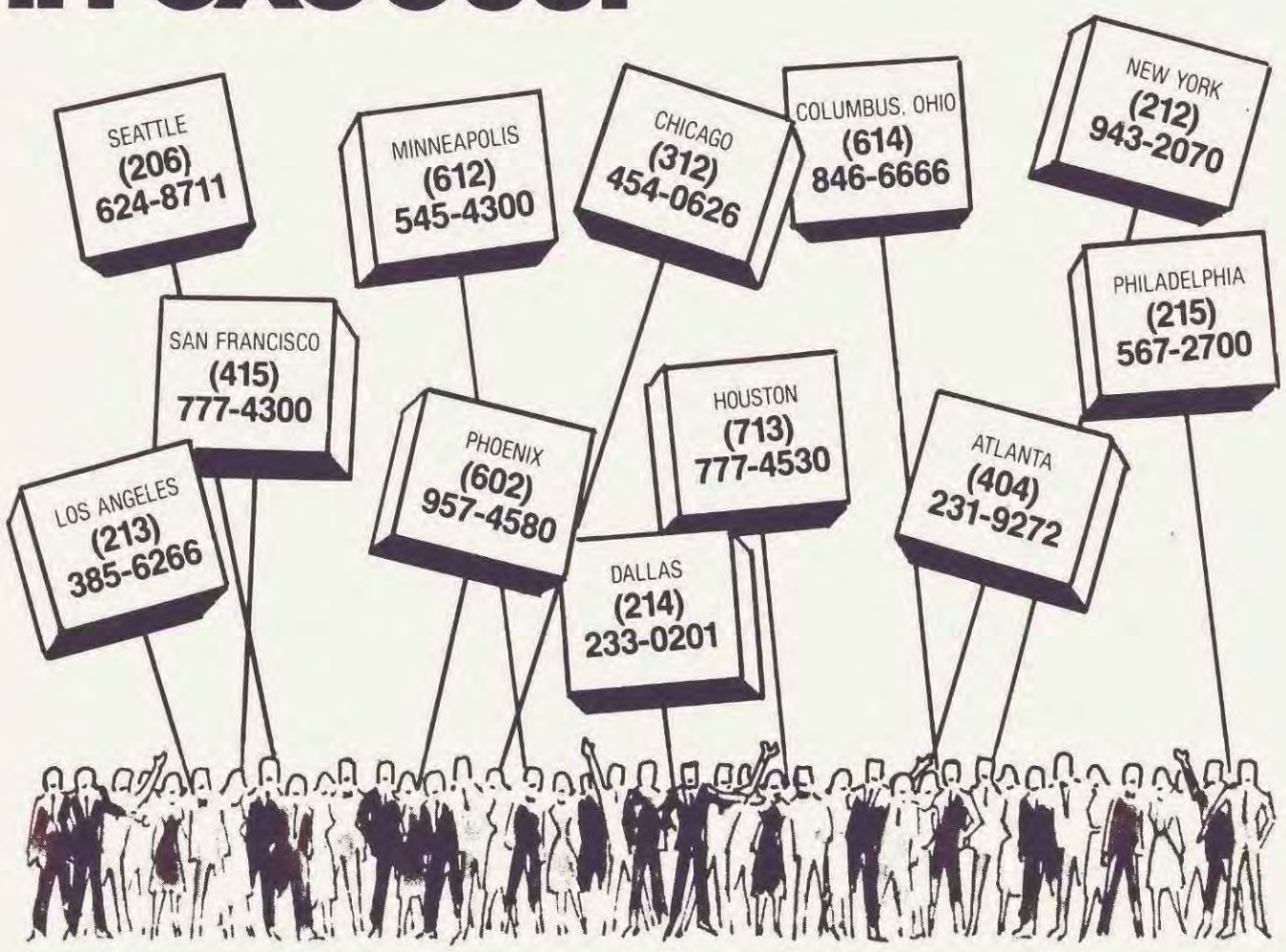
Campbell Soup Co. in Camden, N.J., also employs a staff of dentists, aided by a hygienist and dental technician. They have logged 900 visits from the 1,500 salaried personnel at the firm's facilities in Camden, Morristown, N.J., and Westhampton, N.Y. The program has been so popular the company plans to set up another dental office at its Downington, Pa., facility to serve 1,500 more workers. ■

Canada RIMS forms chapter

OTTAWA, Canada—The Risk & Insurance Management Society has formed the Canadian Capital Region chapter here. The 20-member group, whose nucleus is made up of former Quebec chapter members, is hoping to number 25 by the end of the year.

Officers are Dave Dakers of Campeau Corp., president; Fred Bossons of TIW Industries Ltd., vp; Al Shea of the Canadian Broadcasting Corp., treasurer; Sandra Deschenes of Admiral Leaseholds Ltd., secretary, and two directors, John Roberts of Supply & Services, Canada, membership, and Brian Carmody of Atomic Energy of Canada Ltd., programs. ■

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Benefit execs find retirement trends difficult to predict

By GARY S. RUDERMAN

Employe Benefits

CHICAGO—When is Bertha going to retire?

With amendments to the Age Discrimination in Employment Act raising the retirement age to 70, a lot of employers and benefit consultants are asking the same question.

Inflation and the extended retirement age could slow or reverse the decade-long trend of early retirement. In the 1979 questionnaire sent to the nation's 85 largest corporations, a quarter told Charles D. Spencer & Associates that inflation was the key to an employe's decision on when to retire.

Early retirement is continuing in 1979 compared with 1978, the study found. In the first six months of 1979, 70% of retirements were before age 65; in 1978, 62% of retirees were younger than 65.

At American Telephone & Telegraph Co., the world's largest private employer, the average retirement age has shrunk from 61 in the early 1970s to an estimated 59 this year.

"It's too early to tell if there will be a change or shift in early retirement," said Theresa Pick, benefit administration director at AT&T in Basking Ridge, N.J.

Early retirement continues at General Electric, where only 20% of the employes work until age 65. "We find that 35% to 40% of those workers reaching 65 continue to work," said Ted Bauer, GE's benefit consultant in Fairfield, Conn. While the GE benefit plan continues to accrue benefits past age 65, medical plan costs are offset somewhat by Medicare, Mr. Bauer said.

There is a growing number of reasons workers stay on the job past age 62 or 65, *Business Insurance* found in speaking with corporations around the country.



"They don't need the money as much as the continuing challenge of the workplace," says Ken Keene.

"They don't need the money as much as the continuing challenge of the workplace," said Ken Keene, senior vp of Johnson & Higgins in New York.

A research and development group at American Home Products recently had 20 people up for retirement. "A surprising 17 people of that group told the company they intended to stay on," Mr. Keene reported.

"You can get attached to the workforce," added Mr. Bauer of GE. "There are people whose social life revolves around the company . . . their life is bound up in the job."

At Schwinn Bicycle in Chicago, mandatory retirement was "never in the Schwinn tradition," said Leland Meader, vp of industrial relations. Some 73- and 74-year-old workers continue at Schwinn because they shift to more meaningful, less heavy, custom work, Mr. Meader said.

Older workers will also more readily accept periodic layoffs, leaving the younger workers on the job, he contends. "They don't mind the time off and don't need as much. They want to know they can come back." Mr. Meader calls this concept "juniority." ■

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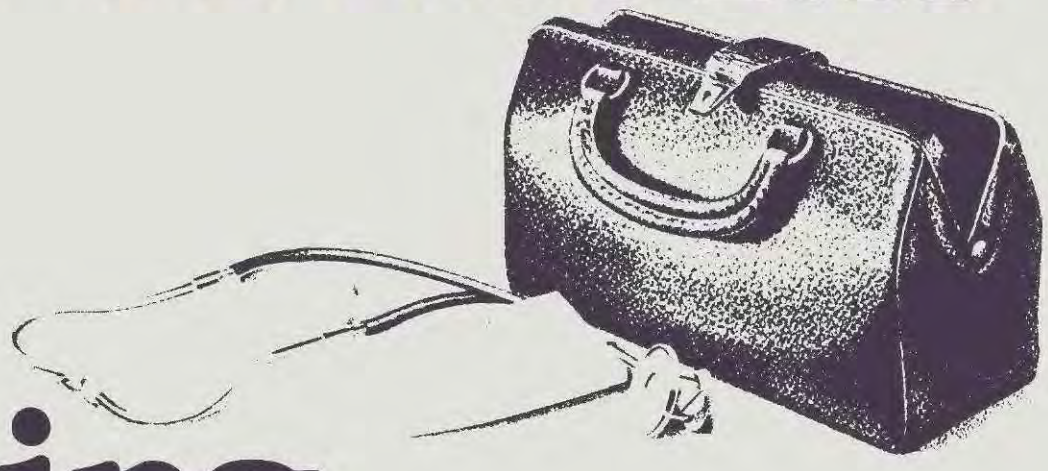
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Two insurers join hospice care movement



Photo: National Hospice

More insurers are considering underwriting hospice care as union demands for such programs grow.

LOS ANGELES—Among insurance companies striving to come to grips with hospice treatment for the terminally ill patient are at least two now offering limited benefits to group policyholders.

The Travelers Insurance Cos. advertises a hospice benefit which it has sold to two major companies in the past year; Blue Cross has added hospice care to several of its subscriber plans.

The popular program is also starting to turn up among union demands for new health benefits (see related story) and more insurers are considering underwriting hospice care.

A hospice is a specialized health care program for the terminally ill person emphasizing control of both physical and psychological pain but making no attempt to

Employe Benefits

cure. Hospices also stress concern for the well-being of the dying patient's family.

The aim is to allow patient and family to live together as normally as possible and to prepare for death as much as they can. Enthusiasts say hospices ease the anxieties of death and humanize modern medical practice.

Beyond that, descriptions of a hospice differ since it is more of a philosophy than a definition of care. Some treatments are administered at home by a hospice team of skilled nurses, psychiatrists, social workers and lay volunteers under the supervision of a doctor. Others apply the principles of a hospice within an institutionalized setting, usually but not necessarily operated by a hospital.

"At this juncture it's safe to say that the majority of our plans have started hospice pilots or are seriously investigating them," reports David Ehrenfried, director of health policy and benefits administration for the Blue Cross/Blue Shield Assns. "The hospice movement is so fast-moving, it's hard to keep track."

These pilot projects tend to take different shapes in different communities, Mr. Ehrenfried points out. Some offer only in-patient hospice services, others may operate in close cooperation with a specialized home care provider.

Blue Cross of Rochester may offer the most extensive hospice care available through BC/BS. In tandem with the Genesee Region Home Care Assn., terminally ill patients get round-the-clock nursing in their homes. In addition, families may be reimbursed for home aids and equipment and the services of a psychiatric social worker and a housekeeper.

Similar, though somewhat less comprehensive, are programs offered in Maryland, Connecticut, Cleveland, Arizona and Washington, D.C., Mr. Ehrenfried says. Blue Cross plans in both Colorado and Massachusetts are about to embark on hospice pilots, too.

Connecticut companies are taking the lead on hospices, perhaps in response to the movement's relative strength in that state. Also, a year-old state law, which automatically extends home care to the terminally ill under major medical insurance, has helped promote hospices.

"We have sold two policies with hospice benefits that I am aware of," reports John Crosby, assistant director of the group department at Connecticut-based The Travelers Insurance Cos. Both were negotiated major medical packages for giant national companies. Cost to the employer was minimal, Mr. Crosby adds. The coverage extends to any hospice service—including non-medical—up to dollar limits of $1,000 or $3,000 depending on the policy.

Connecticut General is also considering a hospice rider to its home health care coverage, says A.J. Perreault, regional claims director in Hartford. "One of the problems is that we haven't been able to truly define the hospice program," he says. Also, there hasn't been much demand, he notes.

"Hospice lacks standardization," says Cliff Hoch, vp of group claims for the Prudential Insurance Co. "We've been studying hospices for some time, trying to determine if we should have a specific policy rider or other way of extending benefits. But what specific services would be included?"

Other health insurers express the same complaint. And certain practitioners on the hospice team have never been recognized by insurance companies as medical personnel. Besides skilled medical care and drugs, hospices often provide psychiatric services for both the patient and bereaved family, financial counseling, legal assistance and funeral direction.

Hospice proponents argue that these services are necessary to alleviate the patient's mental anguish; insurers are wary of extending medical insurance into these uncharted underwriting seas.

"The basic thing to remember is that many so-called hospice services are eligible under standard major medical coverage," Mr. Hoch says. "Private duty nursing, physicians' services and drugs are

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covered in the hospital, and at home if the patient is insured for home health care."

On the other hand, many services are not covered, says Jane Salmon, a spokeswoman for the hospice of Hospital Home Health Care in Southern California. Insurance doesn't pay for special equipment such as hospital beds, oxygen and raised rails for bathrooms that might enable the terminally ill patient to die at home. Insurance also usually doesn't include benefits for bereavement visits and other non-medical hospice services for both patient and family.

Since nursing is covered under most policies, but medical attendants are not, many patients hire RNs at $125 per eight-hour shift when a $4.50 per hour aide could do the job, Ms. Salmon points out.

Up to now, insurers have said they lack the loss experience and actuarial data to properly rate hospice costs—even if standardization could be achieved. Both problems are under widespread study in the U.S.

Experimental hospice programs are getting off the ground around the country. HEW is sponsoring 26 pilot projects nationwide. The National Cancer Institute has set aside $4.5 million for a program to test hospices in three places in the U.S., including Riverside Hospice in New Jersey; Hillhaven Hospice in Tucson, Arizona, and Kaiser-Permanente in Norwalk, Calif. There are another 200 home care programs oeprating or starting up.

Development of hospice standards topped the agenda at the recent meeting of the National Hospice Organization in Cincinnati.

Hospice promoters also tout the treatment on the basis of its low cost compared with hospitalization. They contend hospice care is about one-third cheaper not only because no expensive drugs are used, but also because a number of lay workers are active in care programs.

Some skeptics question, however, how long these cost advantages would continue if insurers extended benefits to pay non-medical members of the hospice team. They think volunteer lay persons would be replaced by paid professionals. Also, use of more medical equipment in the home would increase the cost of hospice care.

"Our approach is that volunteers are central to hospice care," stresses Blue Cross's Mr. Ehrenfried. "The hospice people say the same themselves. They believe volunteers forge the necessary link between a grieving family and the community—one of the goals of the hospice philosophy."

In a meeting of Blue Cross/Blue Shield boards called to discuss hospice issues last year, "We recommended that plans make as a condition of reimbursement a good program of volunteer services," Mr. Ehrenfried notes. In general, he adds, Blue Cross believes family support services are not an appropriate use of health insurance and that every effort should be made to find volunteer services to fill such human needs.

The word "hospice" comes from the Latin "hospes,' meaning guest and host. Initially, a hospice was a way station where travelers could stop for rest and refreshment. Hospices were first established in Europe in medieval times by religious orders to care for the sick and weary. Inevitably, many travelers died in hospices.

The French have maintained hospices for 300 years, run primarily by Roman Catholic orders. The pioneer of the modern concept is Dr. Cicely Saunders, who began St. Christopher's hospice in London in 1967.

Today there are at least 40 hospices in Britain, but three, St. Christopher's, St. Luke's and St. Joseph's, all in London, appear to serve as a model for the philosophy and planning of the three-year-old U.S. hospice movement. ■

Hospice plan to begin at GE, Westinghouse

LOS ANGELES—General Electric Co. and Westinghouse Electric Corp. employes will be reimbursed for hospice care next year.

In recent collective bargaining with the UAW, General Motors Corp. also agreed in principle to a hospice pilot project, although no details or target date have been set.

The driving force behind hospice benefits at the electric companies was the United Electrical Radio Machine Workers of America, which won the new coverage as part of its GE settlement ratified this summer.

"The union has been making an effort for years to improve its insurance package," says Charles Lowell, secretary of the union's GE conference board. "With this contract we tied up a few loose ends. Hospice care, for instance, is not a big cost item, but can mean a lot to affected families."

The plan, effective Jan. 1, provides for hospice care in an insurer-approved facility or the home of the dying patient and becomes part of union workers' 100%-paid medical coverage. About 20,000 GE employes in about 10 states will get the benefit, Mr. Lowell says.

"The Westinghouse plan is going to closely approximate the General Electric plan," reports Eugene Barone at Blue Cross of Western Pennsylvania in Pittsburgh. All 115,000 Westinghouse employes, including salaried personnel, will be covered, he says.

To meet GE and Westinghouse obligations for hospice services, Blue Cross/Blue Shield companies around the U.S. are scrambling to identify and approve hospice facilities in their areas.

"New hospices are cropping up so fast," Mr. Barone says, "it's hard to get them checked out." He estimates there are presently about 200 Blue Cross accredited programs nationwide.

At General Motors, hospice benefits are still in the idea stage, says C. Douglas Eavenson, assistant director in GM's employe benefits section. "In UAW negotiations last September, we agreed to investigate a pilot program, but nothing definite has been decided about when or where," he explains.

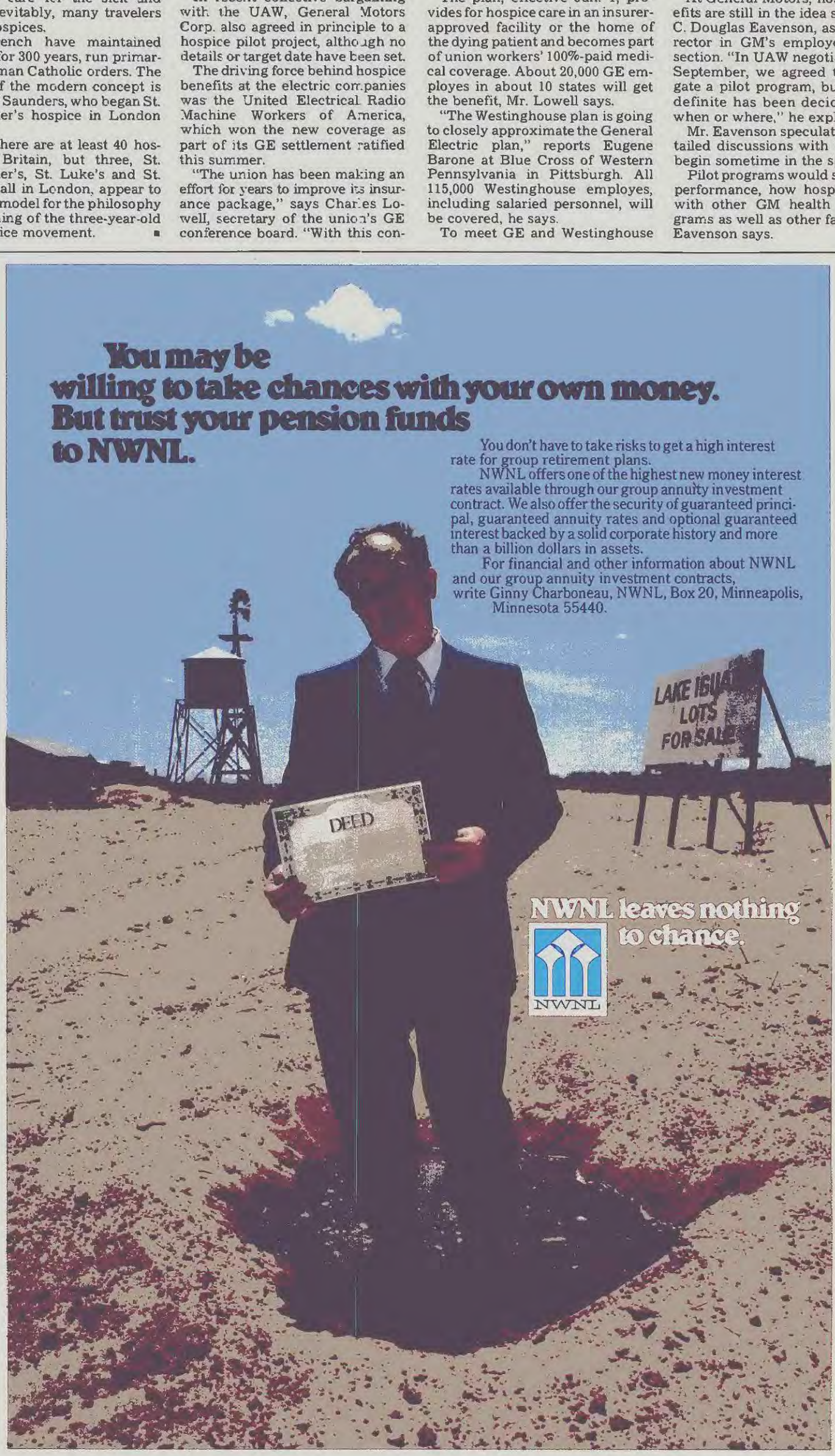
Mr. Eavenson speculates that detailed discussions with UAW will begin sometime in the spring.

Pilot programs would study cost, performance, how hospices fit in with other GM health care programs as well as other factors, Mr. Eavenson says. ■

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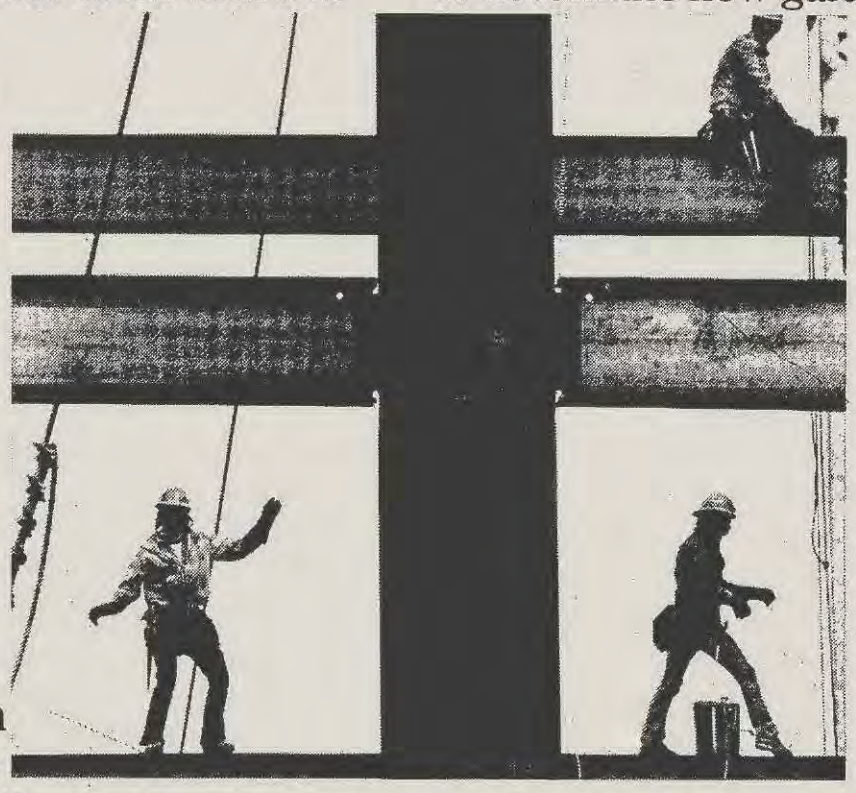
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The determination of a property insurance company to adapt its skills to changing conditions could, likewise, lead it down a path where few dare to tread. To walk such a line would take a great deal of flexibility. It would take the ability to provide coverage in situations that don't lend themselves to rule-book solutions. It would take the ability to be consistent whether the market was hard or soft. It would take, no less than it would to adapt to a career at 1000 feet above the street level, a specialist.

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Employer groups exercise their clout to trim health costs

By STUART EMMRICH

Employe Benefits

NEW YORK—Frustrated by the continuing rise of health care costs and the inability of either government or the medical profession to reverse the trend, more businesses across the country are banding together to try their own business-savvy hands at holding down medical cost increases.

In cities such as San Diego, Washington, Philadelphia, Los Angeles, San Francisco, Birmingham, Toledo and Stamford, Conn., employers are forming formal associations with one aim: pressuring the health care industry to reduce its bills. They use task forces, hospital review boards, regular meetings with health care officials and lobby in state legislatures. In some cases they even threaten to not pay "outrageous" bills.

Group organizers of the groups say their efforts seem to be paying off.

"We really haven't brought about any reductions in costs yet, but there has been some degree of cost containment. We are beginning to get the right attitude across," says Ray Mendoza, employe benefits manager for General Dynamics and vice chairman of the year-old Employers Health Care Cost Committee of San Diego, probably the most organized of these groups in the country.

Since the first meeting in 1978 of some of the area's major employers—Rohr Industries, General Dynamics and the city of San Diego—the group has grown to include 20 influential firms committed to working together to force changes in the way health care has been provided and paid for.

The group, like those in other cities, was prompted by a growing feeling that officials in the health care industry were not paying enough attention to tight budgeting.

"I have read enough to know that there was a lot of waste and inefficiency in the health care system. I am convinced of that when I see annual price increases of more than 10 cents on the dollar," Mr. Mendoza argues.

But employers—who foot an estimated 22% of the nation's health care bills—also admit to being part of the rising cost problem. Bills from hospitals and doctors have gone unquestioned and have been routinely paid.

Now employers say they realize that the only way to reduce those bills is to fight them. What's more, they say they can count on the help of employes, who are equally upset about the rising cost of health care.

At the bottom of these groups' objectives is a feeling that as bill payers, they can exercise some real clout.

"We aren't going to go in there as a single company complaining about a few bills over the past year," says Jack Bush, insurance manager of Lockheed in Los Angeles, one of the organizers of the recently formed employer group there. "A single company would have much less muscle, much less clout, than say, 25. They will be forced to listen to us."

Included in the charter group of the L.A. association are Lockheed, ARCO, General Dynamics, Garrett, Thrifty Drugs and Northrup. Mr. Bush estimates the organization will have at least 20 members later this month, all of which are expected to have at least 1,000 employes.

In Connecticut, companies including Xerox, IBM, Combustion Engineering, PepsiCo, Union Carbide and General Telephone & Electronics joined together for a similar purpose.

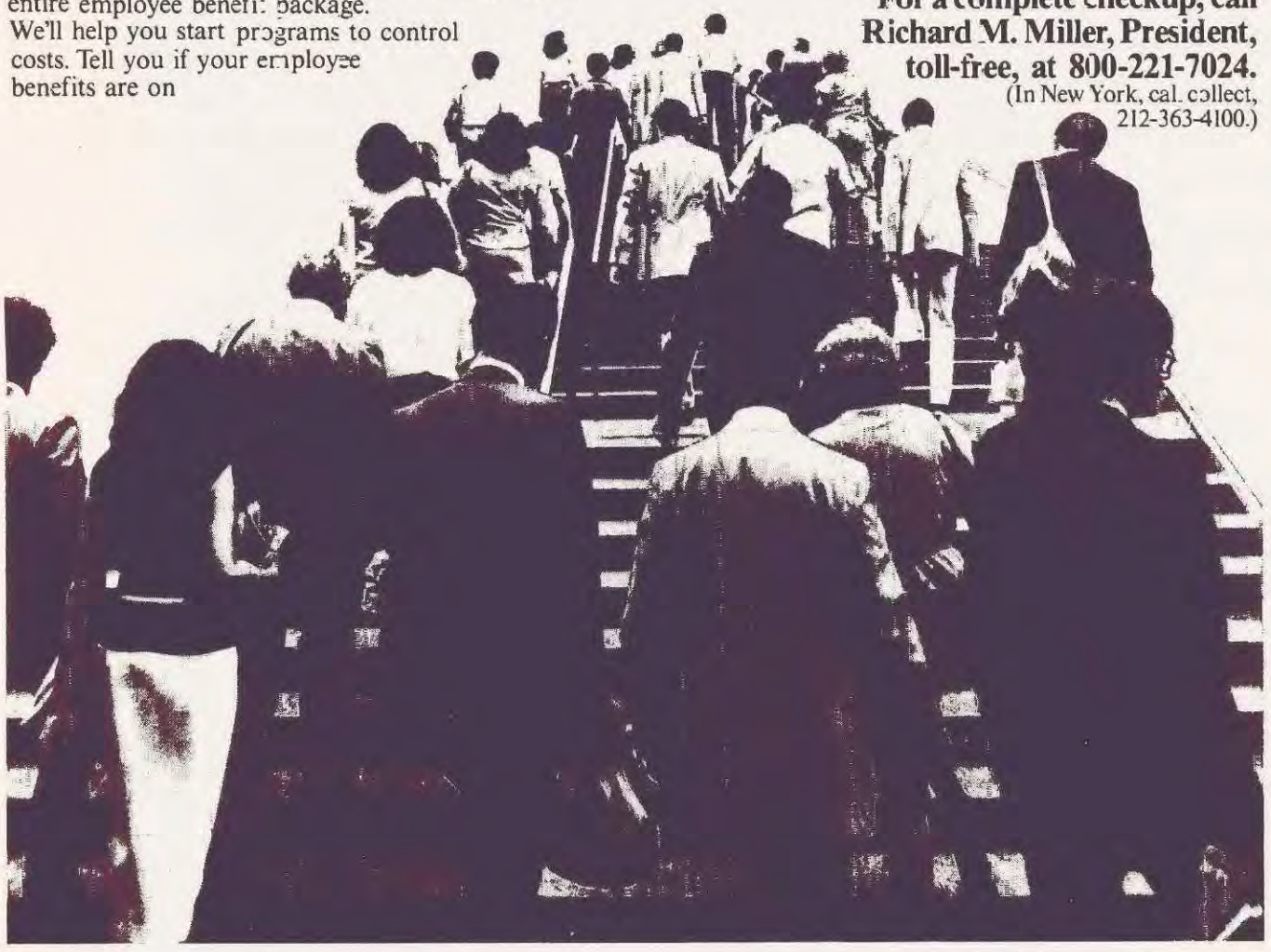
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A task force in Toledo includes Owens-Illinois, Sun Oil, Jeep, General Mills and Champion Spark Plug.

Company officials interviewed agreed business has something it can offer the health care industry that has been ignored too long: a better management approach to prudent use of funds.

"We have to manage our businesses efficiently if we want to stay alive. We don't see that same concern among doctors and hospitals," says Mr. Mendoza of General Dynamics. "We can't imply that we know everything about their business, because we don't. But we do know about business and we do know that we are seeing in the health care system an inefficiency, an unconcern to cost."

Supporters of the group seem unconvinced that government would be able to do any better in this area than the businesses themselves.

"Businesses might be more effective than government because they are motivated by one thing: profit. Government has a lot of other concerns, such as its various constituencies and having to get re-elected, that might color whatever cost containment programs it might come up with," says Mr. Bush of Lockheed.

The employers also say they know they can't depend on medical groups to bring about these changes; the companies have to exercise some cost control efforts of their own.

Most of the firms involved in the increasingly popular movement are stressing such cost control measures as second opinions for elective surgery, pre-admission testing before hospital stays, setting limits on how long employes can stay in hospitals for various surgeries, encouraging annual physical examinations, suggesting alternative methods of health care, paying for out-of-hospital surgery and beefing up education programs to help employes increase their chances of being healthy.

Lockheed has even gone so far as to refuse to pay some doctor bills it believes are too high.

Company officials regularly feed into the computer a list of what average charges should be for various services received by hospitalized patients based on hospital records. When the company receives a health care claim, the computer checks the bill against its memory bank and if it seems excessive, kicks it out and alerts someone in the employe benefits department.

"We paid $30 million in health care last year—80,000 claims," Mr. Bush said. "We look at each one to see if it is reasonable. If not, we go to the doctor, tell him it is outrageous and that we won't pay it. We know what a reasonable charge should be and so does the doctor, and so when we confront him on it, he usually agrees to lower the bill."

Lockheed's figures show that about 70% to 80% of the bills are challenged and that most of them are reduced, some by just $2 or $3, but others by as much as 30%.

While Mr. Bush advocates bargaining with the doctors over these bills, other company officials say they think success can be won in other ways as well.

Mr. Mendoza said one of the prime achievements of his San Diego group was getting a member appointed to a state-mandated agency that regularly reviews area health care services and recommends whether or not the state should approve proposed expansions or requests for additional equipment.

The group has also become more sophisticated about what it takes to change cost containment policies. It recently used a lobbyist to press for passage of state legislation that would create a watchdog agency to regulate the state hospitals and their business practices. The bill was defeated, but Mr. Mendoza said the group will be back next year to push it again.

Members of these employer groups shy away somewhat from forming specific cost containment goals. They argue that if they can just open communication between business and the health care industry and promote greater awareness of the need for more efficiency, they will accomplish something.

But Lockheed's Mr. Bush says business shouldn't be content to settle for that.

"Certainly we should set as a goal that prices of health care should not rise more than the rate of inflation. But we really can't stop there; the base of prices is already too high," he argues.

"If the consumer price index rises 15% in one year and the health costs rise 10%, I don't think we should consider our job done. We still shouldn't be satisfied, because the prices are already too high to begin with. We have to try to bring them down."

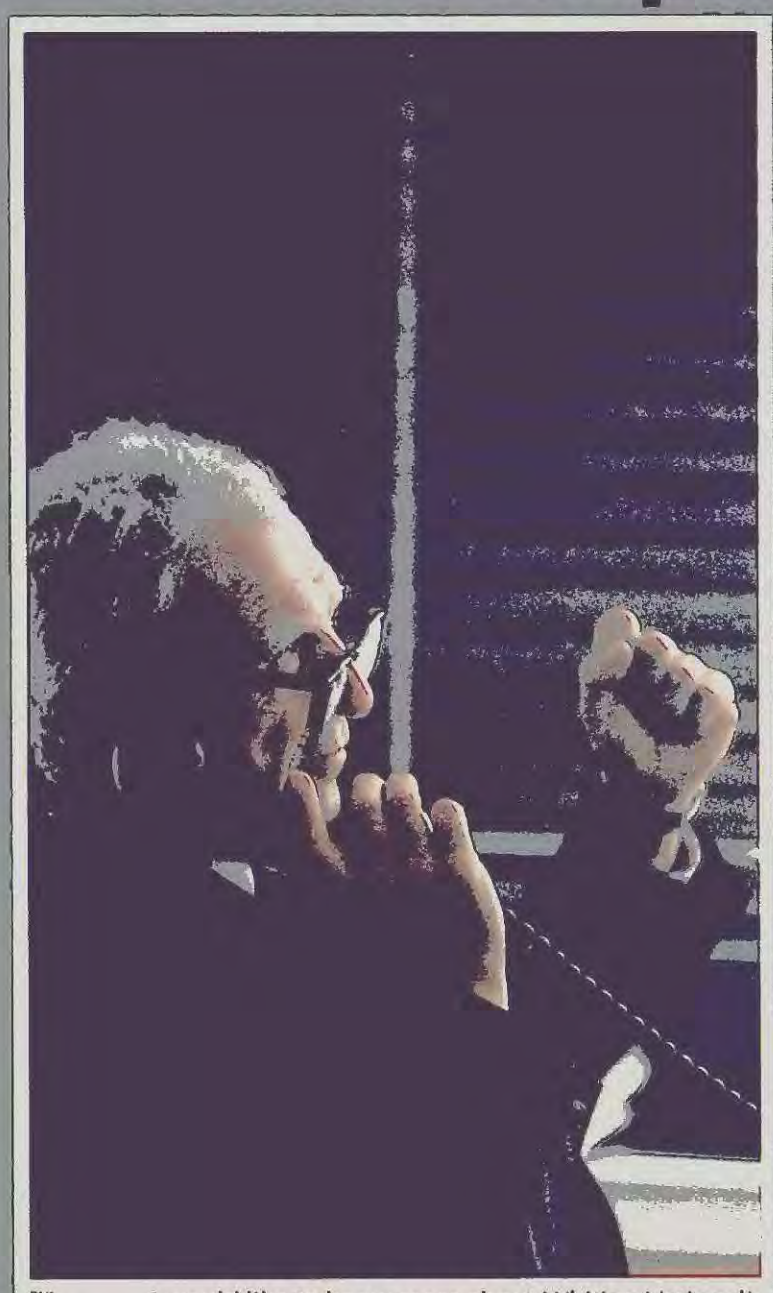
If necessary, Mr. Bush added, someone may have to tell hospitals that maybe they don't need a new piece of equipment or more hospital beds. And that someone may have to be business. ■

Company officials agree business has something it can offer the health care industry that has been ignored too long: a better management approach to a prudent use of funds.

Consulting firm

Allon J. Greene Jr. and Raymond M. Larson have formed a new risk management consulting firm, Advanced Risk Management Techniques in Santa Ana, Calif. Mr. Greene was formerly with Warren, McVeigh & Griffin in Newport Beach, Calif., and Mr. Larson was with a Los Angeles brokerage.

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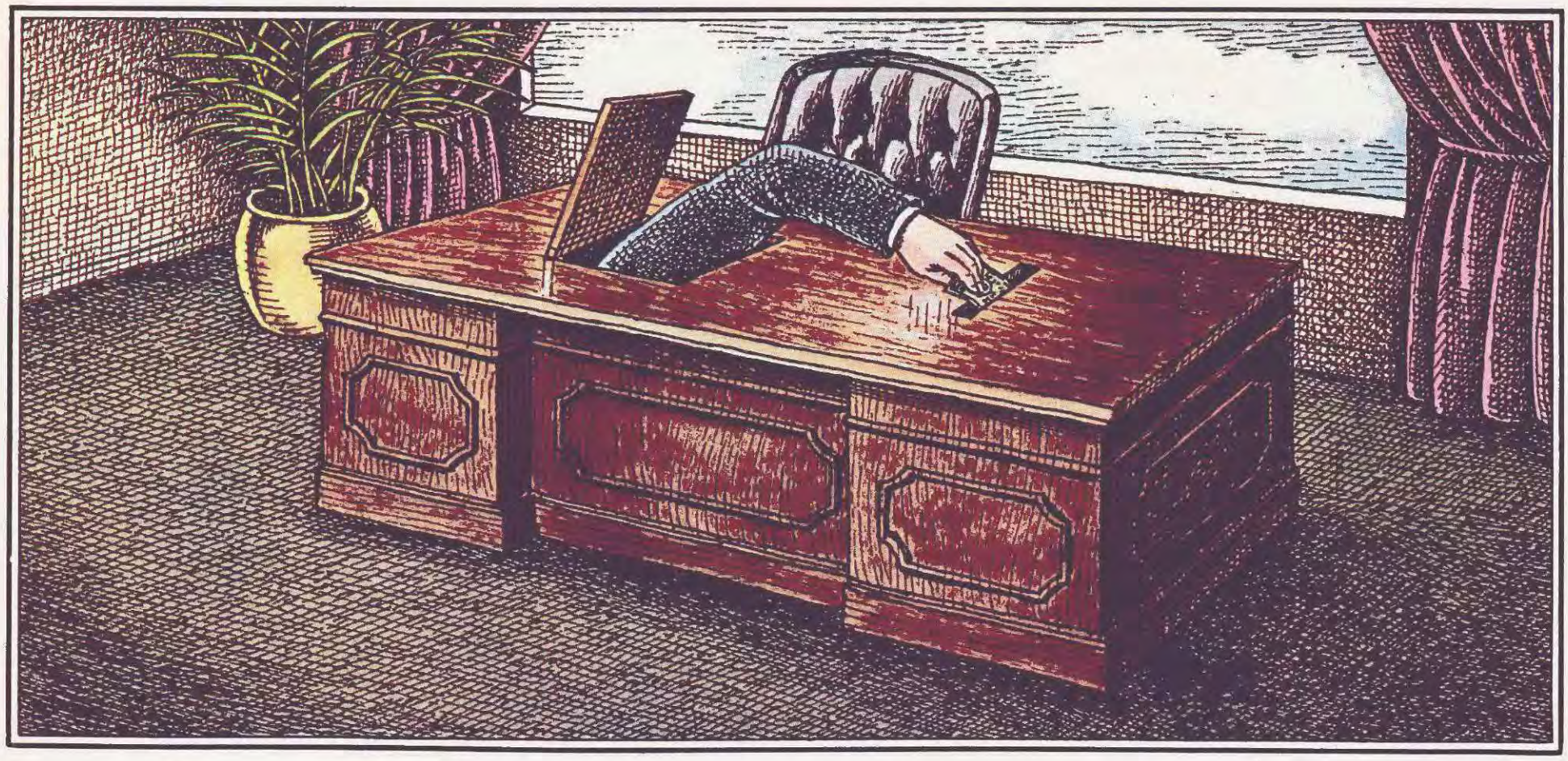
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Self-Funding



Companies which set up a special tax-exempt trust for funding employee benefits, such as health, accident and disability insurance, may realize substantial reductions in costs compared with conventional insurance plans.

A brief review by INA of an insurance topic of interest to business executives.

It is no news to corporate management that outlays for employee benefits have been accelerating at a rapid pace and are likely to continue to do so.

Overall, the cost of providing employee benefits has been increasing at an average rate of 14% a year, going from less than $2 billion in 1950 to an estimated $60 billion in 1978. Benefit plans can cost as much as 35% to 40% of the amount paid in salaries. At many companies, health insurance for employees has become the single most expensive item that the company buys from an outside supplier.

How long can this continue? Since it is the function of employee benefit plans to cover rapidly rising medical costs and to replace lost job income, and since inflation places increasing pressure on employees' real income, they may expect benefit payments to rise accordingly. On the other hand, corporations – which must bear the brunt of the premium costs involved – are looking for sound financial alternatives.

One way now coming into wider use is through benefit self-funding.

No reserves versus reserves

The most direct self-funding technique involves paying claims (for example, hospitalization claims) directly out of the company's cash flow. No reserves for future claims are set aside. And since no premiums are paid, it is possible to save the cost of the premium taxes otherwise payable by the insurance company.

The firm, in effect, becomes its own insurer on a pay-as-you-go basis. However, stop-loss insurance is usually purchased to protect against unexpectedly severe claims experience. Because of ERISA restrictions, such self-funded plans may be suitable only for companies which pay all premiums and do not require employee contributions to their plans.

For many other companies, a tax-exempt trust may be the

Employee Benefits

most satisfactory form of self-funding. This type of trust is essentially a vehicle for setting aside funds and building up reserves through investment. It is limited to voluntary benefits, in contrast to those benefits, such as workers' compensation, which are mandatory under federal or state law. Such a trust may be established and administered so as to qualify for exemption from federal income tax.

A tax-exempt trust is set up to fund a formal plan, drawn to meet the specific needs of an individual company. Employer and employee contributions are turned over to the fund's trustees, who also pay claims and expenses and invest excess funds. With a qualified fund, employer contributions are deductible as business expenses, and benefit payments are generally not taxable to employee recipients.

Shelter from taxes

And most important, the investment income of the trust (other than unrelated business income) is ordinarily not subject to federal income tax.

The result may be a substantial reduction in costs for a plan funded through a trust as compared with traditionally insured plans – particularly on coverages which develop large claim reserves, such as long-term disability. All of which may net out to lowered expenses for employee benefits.

To achieve the potential premium savings involved, self-funding of employee benefits appears to be most worthwhile for companies with over 1,000 employees, although smaller companies also gain under the right circumstances.

In any event, the potential benefits of self-funding should be weighed against cost-cutting plans offered by insurers, such as experience rating and minimum payment plans, which can substantially reduce premiums and increase cash flow while providing full insurance company services.

Administering the plan

Once the decision to self-insure is reached, most businesses find they will have a need for administrative services furnished by a professional outside supplier. These services include consultation on the establishment of a benefit plan, its planning and design, and the creation of a tax-exempt trust.

After the plan is in operation, claims administration becomes the most important function of the outside administrator, together with the preparation of booklets, documents, government reports and other communications. ESIS, one of the INA companies, can supply these services to business through its employee benefits division.

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When a third party determines an employee's eligibility for benefits, the decision may be more readily accepted than when it is made by the employer's own people.

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PERSPECTIVE



The President's Council on Pension Policy is only one governmental group that will be confronting the exploding benefits issues of the 1980s. The quality of their decisions will depend on the information available to them, says Dallas Salisbury.

Booming employe benefit legislation resonates with echoes of deja vu

By Dallas L. Salisbury

EMPLOYE BENEFIT LEGISLATION proposals likely to surface in the 1980s generally won't be new. Most have been discussed for many years, and like most good debate topics, have opponents and proponents in both the public and private sectors. Neither the private interests nor the public decision makers have developed an internal consensus.

The common consideration in coverage, pension and health care questions is that there is no consistency in what terms mean and what analytic factors must be taken into account to make reasonable decisions. In addition, no one is really sure what costs are relevant and how they might be measured.

I have divided the likely legislative proposals of the 1980s into four major categories:

- Coverage and participation.
- Benefits.
- Funding.
- Health.

Coverage and participation

A number of proposals for expanding pension plan coverage, participation and vesting to a wider range of workers are being considered. Specifically, the following have been suggested:

- Incentives or requirements for coverage and participation of all workers, where all employers would be given stronger incentives or be required to provide the choice of pension plan coverage and participation for workers. The basic objective would be to ensure that all firms make pension plan participation available to their workers, much as they are required to make workers compensation and other minimum benefits available. The Harris survey on public pension attitudes conducted earlier this year found that 80% of the public favors mandatory coverage.
- Incentives for expanding the use of IRAs, where employes would be encouraged to establish IRAs through a number of potential incentives, including: higher limits on allowable contributions to IRAs; deductibility of employer contributions to IRAs (also known as simplified employer pensions—SEPs); permitting IRAs for workers already participating in employer-sponsored plans, or permitting homemaker IRAs by allowing married individuals to compute tax deductible contributions on the basis of one half of combined income.

The basic objective of these proposals would be to encourage workers who do not participate in a plan or who would prefer to supplement their basic retirement savings to establish fully portable individual retirement accounts under terms similar to typical pension plans. The House Ways and Means Committee, the House Committee on Aging, Rep. Sam M. Gibbons (D-Fla.) and Rep. J. J. Pickle (D-Tex.) have developed proposals along these lines. The Harris survey found that 60% of those in plans would also like to contribute to an IRA.

- Changes in minimum participation standards, where workers under age 25 or those working less than 1,000 hours per year would be included as participants in qualified pension plans. Because some believe ERISA's minimum standards did not go far enough in expanding participation, this proposal is intended to ensure that younger workers and substantially part-time workers participate in pension plans.
- Requirements for full portability of pension benefits or shorter vesting standards, where qualified pension plans would be required to contribute amounts associated with separated workers' accrued benefits to a common fund for subsequent payment to retirees. This portability proposal or

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Dallas L. Salisbury is executive director of the Employe Benefit Research Institute, a nonprofit group created to contribute to the development of public policy on employe benefits. His remarks are taken from a speech given to the Western Pension Conference in Vancouver, B.C.

Save your key man benefit via insurance

By Robert L. Gordon

KEY EXECUTIVES could lose a highly valued employe benefit within the next few months.

Section 105 of the Revenue Act of 1978 imposes nondiscrimination requirements on uninsured medical reimbursement plans to maintain their current favorable tax status. By removing most of the tax advantages of these popular plans, the law substantially reduces the benefit for the key employe.

Planning with the help of a knowledgeable broker and a cooperative insurer, however, could preserve the status quo of the medical reimbursement plan.

Before the new legislation, uninsured medical reimbursement plans were a popular method of providing tax-exempt payments to highly compensated executives. The executive was "reimbursed" for certain medical or dental expenses that were not covered under the conventional group insurance programs. Since most plans covered a vast array of preventive, as well as corrective, medical and dental expenses for the executive and his family, the employer-established arrangement had the effect of providing tax free income.

Nondiscrimination rules

The new legislation imposes nondiscriminatory rules, similar to those established for qualified pension plans, to continue favorable tax treatment for payments under such plans. If the nondiscrimination requirements are not met, all or a sizable portion of the payments received by the key employe will be considered taxable income.

Corporate employers have four options in view of the new legislation:

- Revise the medical reimbursement plan to comply with the nondiscrimination requirements.
- Continue the plan as is.
- Discontinue the medical reimbursement plan.
- Insure the plan.

Considering the available options, revising for compliance would seem to be expensive to the corporation. Extending the comprehensive benefits of the plan to all employes in a nondiscriminatory manner—for example, as a percentage of gross pay—could prove costly. Although certain employes can be excluded for the nondiscrimination test, the plan would be opened to a sizable portion of all employes. Further, the plan could lose its status as a "special" benefit for key executives.

Continuing the medical reimbursement plan as is also does not appear to be a viable alternative. This option would be impractical because it defeats the purpose of the plan. Including the plan payments in gross or taxable income dilutes the beneficial effect, considering the tax brackets of most key executives.

The third option, discontinuance, is more practical than the above; however, an important employe benefit is lost. Another existing benefit could be enhanced or a new item could be added as a replacement gesture. Research and implementation of any replacement item could be time consuming and expensive. Also, it is difficult to replace exactly the particular benefit effect of the plan; inevitably it will be too much or too little. Substitution is improbable, if not impossible, for a highly valued benefit that was tax deductible to both employer and employe. This option depends on the individual corporate philosophy.

Insured plan

Perhaps the wisest option is to insure the medical reimbursement plan. Currently, an insured plan is not subject to the nondiscriminatory requirements of the new law. The key elements under this approach are the benefit design, definition of classes eligible and the funding vehicle. In most instances, the medical reimbursement plan can be made a part of the conventional group insurance plan. Anticipating a demand for this product, several major insur-

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Robert L. Gordon is an account executive of Mack & Parker Inc., a Chicago-based insurance brokerage firm. Mr. Gordon's area of expertise is employe benefits.

PERSPECTIVE

Consider the hidden costs of rollup when calculating wage increases

By Joseph L. Fromm

ONE OF THE IMPORTANT elements of wage increases today is the hidden cost known as "rollup." Rollup is the cost of employe benefits such as vacations, holidays and overtime premiums that increases automatically as wages increase.

Unions like to ignore these costs.

The recent settlement between General Motors and the United Auto Workers was estimated by a leading business weekly magazine to cost $4.77 per hour more over the three-year agreement. The cost of rollup was estimated to be 82 cents or 30% of the estimated increases in wages and the cost-of-living allowance.

The cost of a negotiated settlement generally is calculated in terms of hours worked. The cost of wages for non-worked hours is calculated separately and rollup results when the cost of non-worked hours increases as wages increase.

In addition to vacations and holidays, statutory benefits such as Social Security taxes and workers compensation also are directly related to wages and their rollup effect should be recognized.

Cost element

Other rollup costs, if they are related directly to wages, could include shift differentials, insurance and pensions.

If benefit costs are discussed across the bargaining table, union representatives are reluctant to recognize rollup as an element of cost, but there is precedent for citing this factor.

Rollup is believed to have been identified for the first time at the bargaining table in the 1961 negotiations between Chrysler Corp. and the UAW. Chrysler agreed to defer 5 cents from wages until the third year of the contract, when that sum was to be put into a separate account for later use as part of the supplemental unemployment benefit fund.

UAW vp Irving Bluestone is reported to have said, "For every penny you are saved, for every hour you are saved, we want the accelerated impact costs figured into that account."

The UAW officially recognized accelerated impact or rollup in the 1967 negotiations when a capped cost-of-living agreement (COLA) was negotiated. Each of the automobile companies sent a letter to the UAW stating the difference between the capped COLA and the COLA that would have been generated by the regular formula would be spent for wages or other benefits in the 1970 negotiations.

The letter stated: "The value of each cent . . . which is spent for purposes other than in wage increases shall be adjusted for the impact (rollup) such cent would have had if it had been paid in the form of a cost-of-living allowance . . ."

Rollup was also recognized as a cost in President Nixon's economic stabilization program of the early 1970s as an "included benefit."

Guidelines issued by the Council on Wage & Price Stability in October 1978 spell out rollup as the "added cost of wage-related benefits resulting from a scheduled wage increase" and require that it be included in determining the cost of a wage settlement.

Rollup, even for companies with modest wage-related benefits, quickly approaches 20% of wages and, in the case of the automobile industry as evidenced by the General Motors settlement, can be as high as 30%.

Assume a company has 10 paid holidays, wages of $6 per hour and employes work an average of 1,800 hours per year. The cost of the holidays before a wage settlement would be 26.7 cents per hour. **(See holiday rollup chart.)**

If an increase of 80 cents were given in a three-year contract, the cost of the 10 holidays would increase to 30.2 cents going through the same calculation (80 hours × $6.80/1,800 hours). This is an increase of 3.5 cents per hour worked resulting from the 80-cent increase.

Shortcut calculation

A shortcut to calculating rollup, particularly helpful when other benefits are included, is done by using a percentage. For instance, in the above example, 80 hours of holidays represented 4.4% of hours worked (80/1,800). The 3.5 cent rollup effect of the 80-cent wage increase is calculated by multiplying 80 cents by 4.4%.

If the average vacation time for employes of a company were 100 hours, the rollup would be 5.6% for 1,800 hours worked (100/1,800) or 4.5 cents on a wage increase of 80 cents.

A few years ago, Social Security taxes were not recognized in rollup because of the low tax base. A recent amendment to the law, however, increased the tax base to $22,900 this year and $25,900 in 1980 and

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Holiday Rollup

10 holidays x 8 hours per holiday	=	80 hours
80 hours x $6 per hour	=	$480 per year
$480 per year ÷ 1,800 hours	=	26.7¢ per hour worked

Average Rollups

	Percent	Amount
Holidays (80 hours)	4.4%	3.5¢
Vacations (100 hours)	5.6	4.5
Social Security taxes	6.7	5.4
Shift differential	2.0	1.6
	18.7%	15.0¢

Joseph L. Fromm is director of employe benefits and risk management at the American Motors Corp. in Southfield, Mich.

Another's loss could shut you down, too

By Ralph A. Korn

YOU WOULD UNDOUBTEDLY have difficulty finding five risk managers out of 100 who could accurately define contingent business interruption coverage and present examples of how it works. At the same time, I dare say, equal difficulty would be encountered in locating five risk managers who have given a single whit of thought in the past 12 months to the contingent business interruption exposure.

Yet, the possibility of fire destroying a company facility with a resultant direct business interruption loss is with the risk manager every time he or she steps into the plant. Spectral visions of the plant in ashes, resulting in a lengthy shutdown, haunt his waking hours (and occasionally his sleeping as well). But how often does he have a mental picture of his magnificent facility standing undamaged, but equally idle because the principal supplier of raw materials or the largest customer suffered a catastrophic loss and is no longer able to produce the vital raw materials or purchase the finished product?

Contingent business interruption (CBI) insurance protects the policyholder against loss if business is interrupted because of a loss caused by an insured peril at premises not owned, operated or controlled by the policyholder. These are referred to as "contributing" or "recipient" properties. Let's look at examples of each:

- **Example I**—"Contributing property" is so named because it "contributes" to or supplies the policyholder's business. ABC Co. manufactures glass and purchases silica sand from XYZ Co., which has only one plant. ABC is the policyholder and XYZ is the "contributing property."
- **Example II**— "Recipient property" is so named because it "receives" material from the policyholder, generally as a customer. ABC, the glass manufacturer in example I, sells all or most of its production (bottles) to a giant brewery with a single bottling facility. That facility is the "recipient property."

A third type of property which, if damaged, may create a CBI loss to a policyholder is sometimes referred to as "leader property."

- **Example III**—Jack's Hobby Shop is a small business in a shopping center dominated by the presence of a giant supermarket. Jack may wish to consider CBI coverage that would protect his profits if the supermarket (the leader property) is destroyed by an insured peril, causing a drastic reduction in the number of people frequenting the shopping mall.

The most important thing to remember is that the contributing, recipient or leader property must not be owned, operated or controlled by the policyholder. This fact can present some interesting problems for the risk manager. The contributing or recipient property may be poorly managed from a loss protection standpoint, thereby increasing the CBI exposure. How does the risk manager tell his company's largest customer that its facility is a disaster waiting to happen?

Multi-level approach

The answer, aside from an obvious "very carefully," is that the best approach is possibly on a multi-level basis involving conversations between the two companies' top management, product development teams and sales and purchasing department personnel, as well as dialogue between the two risk managers. The approach emphasizes the significance of the relationship existing between the two companies and the dependence of each upon the other as market and supplier. If handled properly, the relationship will prosper and the message will get through.

How do you determine how much CBI coverage to buy? CBI values are computed exactly the same as direct business interruption values. Ordinary payroll may be included or excluded as desired. The amount of CBI is dependent upon the answers to at least the following questions:

- Is the policyholder completely dependent upon the contributing or recipient property as the sole source of supplies or as the sole market for the policyholder's product?
- Is another supplier or market readily available? If not, how long will it take to develop alternate suppliers or customers?
- What is the likelihood of a total or severe partial loss at the contributing or recipient property?
- What is involved in getting those facilities restored to production after a loss? (The lead time on very specialized equipment could be alarmingly long.)

These questions are designed to get the risk manager thinking in the right direction. Further and increasingly specific questions should follow, depending upon the answer to the above inquiries. It may be possible for the policyholder to substitute another ingredient in his process and eliminate the exposure from contributing suppliers. However, this may entail costly and time consuming changes to the policyholder's process to accommodate the otherwise acceptable substitute.

At this point, it is apparent that many different people and departments within the insured organization are going to become involved in the effort to determine whether a CBI exposure exists, and if it does, to what extent. The efforts to solve the problem once it is identified will become even more intriguing.

In his endeavors to isolate a CBI exposure arising from contributing properties, the risk manager must initially develop an understanding of the processes used in the manufacture of the policyholder's product. What raw materials are used? What are acceptable substitutes for these materials? If it became necessary, how quickly could the policyholder begin to introduce substitute raw materials into its production process? What modification (if any) would be needed to the policyholder's equipment and how long would it take to make the changes? At what cost?

Investigative effort

The policyholder's purchasing department can answer other important questions such as: Are vital raw materials purchased from only a single supplier? If so, why? Are these raw materials in short supply so all users will be placed on an allocation if a producer is shut down? Although it is generally not insurable under a CBI policy, consideration must be given to the consequences of political upheaval in the world and its effect upon supplies of raw materials from foreign countries.

Perhaps the risk manager's investigative efforts will lead him to the conclusion that CBI insurance should be purchased. Perhaps, on the other hand, changes in his company's policy involving purchasing, inventory control, sales, marketing and product design and development will resolve the CBI question. In either event, the risk manager will become more intimately familiar with the operation of his company and, it is hoped, will alert others within his organization to be aware of the constantly changing conditions that may create a contingent business interruption exposure. ■

Ralph A. Korn is director of insurance for the E. & J. Gallo Winery in Modesto, Calif.

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PERSPECTIVE

Benefits issues evoke sense of deja vu

Continued from page 55
shorter minimum vesting periods could substantially improve pension plan participation and benefits for a large portion of the workforce. Consequently, it could be quite costly as well. According to Harris, employe support for portability is almost universal.

• Requirements for universal Social Security coverage, where all public employe groups would be required to participate in the OASI program. The objective is to eliminate the potential financial gain available to certain public employes but not to others from electing out of the Social Security program. The task force studying this issue is scheduled to submit proposals early in 1980. The Harris survey found that a majority favor universal coverage.

Pension benefits

Congress and others have begun to consider a number of proposals. Specifically, the following types of proposals have been suggested:

• Requirements for indexing private pension benefits, where benefit payments to current retirees would be adjusted over time to reflect both the level and pattern of the cost of living during the retirement years. One popular approach is simply to adjust benefits according to changes in the CPI. The purpose would be to ensure retirees' purchasing power does not decline below acceptable levels during the retirement years. According to the Harris survey, 93% of employes want benefits fully indexed.

• Improved joint and survivor benefits, where such benefits are currently subject to actuarial reduction at the discretion of plan sponsors. Some suggest these benefits should not be subject to actuarial reduction and that they should be indexed or otherwise increased to maintain a constant real purchasing power. According to Harris, 83% of employes desire strong survivor provisions.

• Individual choice of benefit supplementation, where workers could choose to make tax deductible contributions to employer-sponsored pension plans. This would give the worker greater flexibility in selecting the most appropriate mix of pre- and post-retirement saving to achieve retirement income goals. The ERISA Improvements Act of 1979 and the House Pension Task Force proposals address this form of benefit supplementation. According to Harris, 60% of employes would be likely to take advantage of such a provision.

Pension funding

A major purpose of ERISA was to ensure adequate funding for the benefits earned by workers under private pension plans. By establishing fiduciary standards, minimum funding rules and a Pension Benefit Guaranty Corp., the 1974 private pension law helped encourage more prudent funding of private plans.

A number of new proposals have been suggested, including:

• Modifications to the PBGC insurance programs, where current benefit guarantees and funding standards for multiemployer plans would be modified to provide stronger incentives for plan continuation while insuring most retiree benefits, including 100% of the benefits for workers in lower wage industries and occupations. In addition, redefinition of employer liability and a shift from the insurance of terminations to the insurance of plan insolvencies is being discussed. The PBGC proposed such legislation last spring.

• Changes in Social Security payroll taxes, where recent proposals have emphasized the deferral of projected increases in the interest of reducing potential inflationary impacts. However, some have also raised the possibility of accelerating the projected payroll tax increases later in the century to provide a cushion of funding in the next century, when required increases in the payroll tax may be prohibitive or unacceptable to workers.

• Establishment of index bonds or other pension securities, where pension plans can invest in such securities as a hedge against inflation and provide greater retiree benefit security.

• Public employe plan funding standards, where such plans would be subject to the same type of minimum standards as private plans. One proposal, the Public Employe Retirement Income Security Act, would call only for minimum standards of participation, vesting and fiduciary responsibility, and not address funding rules at all. However, the relatively poor funding status of some public plans suggests the establishment of minimum funding standards will be the subject of some discussion when considering the regulation of public employe plans. According to Harris, 66% of employes and 90% of business leaders believe public plans should be subject to these standards.

• Control and investment of pension assets has become a much discussed area. The concerns are both social and political, with politics being the true driving force. The social concerns, however, could lead to legislative proposals which require percentage allocations to certain investments.

Health care

Controversy over health care will not subside in the near future as major proposals of yesterday and today continue to be considered.

• Cost containment proposals will be considered as health care costs continue to move upward with inflation.

• Catastrophic accident coverage will continue to be discussed as an approach if no more comprehensive program can be agreed upon.

• Comprehensive national health insurance proposals will be before Congress until some program is enacted.

• Health maintenance organizations will continue to be evaluated and proposals will be presented to expand HMO coverage.

In dealing with these proposals and others, it is essential Congress consider their long-term consequences. There is a need to know the potential impact, the alternatives available and the degree to which a given proposal helps unify national retirement policy.

The quality of resolutions will depend upon the quality of the information available to decision-makers. There are numerous government groups now working to develop recommendations for retirement income policy, principally:

• The President's Commission on Pension Policy.

• The Universal Social Security Coverage Task Force.

• The Advisory Council on Social Security.

• The National Commission on Social Security.

The employe benefits industry is involved in these efforts, but must also develop the ability to evaluate fully the recommendations of these groups.

Industry must sustain its effort toward a national policy framework of coordinated goals, objectives and policies.

The normal private steps toward new program development or the evaluation of present programs is frequently to look at (1) legal issues, (2) cost issues and (3) consistency with policy goals. For government, the steps generally follow a different order, namely, (1) policy goals, (2) legal issues and then (3) cost issues. Private organizations must recognize the difference and force recognition of all the issues.

As professionals who spend a major portion of our time on employe benefit issues, the challenge is ours. It is time for us to join together and move toward workable national retirement policies. ■

Insurance saves reimbursements

Continued from page 55
ers have developed underwriting rules, amendment forms and computer reports.

The design and implementation of an insured medical reimbursement plan can easily be accomplished by any knowledgeable broker specializing in employe benefits and an accommodating insurer. An amendment to the existing master policy can provide a benefit design and classification similar to those of the uninsured plan. A major medical benefit structure of 100% coinsurance and no deductible would take care of medical expense. Items such as physical examinations, dental care, vision care or any preventive care require some additional technical expertise, but are certainly possible.

These insured benefits must be made available to a definable class. Job title, salary and years of service could be acceptable for class designation purposes. Possibilities of such a class would be "all officers whose basic annual earnings are $50,000 or more," or "all officers and superintendents with 20 years or more of service." Benefit levels could vary by definable class, so it is possible to design a program with greater benefits for higher classes.

Funding vehicles vary among the insurers. Some will charge a higher premium rate for the class benefited by the plan, while others will amortize the additional cost over all classes. Others prefer a "cost-plus" funding mechanism. A higher "pure insurance" rate is more likely for a group on a nonrefund basis.

A "prefunding" arrangement or rate is likely for retention groups, since their ultimate cost is claims and insurer expenses. A large group on a quasi self-insured basis presents the least degree of difficulty from a funding vehicle standpoint, while true self-insureds present unique considerations.

Underwriting rules also vary among insurers and may vary depending on the size of the group. Some insurers require as many as 10 employes within a designated class, while others have no such minimum. With some insurers, the variety of items to be covered under the medical reimbursement plan is also contingent on the total size of the group. Virtually all insurers offering this benefit require a total group of at least 50 employes. Smaller employers will have to vary benefit design within existing product lines.

All insurers offering this approach should be able to report back to the employer amounts paid by individual, under the medical reimbursement plan. In reviewing the claims handling procedures of two major insurers, the majority of claims control responsibilities will rest with the policyholder. This is understandable, since the plan is supposed to cover items normally not found in conventional group plans.

Assuming a corporation wishes to continue its medical reimbursement plan in some format, the insured approach is the best method. Plan costs are predictable and can be controlled, while tax advantages are still present. With an insured plan, the key executive won't lose an important and attractive benefit. ■

Rollup adds to cost of settlement

Continued from page 56
now requires recognition.

The cost of Social Security taxes before a wage settlement would be 40.4 cents and the rollup would be 6.7%. **(See chart.)**

The cost of Social Security taxes at $6.80 per hour would be $825.34 or 45.8 cents per hour, an increase of 5.4 cents. A direct multiplication of the 80-cent increase by 6.7% equals 5.4 cents.

The Social Security rollup also can be determined by a percentage of hours compensated to hours worked times the Social Security tax rate.

The last element, shift differential, would apply if the premium were paid as a percent of wages. Assume a company pays a 5% premium for the second shift and 40% of the employes work this shift. The rollup would be 2% (5% × 40%) and would be 1.6 cents for an 80-cent wage increase.

Putting the four elements in the above examples together would result in a rollup of 18.7%. **(See chart.)**

An increase in wages of 80 cents would generate hidden costs or rollup of 15 cents (80 cents × 18.7%).

If life insurance or pensions are a function of wages, as they often are for salaried employes, these costs, just like vacations and holidays, will increase with wages and should be built into the rollup calculation.

Other rollup benefits include the overtime premium, when time-and-a-half or double time is paid, jury duty, bereavement and short-term military duty. ■

Social Security Tax Rollup

Hours worked	1,800	
Holidays	80	
Vacations	100	
Hours compensated	1,980	
	x $6	per hour
Total wages	$11,880	
	x .0613	Social Security tax rate
Social Security tax	$727.24	

Cost per hour worked: $727.24/1,800 = 40.4¢

Rollup: $\frac{\$727.24/1{,}800 \times \$6}{1{,}800 + 80 + 100} = 1.1 \times 6.13\% = 6.7\%$

Insurer monitoring of health treatment may reduce costs

By RHONDA L. RUNDLE

Employe Benefits

LONG BEACH, Calif.—Looking over a doctor or dentist's shoulder before the ordered care is rendered could slash hospital costs and improve treatment, say advocates of prior authorization and predetermination.

Prior authorization, encouraged by financial rewards, is halving hospital stays for policyholders of one insurer here. Dental plans requiring predetermination, expect better care results.

Health Maintenance Life Insurance Co. in Long Beach for several years has offered policyholders strong dollar incentives to obtain prior authorization for all hospital admissions and the length of stay. The patient's doctor submits a one-page form summarizing the diagnosis and proposed treatment to HML's medical director for approval.

HML statistics show startling reductions in hospitalization compared with those of traditional indemnity insurers. Inpatient hospital days per 1,000 HML members averaged 450 for the first quarter of 1979, compared with the national average of 750 to 800 for other insurers.

"Putting a specific time frame on hospitalization creates an impetus to get the patient out on time," says Dr. Gerard N. Mazo, HML medical director. "This forces the physician to organize his time better, to visit patients in a logical sequence." Evening discharges, he points out, are billable for half a day.

Dental insurance plans have used the "prior determination" approach for years, notes Dr. Dale Redig, executive director of the California Dental Assn. "Most dentists are trained to detail the full treatment and its cost to all patients before undertaking any work." Once a dentist has made an estimate, he'll usually stick by it, Dr. Redig adds.

The largest dental plan in California requires predetermination but not pre-authorization. California Dental Service is a nonprofit, prepaid plan established 24 years ago and is an affiliate of Delta Dental Plans, a Chicago-based conglomerate.

Unlike many dental plans, CDS does not establish a fee schedule for specific dental procedures. Benefits are determined by individual dentists' usual rates, which are reviewed periodically to assure they are customary and reasonable. Nearly 90% of California dentists file their rates with CDS.

CDS lists about 2,000 subscriber groups including General Motors in California, Rockwell International, Aerojet General, McDonnell Douglas, Kaiser Steel, the California state legislature and 600 school districts.

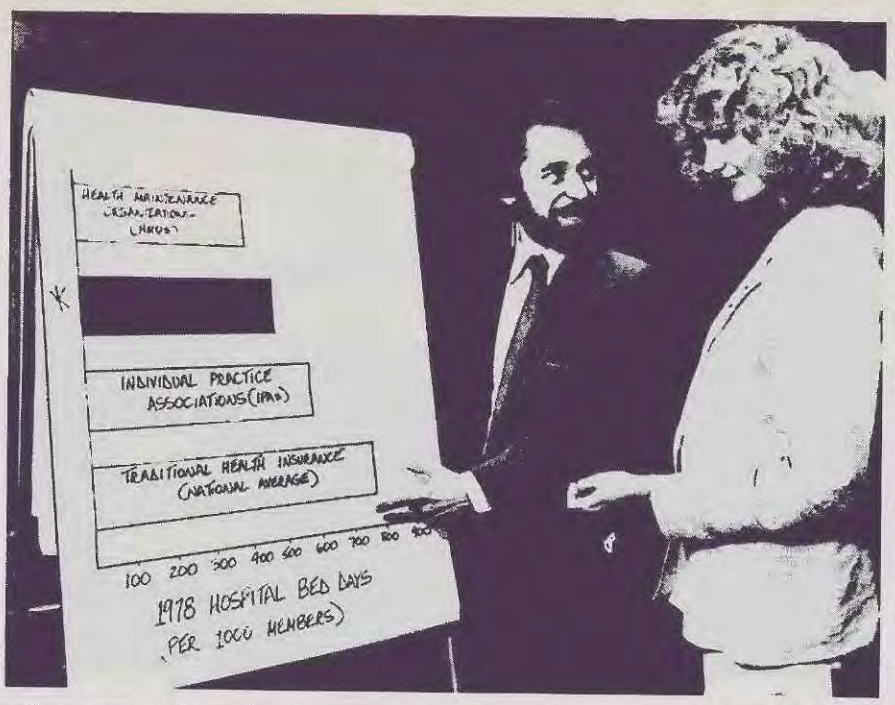
Medical doctors have not been trained to approach treatment this way, Dr. Mazo concedes, but there's no inherent reason why they can't do so. "Physicians are becoming aware of the tremendous over-utilization problem and most are willing to go along with reasonable measures to contain costs," he says.

Although predetermination is favored by many insurers as a mechanism to cut costs, at least in dental plans, some professionals also say it promotes better care.

"Human nature being what it is, treatment plans are carefully planned when dentists know they will be reviewed by peers," observes a former senior vp of Group Health Inc., a New York plan that requires predetermination of dental services.

Predetermined and pre-authorized are not synonymous terms. Predetermined means a treatment plan is prepared in advance and submitted to the insurer; pre-authorization requires actual approval of the program be-

Continued on next page



Prior authorization, or approval of a medical treatment plan before it can be done, could cut the cost of care, contend Dr. Gerald N. Mazo, medical director at Health Maintenance Life Insurance Co., and Judy Shelton, nurse coordinator. "Putting a specific time frame on hospitalization creates an impetus to get the patient out on time," Dr. Mazo says.



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Monitoring cuts cost

Continued from preceding page
fore the medical specialist can proceed. Both approaches typically include special provisions for medical emergencies so treatment can begin immediately without jeopardizing insurance benefits.

HML subscribers are not technically required to seek prior authorization for hospitalization, but the advantages in doing so are compelling. Pre-authorized admissions are 100% covered, while unauthorized stays are only 80% paid, even if subsequent investigation fully justifies the admission.

Many groups, Dr. Mazo says, select HML's plan over a health maintenance organization because HML doesn't disturb a patient's relationship with a preferred family doctor.

Created five years ago by Family Health Program, a 20-year-old California-based HMO, Health Maintenance Life is still the only California indemnity insurer with approval from the insurance department for its prior authorization approach. HML president David LeSueur knows of no imitators in any state.

HML is still of limited size and geographic scope. About 15,000 individuals in 140 organizations in Southern California are members, plus another 50 subscribers in Guam. The vast majority of HML's accounts are commercial enterprises with 75 to 350 lives. HML also insures a couple of local school districts and boasts of a contract with Uncle Sam for government personnel in Guam.

HML's market share is expanding rapidly, however, says Mr. LeSueur, which may force major health insurers to consider a similar plan. HML has charter applications pending in 15 states, largely concentrated in the Northwest and Rocky Mountain regions. Utah is its first expansion target.

HML has also recently been asked by several self-insuring groups to administer prior authorization programs for them.

But insurers and policyholders alike are concerned about physicians' reactions to the paperwork burdens of prior authorization programs. Some users have expressed impatience with physicians' failure to complete forms fully and promptly. "Most of the time there's no problem," Dr. Mazo says.

Three HML group subscribers interviewed by *Business Insurance* were generally positive about the plan, although none of the companies has much claims experience, possibly a reflection of the relative youth of HML.

At West Coast Foods, a small Los Angeles company, Sharon Allen, in charge of insurance for the firm, speaks from first-hand experience. "I had an emergency and my doctor got authorization right over the phone so everything was cleared by the time I got to the hospital," she says.

Some employes, however, have had difficulty getting their doctors to complete the documents, she notes. One worker lost benefits last August because the physician forgot to file the appropriate forms. The employe had to pay the 20% differential, says Mrs. Allen, although the decision is being appealed.

"It seems to work quite well," says Bert Bacho, administrative director with W. Simmons Mattress Co., a Cerritos-based manufacturing company with 90 employes. "Everyone is just as happy to contact a physician in advance in order to assure the 100% payment."

W.R. Grace Development Co. shopped around for two months before settling on HML, says controller Charles Lambert. "We wanted to match our old plan after splitting off from W.R. Grace, our former parent company," he explains. HML was recommended by the firm's insurance broker and the 45-person group is now enjoying benefits comparable to those of W.R. Grace's 70,000 employes at about the same cost, he says. ■

Group life sales

Group life insurance purchased under new or revised group contracts totaled $13.2 billion in September, compared with $11.6 billion a year earlier, according to the Life Insurance Marketing & Research Assn. Industrial life insurance purchases were $392 million, compared with $486 million a year earlier. Group purchases from October 1978 to September 1979 were $133.5 billion compared with $118.9 billion a year earlier.

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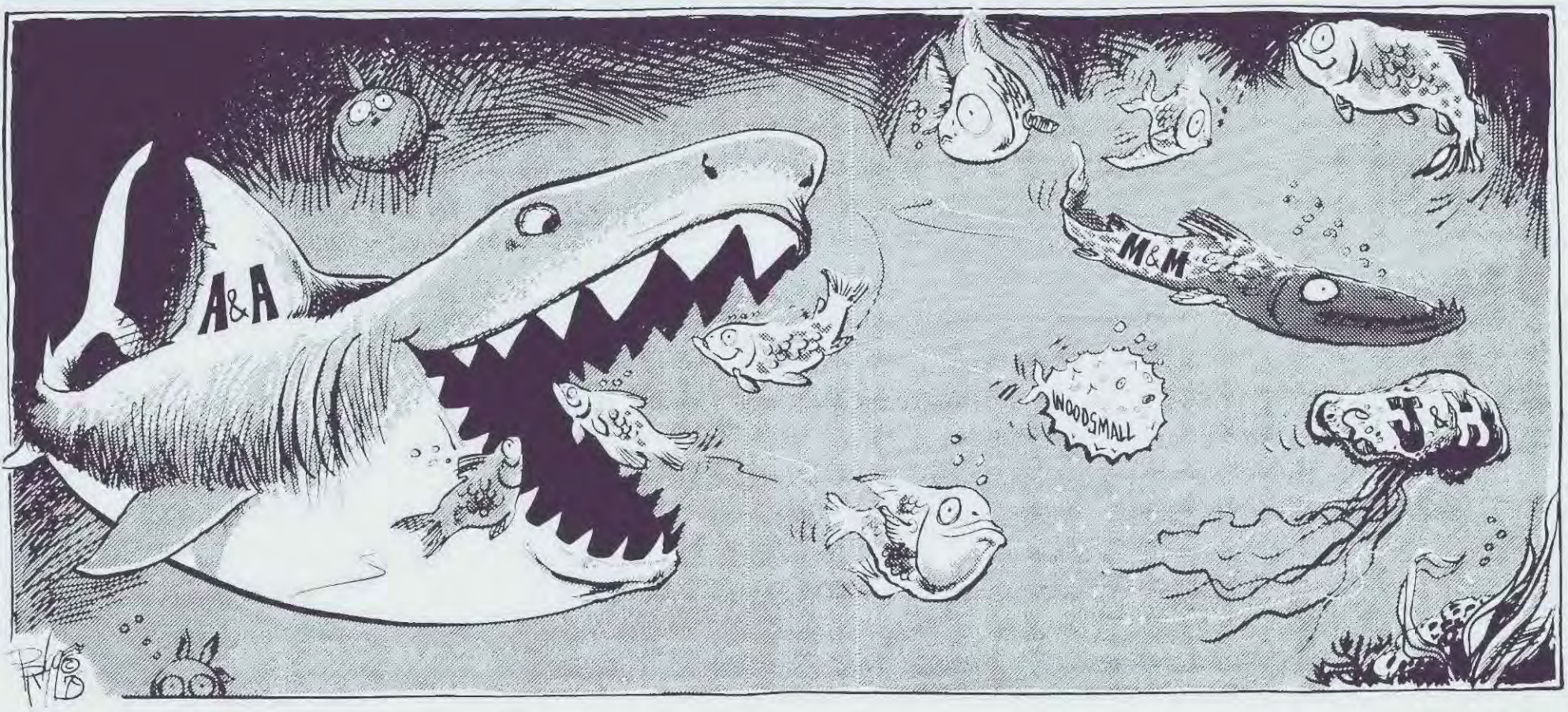
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agent/broker topics

A REGULAR EDITORIAL SECTION EXCLUSIVELY FOR AGENTS AND BROKERS



Brokers go on merger diet

By DAVE GALANTI

CHICAGO—The buy-a-broker boom is over, or so say most of the experts in the merger-acquisition consulting business. But the momentum of the era may be hard to stop.

The last decade has been the heyday of agency mergers and acquisitions, springing from the time national brokers went public and began to buy up smaller regional agencies to keep earnings growing and to fill gaps in marketing plans.

Alexander & Alexander Inc. alone has joined with 140 smaller firms since the big broker became publicly held in 1969. Wherever people, portfolio, place and profitability mixed well, one brokerage bought out another.

Though industry watchers say the boom is down to a fading echo, big brokers continue to seek raw material for their corporate networks, trying to fill geographic needs and the steady demand for super-producers. One national broker consultant recently reported 18 merger-related projects in progress at the same time.

His search found a shrinking pool of talent, however, with more competition for money-making agencies and more individualistic brokers who don't want to join the corporate team.

Slower pace

That isn't to say, however, that acquisitions/mergers won't take place. A&A, which has been acquiring at a rate of nearly one a month, says it can foresee adding eight to 10 a year in the near future. Other brokers aren't so active, but say they will acquire at levels either equal to or slightly less than their past performances.

Also in store is increased interest from foreign lands, with Canadian giant Reed-Stenhouse Cos. increasingly turning toward the U.S. to expand and some interest by London brokers in smaller U.S. retail agencies specializing in surplus lines risks (*BI*, Nov. 26).

One industry expert who says acquisitions will continue but not at an overwhelming pace is Patton Kline, Marsh & McLennan Inc. chairman.

"There has been a lot of activity in the past in this area, but I don't think we can keep the pace up," Mr. Kline says. "Actually, there are fewer and fewer agencies that we're interested in. I would guess others are facing the same situation as well."

But Frank B. Hall & Co.'s senior vp Joseph Johnson disagrees. "I think there are still good agencies out there and brokers are still interested in getting them," he says.

"The capacity is there, but the thirst isn't," counters Russell Miller of consultants Russell R. Miller & Co. "Of course, the brokers are always looking for the unique instance or expertise, but as they get bigger, they don't need to acquire as much."

Few experts, however, are willing to predict an immediate and drastic drop in the acquisition rate, barring catastrophic business losses.

"What could slow it down?" asks Frank Wieczynski, Alexander & Alexander vp.

"Since most acquisitions by public brokers are based on stock, a serious decline in the stock values could slow things down. And of course there's always the possibility of government intervention. But we don't think that will happen because the brokers look pretty hard at the possible reaction to any acquisition move," he observes.

People aspect

The search for expertise and hot salesmen is expected to motivate new mergers.

"I think we'll see some brokers looking to buy expertise in aviation and contract surety in the near future," says Robert Berry of consultants Hales & Associates Inc. "There may also be some interest in coal expertise as their energy-based big oil clients turn in that direction."

"People are a key aspect of acquiring another agency," says Mr. Wieczynski. "If they aren't our kind of people, we're really not interested—no matter how good they are. It sounds like nonsense, but it's true. Many of our senior management have come to us via the acquisition route."

Here's what's up at the big brokers:

- Alexander & Alexander, the acquisition leader, has completed 68 of its 140 mergers since 1974. The newsmaker came in 1978, when A&A acquired R.B. Jones Corp., then the nation's ninth largest broker. The acquisition provided substantial volume gains for A&A and moved the nation's second largest broker closer to Marsh & McLennan in the revenue race.

But A&A also acquired 15 other firms in 1978. **(See accompanying story, page 60B.)** So far in 1979, it has acquired six more. The firm plans to keep adding substantial numbers of brokers to its roster for the near future, Mr. Wieczynski says.

"Our early problem was that we didn't have a geographic balance," Mr. Wieczynski says. "Now you can count on one hand the markets we really need. So we're not looking so much at new towns, but for a complementary firm in an A&A town, or the expertise that can fit into our system."

- Marsh & McLennan will "be doing as many acquisitions in the near future as we have in the past," says chairman Mr. Kline. "Traditionally we've done one or two, maybe three a year.

"The tendency will be to go geographically into areas we'd like to see strengthened: Tennessee, Alabama, Mississippi, Iowa, North and South Dakota and Nebraska," he adds. "We tend to develop our specialty expertise internally, so we'll be looking for the all purpose agency of significant size. We prefer agencies in excess of $2 million in revenues, but we will go down to about $1 million."

- Johnson & Higgins, the nation's largest private broker, will not play a substantial role in the acquisition

Continued on page 60L

INSIDE

Agents question Allstate overture

Allstate's ballyhooed contract has some attractive features, say agents, but they are waiting to see if it holds in tight markets. **Page 60D.**

E&O insurance buys a bargain

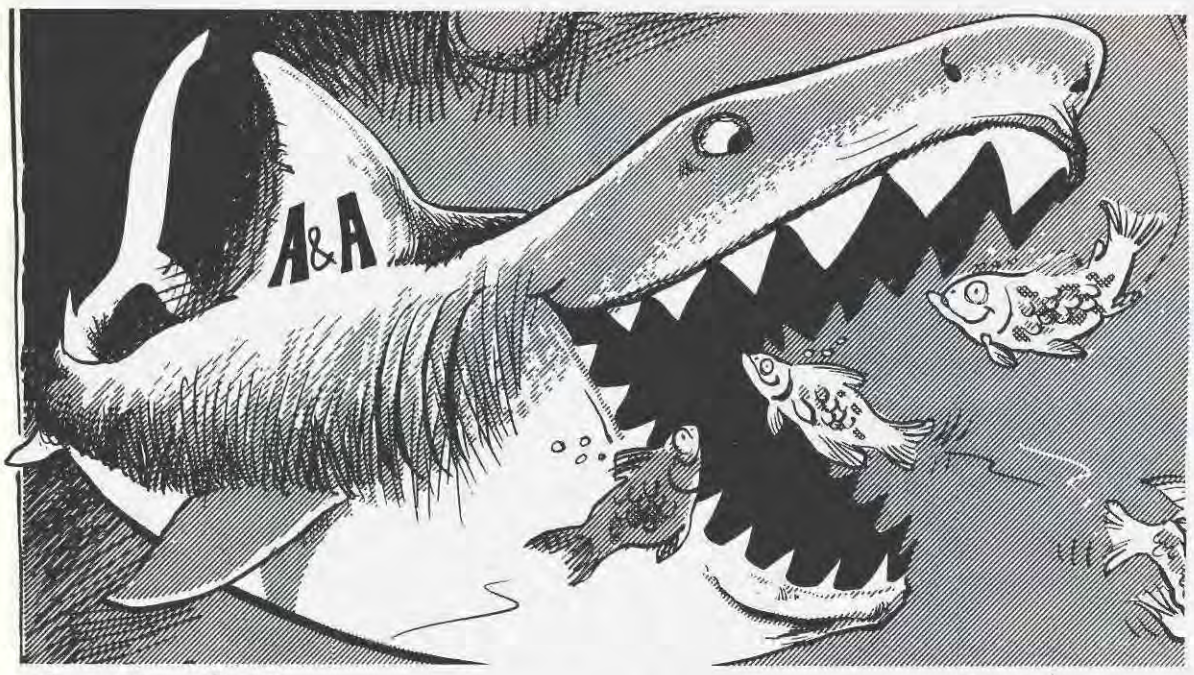
Agents E&O plans can be had for bargain rates, say insurers, but a crunch may be on the way if trends continue. **Page 60E.**

Universal terminal hatches

The Insurance Institute for Research is getting ready to launch a pilot version of the long-awaited universal terminal link to insurers, while the Commercial Union starts its program. **Page 60J.**



CU is starting its agency-company link, says senior vp Wayne Harris.



A&A's merger lineup

The agency: The all-American player. Makes the decision who to negotiate with, makes financial demands on the potential management and decides whether to sign the long term contract or not.

A&A's local offices: The scouting staff. Travels from city to city, looking for the player that can make the home team complete. Identifies, then seeks information about the recruit.

A&A Baltimore: The front office. The money men of the team, A&A Baltimore determines whether the draft choice is worth the money the team will put out. Looks through the scouting reports and picks the best.

A&A executive committee: The head coach and general manager. Makes the final decision based on financial information, gut reaction, or both.

A&A's merger machine leads the hunt

NEW YORK—Year in and year out, Alexander & Alexander is the Jaws of the broker merger-acquisition industry. But the second largest broker doesn't rely on a hunter's instinct.

A&A has developed a sophisticated internal machinery to deal with its large appetite for acquisitions. Industry observers believe that of all the national brokers, A&A's acquisition process is the most refined.

A look at the totals tells part of the story: 140 mergers/acquisitions in all, 68 of them completed since 1974. That's an average of 12 a year, at a time when other national brokers—including giant Marsh & McLennan—may make less than five.

"We have what we feel to be the most aggressive program in the insurance industry," says Frank Wieczynski, vp and secretary of A&A.

The process usually starts in A&A's 10 geographic regions, where regional directors, each with responsibility for one to 11 local offices, keep tabs on agencies that are likely acquisition prospects, he explained. They then team these "available" agencies with whatever needs the region may have, such as the desire for additional market share in a particular city or the need for a particular expertise, like aviation or employe benefits.

"In concert with his office managers, the regional manager discovers who in a particular city should be approached to fill a gap," Mr. Wieczynski says. "After an exhaustive study of the marketplace, they might identify one, two or three firms to approach."

The next process is to check the insurance community for its impressions of the agency, including its standing, book of business and acquisition interest.

"We then identify the right candidates, if indeed there are any, and approach them to see if they're interested," Mr. Wieczynski says. "If they are, our Baltimore office gets involved to do a complete financial analysis."

The acquisition/merger team in Baltimore consists of Mr. Wieczynski and three other full-time employes. They check the agency's size, ethics, account retention, markets, history, personnel, compensation policy and whatever else will affect the agency after an acquisition is made.

"We also check the intangibles," he says. "For one thing, we want to make sure the principals want to stay in the market with us."

Once the data is obtained, A&A's staff plugs it into its own expense load, figuring volume and profits using A&A's levels of producer compensation, tax rate and costs. The result gives A&A an idea of what the agency is worth.

"We then send those figures to our regional people and the prospect so that they can check them for accuracy," Mr. Wieczynski says. "Once that is done, we forward to our executive committee a recommended price. If that is agreed upon, we then propose it to the agency and see if we can make an arrangement."

Once the wedding takes place, the A&A Baltimore team remains with the agency to make sure the couple has a happy honeymoon.

"The last step comes when the post-merger coordinator takes over," Mr. Wieczynski says. "That person works to make everything fit, from telling agency people where to go to get business cards to tying the agency in to our payroll and accounting systems."

Even with all the exacting procedures, however, he admits there still remains a dab of guesswork.

"Much of it is financial, but there is still a lot of gut reaction involved," he says. "What will the firm do in the future? If set free from the management constraints of running an agency, will this producer really blossom? And how bad does A&A really want an office here? We may bend a little more financially if we don't already have three or four offices there already."

The system doesn't always result in acquisition.

"We visit about three firms for every one we acquire," he says. "We'd like to believe we turned those other two down, but sometimes they decide to go it alone for a while longer. We can't say we got them all." ■

Acquisitions fill different needs

CHICAGO—What makes a broker want to buy a particular agency? What makes that agency decide to sell?

More often than not, it's not for the fast buck, say 13 industry experts, including agents, brokers and agency consultants. An agency, of course, wants a fair return on the business it has built over the years and the acquiring brokers want to increase earnings. But the final decision to sell or buy hinges on a number of events, both expected and unexpected, these experts say.

Many successful agency principals are entrepreneurs as concerned about continuing their present lifestyles as they are about the purchase price. This not only determines who these principals will sell to, but whether the sale will come at an opportune time or not.

The broker's decision to acquire may not hinge so much on the purchase price as the ability to fill a void, either geographically or in a specialty.

Experts agree that a "bail-out"—where the agent is forced to sell his business quickly—is not a good prospect for seller or buyer. While desperation forces some agencies to sell, other principals prepare for and anticipate the future, allowing them to be courted by the national brokers and sell out of choice.

Whatever the immediate circumstances, agencies are sold for two basic reasons, experts say. Either something happens to the principal so that he chooses to liquidate his assets or something happens to the agency so that it is, or soon will be, no longer able to compete with the national brokers or other agencies. **(See accompanying list.)**

In all these cases, however, the selling is easier if the producer has taken the time to think about the future and plan ahead.

"Everyone is going to lose control of his agency sometime, whether he dies or decides to sell out," says Russell Miller, head of Russell R. Miller & Co., a firm that advises agents and brokers on merger-related deals. "In either case, the problem is one of orderly preparation for the future. If this preparation is done, I think there's a good future for the private insurance agent. After all, selling out is only one way to get value out of an agency.

"Most principals don't do this planning, however, and find that their agencies aren't really that salable when the time comes," Mr. Miller adds. "He finds few buyers, because the agency isn't really worth that much anymore. The principal has taken all the value out through large salaries and other compensation."

Mr. Miller estimates that out of the estimated 68,000 agencies in the U.S. about half "don't have a business—they have a living."

"Another 20% to 25% are the industry leaders, actively thinking about and preparing for business in the '80s," Mr. Miller adds. "The rest won't be around too much longer because competition will squeeze them out."

In short, the road to a successful sale of the agency, whatever the motivation, is the same as the road to keeping the agency privately held, he says.

"Brokers are looking for the very good agency," Mr. Miller says. "Therefore, principals have to build up their agencies no matter what.

"The principal should put some of the earnings back into the agency to keep growing. Too many squeeze their businesses for all they're worth," he says. "They should also have a plan for the future—know their strengths and weaknesses so they predict what may come up. And they have to keep selling. Too many give up on that."

"Why do we buy?" asks Alexander & Alexander vp Frank Wieczynski. "Well, we've tried to open up new operations around the country, but it's time consuming and expensive—even if you've hired local people. We tried that in Richmond and the office is showing good growth now. But it took us two to three years to get properly staffed and off the ground."

Why an agency wants to sell:

- The principal dies.
- The principal is facing a divorce.
- The principals want to liquidate their assets.
- The principal is approaching retirement.
- The agency's major clients are outgrowing the agency's ability to provide services.
- The agent wants to add greater capacity and expertise to serve his clients.
- The agent has good contacts, but can't use them because the agency is too small or locally oriented.
- The principal is getting bogged down in management duties and wants to find more time to sell.
- The principal wants to join a larger organization so he can move further up the power ranks in the acquiring company.
- The agent wants a bigger playing field to obtain more business.
- The principal has milked the agency for all it's worth and wants to bail out.

Why a broker wants to buy:

- To grow quickly.
- To enter a market it is not already in.
- To increase penetration of a market where it already has a toehold.
- To add additional expertise in an insurance specialty.
- To add the "super" producer to its ranks.

Agent won't put price on independence

A/BT local leader

KANSAS CITY, Mo.—Some experts in the agency merger-acquisition business believe every agency has its price. But don't tell that to Peter L. Woodsmall.

Mr. Woodsmall is president of Woodsmall, Frick & Innis Inc., a prosperous Midwestern agency that brought in more than $9 million in premium last year. Although the broker has gained national notice, Mr. Woodsmall says he has no intention of selling out to a national broker.

A meeting of the agency's top management recently produced a 32-page report on how not only to keep the agency afloat and out of the big brokers' jaws, but also how to grow and compete with them on a more equal basis.

"In 1977, we made a decision to operate our agency the same way a big public broker does—that is, we wouldn't take every dollar we could out of the agency so as to strip it down," Mr. Woodsmall said. "We decided to put that money back into the company, attract new, young producers and take an aggressive stand." About 20% of the agency's annual revenues, which were $1.2 million in 1978, are plowed back into the agency.

As a result, the agency principals have to settle for less compensation—about 30% less—and fewer incentives than they might otherwise be able to glean from the agency's profit. But that really wasn't a big consideration in deciding to take the path they did, Mr. Woodsmall says.

"A lot of agency principals take a lot out of the company, which is fine if that's what they want to do," he says. "But we believe that money and satisfaction are of equal importance. We're gambling that by giving up a few things today we can reap big rewards later."

The agency has brought in seven new producers since the 1977 decision to grow, bringing the total in the agency to 13. Mr. Woodsmall says two more will probably be added this month, with plans for the addition of three more producers in 1980.

The additions are no accident, Mr. Woodsmall says. The dates and number of producers to join the group are set far in advance so training programs can be set up. The first three weeks of a novice producer's career is spent within the agency, learning the ropes. The next six weeks are spent at the Aetna School in Hartford. The producer then spends another three weeks learning a specialty.

"Most of our new producers are in their late 20s or early 30s," he says. "Of our current producers, about one-third have come from outside the industry. We're more concerned that the person has the ability to sell than whether he has an insurance background."

Deciding to follow a policy of growth has other implications. As the producer force grows, so must the support staff.

"It used to be that we had everybody in production," he says. "Just recently, we've decided to increase our management depth to back it up. We've added a sales manager and other people—not to just monitor business, but to roll up their sleeves and help our producers become and stay successful.

"It's a decision we knew we had to make," he adds. "We can't hire people and then not back them up and help them succeed."

No matter what the details of a growth plan, however, Mr. Woodsmall says the most essential decision an agency has to make if it wants to stay independent and competitive is the decision to act.

"If you're going to be independent, you have to be oriented toward growth," he says. "You have to keep up with what other people are doing.

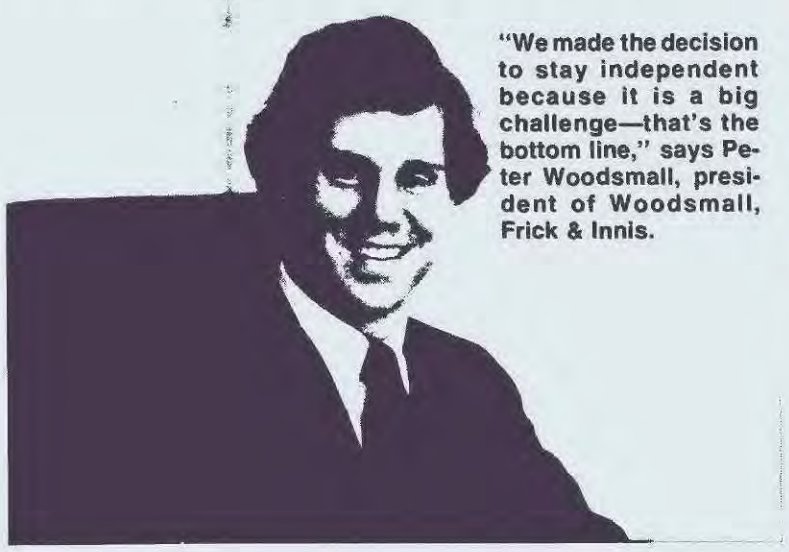
"When you do that, you soon find a kind of excitement and camaraderie around the office," he adds. "You find that a momentum begins to build. Around here, we have nine producers between their late 20s and their late 30s (Mr. Woodsmall is 32). With a core like that, things really get hopping."

And once the planning is done, the organization begins to fall into place, he says.

"We know what our revenue figures should be in the year 1989," Mr. Woodsmall says. "When I looked at the figure the other day, it seemed mighty high. But we also know what our revenue figures should be for each year between then and now. So when you look at the progression, you see how our planned growth builds upon the growth of the year before. It gives us something to aim for—we can see how it can happen."

With that in mind, it isn't so hard for producers to deny themselves a little gravy now, he says.

"We made the decision to stay independent because it is a big challenge—that's the bottom line," Mr. Woodsmall says. "The compromises weren't that critical. We all are making enough money to put bread on the table. We believe what we're building here is something substantial and we plan to stick around to watch it happen." ■



"We made the decision to stay independent because it is a big challenge—that's the bottom line," says Peter Woodsmall, president of Woodsmall, Frick & Innis.

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Agents remain wary of Allstate courtship

SOUTH BARRINGTON, Ill.—Like pioneer peddlers preparing to move West, Allstate's new commercial insurance company is gearing up to carve out a share of the commercial market. But agents they are courting can't tell yet whether they are getting the capacity medicine they need or just the medicine show.

For the past few months, Robert Leibold, president of Northbrook Property & Casualty Insurance Co., has been riding the agency circuit, selling what his firm has to offer: capacity, a "commitment to service" and a realization that Northbrook needs the independent agent to succeed.

A/BT

Agency organization officials, however, are taking a wait-and-see attitude and keeping a wary eye toward the future.

Donald C. Brain, president of the Independent Insurance Agents of America, says he welcomes the new capacity Northbrook promises. But, he adds, "I think the jury is out on how much they will fulfill their promises of today." It's easy to be benevolent in today's marketplace. We will know more a few years from now."

Capacity and flexible markets are a continuing need for agents, Mr. Brain noted. "If we don't have a multiplicity of markets, we're in trouble," he says. "If agents use Northbrook intelligently, it will be a welcome addition to our insurance capacity."

Not everyone, however, is sold on Northbrook's promises. One of the skeptics is Russell Howard, president of the National Assn. of Professional Insurance Agents.

"If they're helping to solve a market problem, that's OK," Mr. Howard says. "But I don't think they are, because they've said they're going to compete in the same areas everybody else is already in. I certainly haven't seen anything innovative yet."

Despite their differing views, both association presidents say they will be watching what Allstate will offer the independent agent via Northbrook. One major point they will watch is Northbrook's agency and bonus commission (profit sharing) contracts, they add.

Northbrook marketing director John R. Larson says the agreements will play a relatively small role in Northbrook's plan to enlist agents. However, both he and Mr. Leibold have said the contracts have some "attractive provisions" for agents.

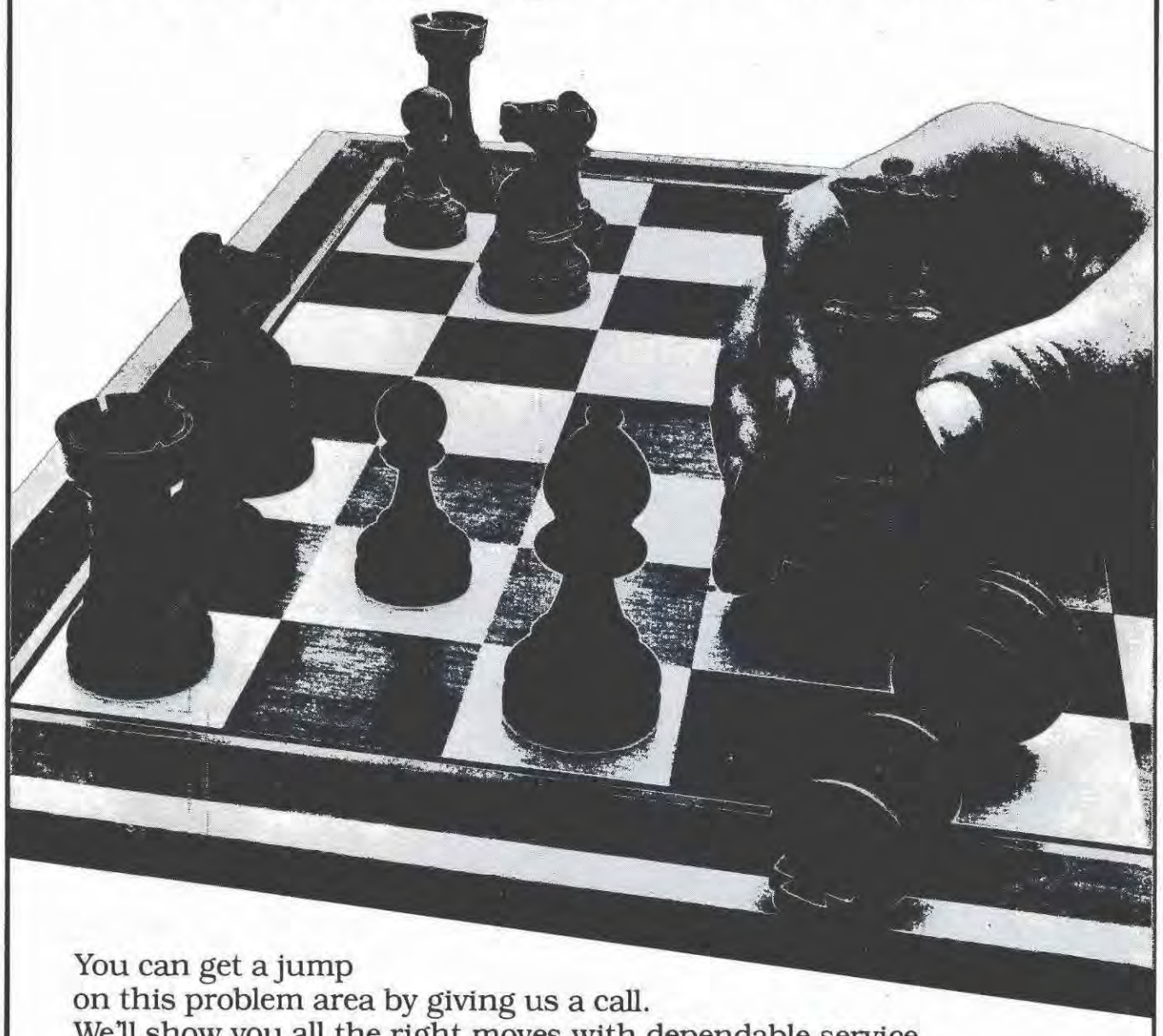
Northbrook officials say these provisions are included in the agency contract:

- A clause providing for a full 60 days notice to Northbrook of uncollectibility and consequent company collection.
- A blanket hold-harmless clause for damages to policyholders caused by the company.
- A provision permitting Northbrook to change commissions only after 90 days notice, with no further changes for a year unless the agent consents.
- A 120-day pre-notification of cancellation in many instances.
- An agreement to arbitrate disputes.

Features of the bonus commission plan, Northbrook officials say, include:

- A provision excluding IBNR in determining the agent's share of the profit, except where a final calculation is required upon termination.
- A stop-loss of $100,000.
- An underwriting-profit-percentage calculation that uses earned premiums.
- A clause providing that the company will give the agent at least 90 days notice of any revision and that any revision applies to the succeeding years only.
- An agent's participation percentage based on the amount of annual written premiums, the percentage of profit, the growth of volume over last year and the percentage of retention of business placed within the company. ■

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Expect tighter agents' E&O market

CHICAGO—As a late-night television commercial might say, "Right now is a good time to buy agent and broker errors and omissions insurance! But hurry. Send before midnight tonight to ensure delivery!"

The market for agents errors and omissions insurance is soft right now, say insurance companies and agent associations. Old standbys such as Fireman's Fund Insurance Cos. and St. Paul Fire & Marine Insurance Co. are continuing to write the insurance, while new kids such as the INA Corp.'s INAX Underwriting Agency are working hard to grab a big foothold.

But, many of these same experts warn, agents errors and omissions is not exempt from the cycles of the insurance industry. It may not be too long before the market tightens up again and agents are forced to look far and wide for their professional liability insurance.

"Agents E&O isn't a big market, but it's a competitive one," says Fred Themmas, general liability underwriting officer for the St. Paul. "We worry about it somewhat because the frequency and severity of claims are on the rise. And the severity of errors gets larger as inflation increases."

Despite the increase in claims, agents shouldn't have to worry about premium hikes such as those in medical malpractice insurance or other more publicized professional liability risks, he adds. "There have been substantial increases in this line over the past two years," Mr. Themmas says. "But I think they have been fair increases."

But the real action in E&O insurance isn't price. It's availability.

"The real test of the market isn't how much you're going to pay, but if you're going to get it," says Bob Radloff, sales manager for the New York-New Jersey-Connecticut Professional Insurance Agents groups.

"Over the years, we've watched many companies get in and get out of this kind of business," Mr. Radloff says. "Right now the market is soft and the pricing may vary somewhat. But there is the likelihood that a year from now, companies that undercut the field today will either be out of business in this line or charging substantially higher premiums."

Mr. Radloff considers stability the most important thing agents should consider when buying errors and omissions insurance.

"You need rate adequacy to write this kind of insurance," he says. "Our data tells us that one out of every nine agents will have a claim this year. A ballpark figure for an average claim would be around $7,500. If an agent had to dig into his pocket and come up with that kind of money he'd be in trouble."

Underwriters generally want to do business with large state agent organizations rather than with individual risks. However, Les Mungle, director of field operations for Fireman's Fund, says his company tries to buck that trend.

"Our philosophy is to write for all eligible agents," not just Fireman's Fund agents, he says. "We look at the size of the agency, the number of staff members, and the agency's volume and business mix. We also look at the management—how the agent handles his office. That's sometimes hard to check, but it helps us determine what kind of risk we are being asked to write."

But an agent who has attended a seminar on how to avoid errors and omissions probably won't get a premium cut, he said.

"The seminars are relatively new, and it would take a long time to determine if they will do any good," Mr. Mungle says. "I think

A/BT

the motivating factor behind these is to stabilize the problem and keep it attractive to the few companies who still do business in this area rather than an attempt to lower rates."

Agency size, however, increases prices.

"I don't know if it will be harder for the bigger agencies to get, but naturally it costs more," Mr. Mungle says. "When you deal with the larger organizations, the risks are probably going to be bigger and involve bigger sums of money. That will affect the price.

"In addition, some companies aren't a market for large, multilocation brokers," he adds. "They tend to be much more complex and provide many more insurance services than some underwriters want to consider and take a chance on."

Despite the possibility of higher and more frequent claims, at least one new market has opened. INAX is in the market because it is profitable and corporate officials believe they can go out and get a substantial amount of business by courting state agent associations, says INAX Underwriters Agency president John Van Cleave.

"As far as Fireman's Fund is concerned," Mr. Mungle says, "we see a need for it and a responsibility to provide the coverage. Unless something unforeseen comes up, we'll be in the business until the loss experience gets so bad we're forced out." ■

Utica covers PIA majority

One of the largest agent and broker errors and omissions programs is the national plan written by the Utica Mutual Insurance Co. for the various state PIA organizations.

Utica Mutual's plan uses a broad-based, claims-made policy, says Bob Radloff, sales manager for the New York-New Jersey-Connecticut PIA groups. Participation in the plan varies by state, but Mr. Radloff says from 55% to 75% of PIA agents in his three states buy the insurance.

"The policy is rated by staff size. In cases where an agency's staff size isn't comparable with its premium volume, a surcharge may be assigned to take care of the added risk involved," Mr. Radloff says.

"Deductibles range from $500 to $5,000, with the tendency today running toward the larger deductibles to save money," he adds. "An average policy, rated in upstate New York with a $1,000 deductible and $300,000/$900,000 limits, runs about $1,018 in premium."

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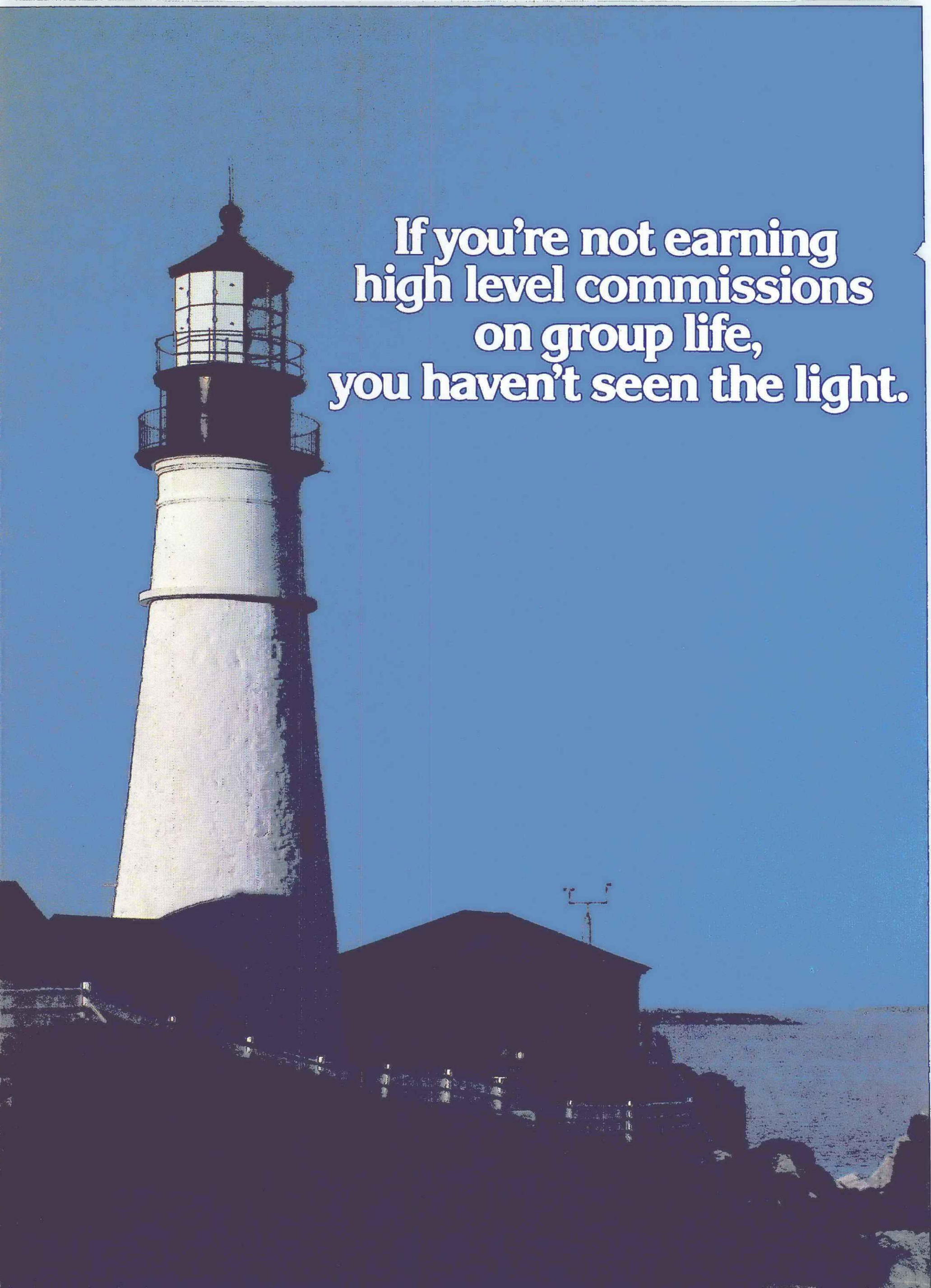
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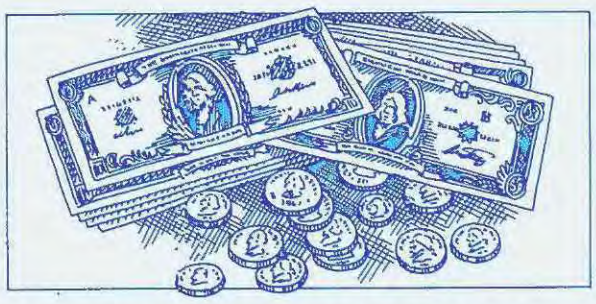

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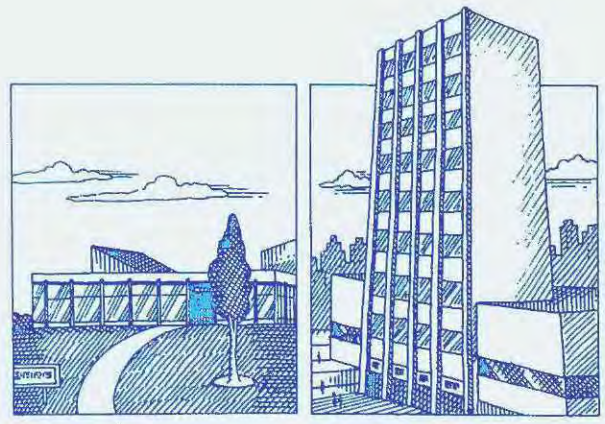
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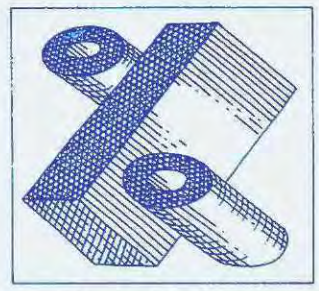
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Outspoken officials turn A/B heads

THEY HIT MY DESK within a half hour of each other.

The first was a message. The National Assn. of Professional Insurance Agents had called to cancel a statement by their new president, Russell A. Howard. It seems that Mr. Howard had accused (without proof, as it turned out) the alphabet brokers of conspiring with California communities to kill off the independent agent.

The second was a press release. Donald Brain, Mr. Howard's counterpart at the Independent Insurance Agents of America, had dropped *Business Insurance* a note to say the American agency system is in good shape, primarily because the direct writers were beginning to add new capacity to the marketplace.

As you might expect, the items raised some eyebrows around here. You wouldn't expect the PIA to publicly blast the alphabet houses without being pretty specific. (The statement wasn't.) You also don't expect a major IIAA official to blow kisses toward a (heaven forbid) direct writer.

But it isn't a dream. Those statements were actually made—in public, even. Mr. Howard's comments were made at the Boston PIA convention; Mr. Brain's in front of a gathering of the Independent Insurance Agents of Illinois.



And so, even though Mr. Howard has apologized to the large national houses and their association, the National Assn. of Insurance Brokers, the times may be a'changing. At least during the first month of their presidencies, Mr. Howard and Mr. Brain have shown a willingness to speak out and be controversial.

In Mr. Howard's case, his problems stem not so much from speaking what was on his mind as getting what was on his mind from an unreliable source.

A little background is necessary. A few California communities are considering a plan that would set up monopolistic, community-funded pools to underwrite all fire insurance under their jurisdictions. The plan, negatively received by risk managers and the insurance industry alike (*BI*, Sept. 17 and Nov. 12), is naturally an item of concern to Mr. Howard and his fellow agents, who write of lot of fire insurance.

So when he heard from a California source that "even the alphabet houses are working against us by trying to help the municipalities," he took it to be common knowledge and put it into his inaugural address. He was quoted as saying that although the PIA was fighting this threat to free enterprise, the alphabet houses were "greedily vying with each other to find ways to implement such plans." He then asked the question, "Are these members of our industry or enemies in our midst?"

Reaction, of course, was swift. NAIB executive vp Ronald Remington called for specifics, and Mr. Howard found he couldn't list any.

"So, I did the only thing I could do," Mr. Howard says. "I apologized."

As for the saga of Mr. Brain and the direct writers, the IIAA president is sticking behind his rather unusual comments. Primarily, they were directed at Northbrook Property & Casualty Insurance Co., Allstate's entry into the world of medium to large sized commercial risks (see story, page 60D).

Companies like Northbrook are recruiting independent agents throughout the country, offering them new and different outlets, Mr. Brain told the Illinois agents. This will give independent agents numerous opportunities to grow and prosper, he added.

Now, if you've been listening to any group of independent agents for any length of time, you realize that the name State Farm or Allstate is anathema to them. Direct writers and agency companies just don't mix, and any effort by one to woo agents of the other persuasion is viewed with just a little contempt.

Despite this, Mr. Brain says he doesn't think his comments are all that unusual.

"I've heard the complaints like everyone else," he says. "But if I heard them right, Northbrook is out to find out what the customer wants and then determine how best to serve those wants. That's what the independent agent is supposed to be doing as well. Maybe we should work together to do it."

"Of course, we really don't know what they're up to yet," he adds. "But anything that adds capacity to the market is a good thing."

It remains to be seen what Mr. Brain will be saying in two years. In any case, however, it's refreshing to hear a new point of view. ■

James opens Wyo. office

EVANSTON, Wyo.—Fred S. James & Co. has opened an office here to specialize in insurance and bond services for the construction, oil, gas and mining industries of the region.

The branch, a satellite of James's existing Salt Lake City operation, will also provide other insurance and risk management services. Curt Bateman, formerly with Lumbermans Underwriters Alliance in Oregon, will manage the new office.

To facilitate the move, James has purchased the business of the Johnston Insurance Agency. Newell Johnston, principal of that firm, will continue in the management and servicing of these accounts. ■

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Often seen but less often heard, 'girl' speaks up

Note: the following letter was received in response to a column by features editor Len Strazewski (BI, Sept. 3). *The column concerned the current status of women in the insurance industry.*

A/B/T letters

Dear Mr. Strazewski:

Even though you will be called many names by the insurance *BOYS* I think I love you.

I would guess you aren't receiving too much mail from the *GIRLS* since they are not usually granted access to the trade journals. I managed to sneak one into the ladies' room and read your article.

I am 5-foot-6 and 32 years old. It really seems odd that I can still be called the "GIRL," but that's how it is.

Or I'm dubbed the "Secretary." I have worked for 13 years in this business trying to be the best I can be as a Jack-of-all-trades, but I still get called the secretary. It makes my skin crawl.

I would make zilch as a secretary. My typing is average but I never use shorthand. But I still take care of secretary-type duties since I am *THE GIRL*.

I am a licensed agent, broker and surplus lines agent. The latter occurred when one agency I worked for wanted to go into the surplus lines business. Since I was the only one who had previously worked in that line they asked me to obtain the license. I informed them that to license the corporation I had to be an officer.

I did not want control of the business but that was the only way they could get the corporate license. I went ahead and took the exam, passed, and then was told that they could not make a woman (shudder, shudder) an officer of their corporation. It just isn't done.

So I sent back the license, which will be held in escrow. I was not about to shoulder the responsibility of the license when I was not permitted to be effective as the agent. The men had intentions of handling the business and since surplus lines is so regulated I was afraid to let them do it.

I would just like to know how many of the BOYS could handle the GIRLS' jobs: public relations for the agency, clerical work, bookkeeping, collections, sports tickets, company parties (which usually end up by the GIRL pouring the BOYS into cabs to get home), customer complaints, policies and all that goes with them, billing, coding, adjustments and acting as agent 90% of the time.

I could go on and on, but I've been the GIRL so long that I think my good old typing fingers are subconsciously rebelling after all these years. Besides, the phones are ringing and God forbid I should let the men answer the phones.

While I love this job, it sure isn't for the pay, which is just a bit better than clerical since I have a big mouth. The other BOY in the office, who is paid three times better than me, needs the GIRL to show him how to put a policy together and explain the coverages. Then the GIRL will bill it, send it out with a nice letter, debit the insured's account and collect the premium so the BOY can earn his pay.

Incidentally, out of less than 150 surplus lines agents in this city I am the only female. Shame on me.

Anyway, thanks for the vote of confidence and keep it up. I doubt if it will do any good but it sure is nice.

Ann Fonner

Pittsburgh, Pa.

Crowther MGA

John H. Crowther Inc. has been appointed a managing general agent for Minnesota, North Dakota and South Dakota by the Northland Insurance Co. of St. Paul. Through Northland, the firm will underwrite long haul trucking risks.

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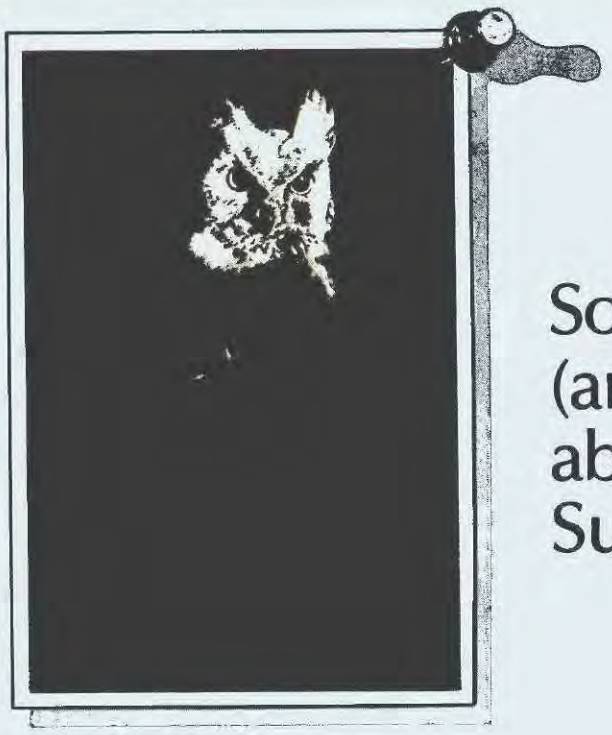
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COMPUTERS

IIR schedules pilot insurer linkup

A/BT

WHITE PLAINS, N.Y.—The Insurance Institute for Research is planning to devote about half its 1980 budget of $2 million to develop a practical application of an industrywide agent/company interface of computer systems.

By the fall of 1980, IIR officials plan to enlist five to 20 companies and 50 to 100 agents in the pilot program, with the intent to discover the feasibility and justification of automated interfacing.

Under an interface system, agencies and companies using different computer systems and forms would be able to communicate with one another through a centrally located coding and uncoding device.

To accurately test the system's feasibility, agencies using both mini-computer systems and standalone terminals will be used in the fledgling system, says IIR director Irwin Kelson. The systems chosen will be typical of those currently marketed to agents, he says.

A fully established link will take over certain types of transactions currently conducted by mail and telephone, such as filing and updating policy applications, changing information, and providing claims information, message switching (electronic letters) services and accounting reporting. For the first test, specific transactions from these broad areas will be chosen.

The goal of the pilot: to streamline the insurance industry, make it more efficient and in the end save companies and agents money, Mr. Kelson says.

"If the interface system works, we should see shortened response time and greater accuracy," he says. "In addition, the industry is spending a lot of money right now on this type of communications—millions each year for IIR member companies alone. With an effective interface, they can save much of that money."

Another benefit of the tie, Mr. Kelson says, would be that independent agencies could remain independent, because their own equipment could be connected to the equipment of several companies, whether the companies' equipment was originally compatible with the agent's own or not.

IIR, a nonprofit corporation created in 1978 to research interface systems, is funded by the Independent Insurance Agents of America, the National Assn. of Professional Insurance Agents and nearly 20 member insurance companies. It has learned there are two basic problems in developing an interface.

"The first is technical," Mr. Kelson says. "Since agents and companies have chosen systems that can best help them in their own unique situations, there are many different computers in use today. Those machines in turn emit a wide number of electronic signals and codes and work at varying speeds. The first step in developing an interface, therefore, is to find a machine that can understand and translate these varying signals.

"The second problem is putting all the needed information into a format that is acceptable to each insurance company," Mr. Kelson adds. "The interface has to recognize what information is being provided to it and then put it into the order the insurance companies want it in."

The simplest solution would be to have all companies and agents use the same machinery. But that isn't feasible considering the investment already put into individual computers, he adds.

"Realistically, we need the 'black box' that can translate everything for us," Mr. Kelson says. "The technology is there to do it; we don't need a real breakthrough. We just have to decide which of the technical companies that could do the job for us would be best suited to our needs."

Before that decision is made, he adds, IIR still has some homework to do.

"Right now we're taking a survey of independent agents to see what equipment they are using," he says. "Once we have that information, we can see who uses what equipment and what computer hardware should be programmed into the initial test.

"When that happens, we can choose companies and agents that have the computers we want to use," Mr. Kelson says. "We should have those specifications by early spring."

Much of the approximately $1 million spent in 1980 will be used to buy the interface black boxes and position them in strategic central locations around the U.S. After that, the participants may have to share some of the costs.

"Once we implement the program, then we'll have to decide whether the individual participants should share in the costs of running it," Mr. Kelson says. "It only makes sense that if they share in the benefits of such a system, they should have to pay for at least some of it." ■

Commercial Union activates its system

BOSTON—While the IIR gears up its computer-link system, Commercial Union Assurance Cos. has been de-bugging its modest test system since last September.

Commercial Union's interface system involves eight producers in California and Georgia, says Wayne Harris, marketing senior vp. The system, which just recently began actual production, allows participating agents to rate, issue, endorse and cancel policies for CU's custom auto, commercial auto and merchants' package policies.

Agents will also be able to report claims and issue drafts on Acord forms and reconcile their CU accounts. The pilot also includes a message sending and receiving capability tying the agent and a CU regional office, Mr. Harris says.

"We're in the process of giving our agents more underwriting authority," Mr. Harris says. "That, combined with the need for greater efficiency in processing these types of information, led to us experimenting with the link system."

The system, which will initially involve only Redshaw Inc. and ARC Inc. agency equipment, will eventually expand to more than 20 states by the end of 1980, he adds. CU is also talking to AID-Insurnet to develop a software link for agencies using its systems.

Mr. Harris says the program doesn't conflict with the IIR plan. In fact, he adds, CU is a sponsoring company for IIR.

"We know what they are doing at IIR, but we decided to go ahead and do our own pilot program now," Mr. Harris says. "Our concept isn't very far removed from what they are doing, however, and any knowledge we get we will share with them." ■

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'Tele-Claim' brings Acord to Aetna L&C

NEW YORK—Instead of listening to telephones ringing and employes scurrying, the claims staff of Aetna Life & Casualty Co.'s Manhattan office now hears the plop of a bundle of agent's claims.

That bundle is a result of "Tele-Claim," a word processing system that Aetna officials say has simplified their work days by streamlining and speeding agent reports on a universal Acord form.

Producers benefit, Aetna says, because use of the system shortens claim reporting time and notifies them that a claim application has been received and is being processed.

In Manhattan, Tele-Claim is used by 315 authorized agents in Manhattan, Staten Island and Brooklyn, says claim superintendent Joseph Langana. To use the system, an agent calls a special Tele-Claim phone number, listens to a short recorded message, then reads a three to four minute claim report into a recording device located at a Long Island word-processing service. The system operates 24 hours a day, seven days a week.

The word-processing service then takes the recorded tapes, transcribes them onto Acord forms, and delivers them to the Manhattan office twice a day. The whole system translates into greater efficiency and less confusion for the Manhattan claims staff, Mr. Langana says.

"Taking these claim reports over the phone can be a real hassle," Mr. Langana says. "You can have phones ringing all over the place, creating an interruption for your staff. And if that staff is busy doing other things, before you know it you have supervisors, or other people who really shouldn't be taking these reports, on the phone, wasting their time as well."

With Tele-Claim, Aetna employes are freed to do other work, while the system processes an average of 20 claims reports a day. Its capacity, however, is higher; Mr. Langana says the system has handled more than 30 calls on some days and will probably handle more as Tele-Claim is opened up to more producers next year.

A/B/T systems

Mr. Langana says he has had few negative responses from producers.

"If anything may be hard to take from the agent's point of view, it's probably that some people don't like talking to a machine," Mr. Langana says. "On the other hand, some agents like it because it gets the job done fast, without unnecessary chit-chat or having to wait while our staff takes another call.

"In addition, the word-processing service prepares the reports in triplicate, and the agent gets one of these as an acknowledgment that the report has been received," he adds. "That acknowledgment is sent within 24 hours and has the code number and name of the person dealing with the report placed right upon it. That helps when producers have questions."

Tele-Claim also helps agents better organize their time, Mr. Langana says.

"One of the main benefits is that an agent can call that claim in whenever he's ready," he says. Producers often work late or on weekends. With Tele-Claim, they don't have to wait until the next morning or Monday to phone in their report. They also save the two-day waiting time that would occur if they mailed their own Acord form in to us."

Despite the $3,000 to $3,500 price tag for the equipment, the program is worth it, Mr. Langana says.

"There's a saving in efficiency, if nothing else," he says. "Where we may have 10 people in a clerical function today, we may be able to go with seven or eight in the future. The reports are also sent to the same person every time, a person that knows where they are to be sent to be worked on."

Even though agents have the option of phoning in difficult claims in person, Mr. Langana says Aetna's producers have responded well to the program.

"The compliance has been great," he says. "I know that because our producers are a very vocal lot. If they didn't like something, we'd know pretty fast." ■

Tips help avoid E&O claims

CHICAGO—Fred S. James & Co. executives Leo Havey and Charles O'Malley have been touring the broker's regional offices teaching managers how to avoid errors and omissions claims.

Here are their 14 tips on keeping E&O claims down.

- Confirm all understandings with the client in writing.
- Notify the client in writing of any change in coverage.
- Be able to say "no" to a client if you are unable to market the risk.
- When a loss occurs, never make a statement that puts a broker in the middle. Do not interpret coverage at the time of loss. Do not tell the client it is covered and it was the intent to cover if the company is saying "no coverage."
- Avoid manuscript forms. If manuscript forms are required, be sure to have them reviewed and approved by another expert.
- Make written notes for the file of telephone conversations.
- Personal accounts should notify all policyholders of: new limitations in homeowners policies, the option to buy increased uninsured motorist coverage and the availability of replacement value on contents.
- Never advise a company on an application that there is "no exposure" for any given peril. Use "no known exposure."
- Avoid safety engineering services for self-insured clients without a hold harmless clause.
- Report to the head of office all incidents that have a possibility of an errors and omissions claim.
- All binders should be numbered and a record kept of issuance.
- Make certain that expiration records are properly maintained with the notation of: bound, dropped or renewal ordered and delivered.
- Have monthly educational meetings for the staff to improve technical knowledge and discuss errors and omissions exposure.
- Errors and omissions insurance does not cover loss because of insurance company insolvency. ■

The IIAA applauds Zurich-American



The IIAA Agency Contracts Committee knows a good profit-sharing agreement when it sees one–Zurich-American's.

After an analysis of 24 company agreements, Josiah H. Welch, chairman of the committee, cited Z-A for its agreement saying Z-A should be "applauded" for its cooperation in considering and responding to the committee's recommendations and that "Zurich-American is establishing itself as a leader in the field of agency profit-sharing agreements."

Z-A thanks the IIAA for its highly complimentary review. The comments support not only our agreement, but Z-A's corporate objective of building stronger agency relationships through better communication.

If you're a Z-A agent, you know what we're saying. If you aren't, maybe you should be. Talk with a Z-A branch office today.

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Crump appoints three new executives

A/BT **people**

Milton O. Johnston has been appointed president of the new Crump-Davis of Houston office, which was formed as a cooperative effort of E.H. Crump Cos. and Crump-Davis Inc. of Dallas. Also at Crump, **Earl R. Lanning** and **Halbert Leroy Carter Jr.** have been named vps. Mr. Lanning, executive vp of Crump London Underwriters Inc., will be working with the Memphis-based insurance holding company's brokerage offices throughout the country. Mr. Carter will be responsible for assisting Crump's 14 retail insurance offices in the development and expansion of employe benefit insurance programs.

* * *

Jonathan M. Chettle has been named senior vp in charge of international accounts for the national sales division of Fred S. James & Co. Mr. Chettle was previously vp of the division. At Fred S. James of Illinois, **Walter T. Derk** has been elected executive vp. A specialist in construction insurance, Mr. Derk is vp of the National Assn. of Insurance Brokers.

* * *

Gerard F. Curtis has been elected senior vp and member of the operations committee of Alexander & Alexander. In his new role, Mr. Curtis will continue as president of AAMET Inc., A&A's brokerage subsidiary for the New York Insurance Exchange; director of KCC Syndicate Managers, an A&A joint venture for exchange underwriting management, and manager of IMPACT, A&A's marketing, planning and product development program.

* * *

Lawrence L. Drake has been elected senior vp of Marsh & McLennan Inc. Mr. Drake joined the Seattle office of M&M in 1968 and was assigned to the property marketing department. Later, he assumed responsibility for all marketing departments and was elected a vp in 1974.

* * *

J. Edward Townes has joined B&F Special Risks Inc. as manager of the marketing department and as a commercial property account executive. Before joining the New Orleans-based wholesale insurance brokerage, Mr. Townes held various underwriting and supervisory positions with The Home Insurance Co., Metairie, La.

* * *

Mollie M. Day has joined Associated Insurers Inc. as claims manager. Mrs. Day previously worked in the consumer insurance information division of the North Carolina department of insurance. Also at Associated, **Stephen K. Zaytoun** has become an account executive. Mr. Zaytoun is a 1979 graduate of the University of North Carolina at Chapel Hill.

* * *

Dana F. Rice has been elected chief executive officer of Buffalo Fire Office Inc., a general insurance agency. Mr. Rice, who was president and treasurer, will continue to serve in the latter capacity. Also at Buffalo Fire, **Frederick R. Dentinger** was promoted to president and **Charles F. Geyer** was named executive vp. Mr. Dentinger was executive vp; Mr. Geyer was a vp.

* * *

Brian Hardy recently joined Grindlay Brandts Insurance Brokers of London as director responsible for the activities of the insurance group in the U.S. and Canada. Mr. Hardy was formerly with Beresford Mocatta and the North American division of the C.T. Bowring group.


Kelly


Shamblin

* *

At Bayly, Martin & Fay, **Donald C. Fitch** and **Joseph E. Kelley** have been named account executives. Mr. Fitch will work in the broker's Newport Beach division; Mr. Kelley in the Los Angeles division.

* * *

Also at A&A, **Phillip R. Henry** has joined the management consulting staff as vp. He will work with the Frank B. Manley division based in Greenwich, Conn. He was director of organization planning and development for the American Natural Resources Co. **Larry R. Thompson** has been named managing vp of the Denver office of A&A. Mr. Thompson was a vp and producer for A&A in Omaha. He joined the firm through the merger of Pinkerton, Madden & Burford. At A&A in Lincoln, Neb., **David P. Shamblin** has become a producer in the association department.

* * *

Markel Service Inc. of Richmond, Va., has announced the appointment of **James T. Perry** as regional manager of its Atlanta office and **Richard F. Pettit** as an excess and surplus account executive in the Richmond branch office. Mr. Perry was formerly with Bowes & Co. Inc. of St. Louis. Mr. Pettit comes from The Travelers Insurance Co. where he was an underwriter and marketing analyst handling commercial property and casualty lines. Also, **Mark R. Werner** has joined Markel as a senior account executive in its Richmond office.


Perry


Plumhoff

* * *

A number of executive promotions have been made at Adams & Porter Life Associates Inc., the employe benefit and estate planning subsidiary of Adams & Porter Associates Inc. **W. Craig Plumhoff** has been named president and **Stephen B. Holaday** and **John A. Currle** have been promoted to vps.

* * *

Robert E. Mackin has been appointed deputy director of the National Assn. of Insurance Brokers. Mr. Mackin formerly served as chief of staff to John R. Dunne, chairman of the New York state Senate committee on insurance. He will report to R.L. Remington, executive director.

* * *


Mackin


Garner

Thomas R. Garner has been named account executive at the Houston office of United General Insurance Co. Before joining the firm he served as southwest division director of properly insurance sales for Liberty Mutual Insurance Co.

* * *

Bob Wolf has been appointed assistant vp of IMS Excess in Santa Monica, Calif. Mr. Wolf has six years of experience in the insurance industry with Chubb & Co. and Marsh & McLennan.

•

We'd like to report on staff changes. Just drop a note to Dave Galanti, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. We'd also like to receive pictures of those involved.

Reed-Stenhouse reorganizes

TORONTO—Reed Stenhouse Cos. has undergone a major reorganization of its operations, president and chief executive officer W.M. Wilson said.

Jack M. Moon, formerly responsible for operations in North America, relinquished those duties but will remain on the parent company's board. He will now concentrate on business development in Western Canada.

C.G.E. Gyles and A.F. Salvatore, chief executive officers of the group's Canadian and U.S. operations respectively, will now report directly to Mr. Wilson.

H.J. Harvey of Calgary, who will coordinate international marketing, development and services; and J.M. Riley, vp corporate office, will also be responsible to the president of the parent company.

In the United Kingdom, the board of A.R. Stenhouse Reed Shaw & Partners has been reconstituted. J.B. Devine has been appointed managing director and H. Houghton has been appointed chairman. ■

N.J. agents accept Kemper broker pact

CHICAGO—All of the New Jersey agents who were offered brokerage agreements with the Kemper Group have accepted the offer, a company spokesman says.

Brokerage agreements were offered to about 80% of Kemper's former agents in the state after the company terminated all contracts with New Jersey property/casualty agents, the spokesman added.

The agreements came after a stormy period when the Professional Insurance Agents of New Jersey and the Independent Insurance Agents of New Jersey sought to determine whether accepting the agreements would jeopardize valuable renewal rights by accepting broker status.

New Jersey law requires companies to give agents 90 days written notice of contract termination and guarantees terminated agents renewals at the same commission rate specified in the terminated contract for nine months after the effective date of termination and for three years for basic auto insurance policies.

The state's no-fault and assigned auto risk system and its failure to approve Kemper's rate increase filings have resulted in mounting losses for the company which other New Jersey operations have not offset, says James Wilson Jr., president of Kemper's mid-Atlantic division. In all-lines underwriting, Kemper lost $1.6 million in 1978 and $11.6 million in the last five years.

Under the no-fault system, the state-imposed rate limitations mean Kemper loses money on every auto policy it writes, Mr. Wilson added, and these losses far exceed any profits made on other lines of business or from investment income. And in 1978, 21 cents out of every dollar in premiums earned from voluntary market policyholders went to pay the deficit caused by the assigned risk plan, he said.

During 1975-77, Kemper filed for private passenger rate increases three times, but the insurance department never acted on any of the requests, Mr. Wilson complained. The only rate changes the company received resulted from ISO filings.

Kemper's fourth filing, in May 1978, requested a 40.3% increase in private passenger rates. In December, the ISO was granted a 13% rate increase and Kemper notified the commissioner that as an ISO member, it would adopt those new rates. The commissioner said that Kemper was not authorized to do so.

On March 7 of this year, Kemper was granted an 8.6% increase and appealed the decision to the state appellate court. The state chancery court issued a permanent injunction July 2 requiring the company to use the 8.6% increase rather than the ISO rates.

Kemper plans to fight for approval of its original rate request, Mr. Wilson said. "Several auto insurance companies have left or are leaving the state because they can't accept the losses which result from inadequate rates. If that trend continues, it will create problems for New Jersey motorists which will linger long after the commissioner leaves his appointive office."

Kemper writes only 1.6% of the overall market and less than 1% of the auto lines. Under state law, auto, homeowners and commercial policyholders will not be affected by the move for at least one year.

"In the long run, we see our action being constructive. Maybe it will wake up those who have ignored the legitimate interests of insurance policyholders and stockholders for the benefit of more politically powerful groups," Mr. Wilson said. ■

Brokers slow their acquisition pace

Continued from page 60A

marketplace, sticking to its policy of developing growth internally, president Robert V. Hatcher says.

When J&H does make a move, it is often more concerned with people than with the book of business, Mr. Hatcher adds. The key factor is whether the acquired producers can grow within the J&H system.

• Frank B. Hall & Co. won't come close this year to topping the gain last year of British broker Leslie & Godwin (Holdings) Ltd. Hall was the first and so far the only U.S. broker to finalize such strong ties to London.

"So far, this year we've made about a half-dozen acquisitions, but none in themselves big," says senior vp Mr. Johnson. "It could be more soon, however, because we've got a lot in the hopper now."

Agencies to be acquired will be divided about equally between geographic and specialty needs. Mr. Johnson mentioned the mid-Southern belt as a center of Hall's interest.

• Fred S. James & Co. is seeking growth in geographic areas and special-class expertise, a company spokesman says. In recent years, the firm has acquired Atlanta trucking specialists Mitchell Gaines & Henry and a consulting firm, Olanie Hurst & Hemrich.

Different philosophy

• Rollins Burdick Hunter has "a different philosophy about acquisitions—we're really not in the acquisition business per se," says vp Michael J. Starshak. "Buying agencies just to get larger is a secondary thought for us."

RBH has acquired about two to five agencies a year, although this year the firm has acquired seven firms, Mr. Starshak said.

"You really never know when these things are going to happen," he adds. "The decision-making process can take years in some instances. It all depends on the circumstances and the marketplace at the time."

• Bayly, Martin & Fay International Inc. is "looking to build up many of the areas we're already in," says vp Sam Alcorn. "There will be less of an emphasis on moving into new cities.

"We're also looking at specific areas to add expertise," he adds. "Last year we moved into aviation and we're looking at some segments of marine and aviation."

BMF expects to maintain its level of acquisition, he said.

• Reed Stenhouse Cos. is "almost always talking to someone in the U.S., but you don't know what's going to happen," says vp J.M. Riley. "We certainly want to play a greater role in the U.S.

"In Canada, we're much like Marsh & McLennan—we're already here," he explains. "Our expansion here came in the early '70s, so it is only particular expertises that we look for here. We're looking to the U.S. to expand.

Confirmed bachelors

"In the U.S., we're in a different position than the major national brokers. There are a great number of places we aren't located, so we can offer the agency a chance to become our agency there rather than join a former competitor of another brokerage."

But there will still remain a number of good regional brokers and agencies, experts say, just as there are always confirmed bachelors.

"Somebody once told me that going through this process was worse than getting married," says A&A's Mr. Wieczynski. "At least when you get married, you can get a divorce. With our agreement he's agreed not to compete with us if he quits, so he's with us for a long, long time." ■

Health care crunch squeezes tiny firms: Trade organization

By LEN STRAZEWSKI

Employe Benefits

WASHINGTON, D.C.—Skyrocketing health care costs and the lack of interested insurers have knocked group health plans out of small business benefit planning, charges a trade group that represents small firms.

"A recent Health, Education and Welfare department study showed that half of the estimated four million firms which employ fewer than 25 persons do not have group health insurance," explained Dennis L. Irish, vp of the Small Business Service Bureau Inc.

Lacking competitive benefits, employes of smaller firms are said to be ripe for the picking by larger corporations with comprehensive benefit packages. The businesses are also more vulnerable to acquisition offers that promise lucrative benefits for executives.

"The problem is not exclusively one of availability," Mr. Irish continued. "The relative affordability of comprehensive group health insurance is a contributing factor to this problem also. Comprehensive group health insurance premiums, like health care costs, are skyrocketing."

The Small Business Service Bureau recently told a House of Representatives small business oversight subcommittee that health care costs for small businesses are increasing more rapidly than sales or income.

"In the case of the small retail business which employs approximately 20 persons, group health insurance has tripled when expressed as a percentage of sales in the period between 1970 to 1977," Mr. Irish said, "and doubled when expressed as a percentage of total payroll.

Another SBSB case study of one firm indicated a small manufacturing firm does slightly better in the inflation-plagued group health marketplace. "The small manufacturing firm which complied with our request for information fared slightly better; group health premiums have risen from 1% to 1.4% of sales and from 3.7% to 5.9% of total payroll," Mr. Irish said.

The larger the firm, the more likely it is to have a group health plan at rates deemed "affordable" and comparable to large corporate plans. Even among firms of more than 100 employes, however, about 10% of the companies lack group health insurance. **(See chart on next page.)**

Brokers and insurers, however, counter that multiple employer trusts, trade groups and insurers pressed into new markets by the increasing number of self-insured large corporations have improved the health benefits market for small employers. The SBSB charges are outdated, they charge.

Insured multiple employer trusts, designed to handle benefits for firms with 200 or fewer employes, are beginning to reach into groups of 25 or fewer lives. The National Employers Trust, for example, managed by Corroon & Black Benefits Inc., serves nearly 16,000 small employers. Republic National Life Insurance Co. underwrites the trust.

"Insurance companies are not set up for the small guy," remarked Gibbs Smith, vp of Corroon & Black Benefits. "Generally, with our administrative program, we can be more cost effective and maintain tighter expense levels."

Though the National Employers Trust has groups of up to 200 lives, the one-to-25 employe firms have become a new business target. They are attracted by 5% to 8% savings on insurer rates when the coverage is available, Mr. Smith says.

The NET can underwrite "98% of the groups that come to us," he added. "We have a very small list of exclusions."

The National Employer Trust is

Continued on next page



"A recent Health, Education and Welfare department study showed that half of the estimated four million firms which employ fewer than 25 persons do not have group health insurance," says Dennis L. Irish, foreground, vp of the Small Business Service Bureau Inc.



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Health crunch squeezes tiny firms

Continued from preceding page

sold by agents to small employers, using published rates for faster pricing than some insurers. Some agents and employers, though, are reluctant to put business in a trust, citing trusts' poor reputation fueled by horror stories of stolen premiums and mismanaged funds in self-funded METs.

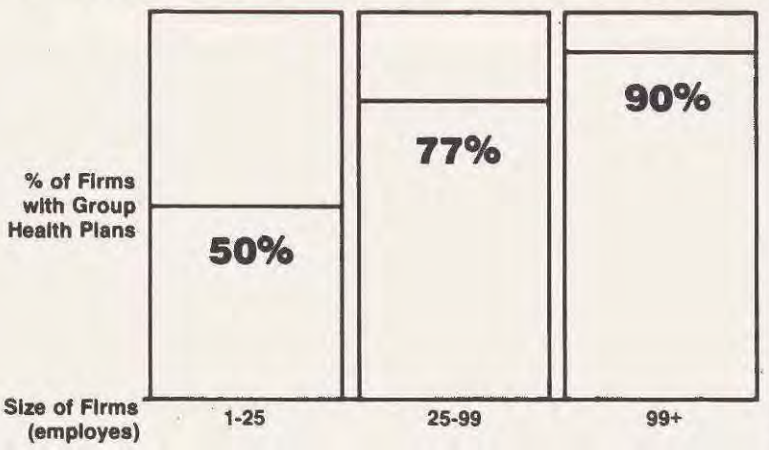
Policyholders are sometimes concerned because many METs were not set up correctly. "Some were set up by crooks," admits Mr. Smith. "They would collect premiums and then never pay claims."

METs will earn a good reputation, he said, as properly managed trusts survive and thrive. "Insurance companies have failed in the past and yet people continue to buy insurance. Trusts will continue and grow."

Trade association groups are also touted as the key to purchasing group health coverage at reasonable rates. The Illinois Manufacturers Assn. group plans, underwritten by The Travelers Insurance Cos. since 1954, is a classic example of good group purchasing, says A. William Greenfield Jr., manager of employe benefits for Arthur J. Gallagher & Co.

The IMA plan is recommended by the broker to small local Illinois clients for life, health and long term disability coverage.

With more than 300 firms insured through the association, IMA is seeking to expand its smaller accounts of 50 or fewer lives, says group insurance manager John Babcock. The attraction is a 5% reduction of The Travelers manual rates for group health and larger discounts on group term life.



Exclusive of the IMA plan, The Travelers is looking to write for more small employers above the size attracted to an association "because we think it is a very fertile market," said David P. Harris, manager of The Travelers' Chicago office group department.

The Travelers and other insurers—including the waning king of group insurers, Blue Cross/Blue Shield—are responding to a new industry dynamic set in motion by big self-insuring corporations.

Insurers are turning to smaller groups to maintain a flow of new business. Blue Cross/Blue Shield of Greater New York, for example, is promoting three new benefit programs for small businesses which feature extended benefits including up to $1 million in lifetime major medical benefits for groups of up to 100 employes. Dental coverage is also available.

"It's not really a response to the small business market need," said a BC/BS spokesman. "We just felt that the smaller firms are a market that we should tap."

Small business group health may even be becoming a buyers' market, brokers say. "We can find a small employer many markets these days, even for firms as small as $1 million in sales," contends Arthur J. Gallagher's Mr. Greenfield. "I can find 40 markets right now without going to an association.

"Small firms shouldn't just be looking for someone to give them health insurance," he continued. "They should be looking for a good broker to get the best price." ■

Exec shames industry for small plan neglect

SAN FRANCISCO—Failing to meet the needs of small group employe benefit plans "is the single area where the entire field of employe benefits is the most vulnerable right now," says Ernest J. E. Griffes, director of employe benefits at Levi Strauss & Co. here.

National health insurance proposals reflect the lack of sound benefit plans for millions of employes who work for small employers, he told the Northern California Employe Benefits Assn. recently.

"If any single factor ultimately leads to nationalization of the private pension system . . . it will be our failure as a profession to devise economical means for small employers to provide pension plans for their employes," he predicted.

When the Levi Strauss employe benefits executive challenged the group insurance industry to devise a comprehensive package of life, health, disability and pension benefits at a cost that would mean low profit or no profit for them, reaction was swift and defensive.

"I'm not sure the insurance industry has a social obligation to provide no-profit products to small employers," an executive from a leading independent San Francisco brokerage firm responded. "The insurance industry is as much entitled to a fair price for its products as Levi Strauss is for their blue jeans."

"If we don't do something, the government will," Mr. Griffes countered. "The insurance industry didn't make itself heard when ERISA was being developed and we got what we deserved. We'll get what we deserve in the future if we don't consider the needs of small employers now."

Another representative of a group health insurance company accused small employers of "being behind insurance companies in their unwillingness to finance benefits for their employes. We can't do it for them."

Mr. Griffes's suggestion that retired benefit professionals organize themselves as a corps of advisers to small businesses at no or very little cost was more favorably received by the audience.

A broker, however, pointed out that the field of employe benefits is changing so rapidly "someone not in the mainstream would have a hard time keeping up."

Mr. Griffes also urges "refining out the jargon and double meanings in our competition for business that often confuses competitiveness to the point of absurdity. This makes meaningful evaluations of products and services almost impossible."

The current trend to self-funding and use of third-party administrators for employe benefit plans is induced by insurance products that "are too limited in scope," Mr. Griffes said.

He also charged the insurance industry lacks imagination and willingness to expand its products, provides claims service and determines costs in a manner that is "murky and filled with jargon."

Describing the newly emerging group of benefit managers as "bright, knowledgeable and competitive," he chided the insurance industry: "No wonder selling the same old goods from the same old stand doesn't work as well as it used to." ■

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Jury remains out on need for legal plans

By ELLIS SIMON

Employe Benefits

NEW YORK—Without the United Auto Workers catapulting prepaid legal coverage into a hotly coveted item this year, insurers look to the mid-1980s for growth of the benefit.

Ford and General Motors were expected to submit to UAW pressure for prepaid legal plans in recent negotiations since Chrysler workers have a plan paid for by unused supplemental unemployment benefit funds. But prepaid legal didn't make the contract.

"We were looking for the UAW negotiations to heat things up," said David H. Lemire, assistant director for product research and development at Connecticut General Life Insurance Co., which is exploring development of a prepaid legal product.

"But until prepaid legal gets bargained for and won by large unions, it won't trickle down to other employers.

Among the few existing prepaid legal plans are the large plans of District Council 37, which represents 100,000 civil service workers in New York City, municipal employes in Columbus, as well as the 150,000 UAW members employed by Chrysler.

Don Caldwell of Sacramento, who administers a program covering 200,000 persons in 32 states, says people are "just learning of their needs for legal services."

The Caldwell program, which serves 19 national accounts, provides unlimited telephone consultations, free will preparation and document review for an annual premium of $28. It uses a modified open panel whose members agree to charge between $30 and $40 per hour for other services.

George Umans, president of Washington-based Prepaid Legal Services Inc., which has marketed the Caldwell plan since August, reports inquiries from banks, manufacturers, utilities and credit unions. Mr. Umans has signed up the 60,000-member National Management Assn. and is negotiating with a labor union with a membership of one million-plus.

Prepaid legal coverage can maximize employe productivity and reduce absenteeism because early access to attorneys can avoid prolonged legal problems, Mr. Umans contends.

"About 73% of legal problems are answerable over the telephone," Mr. Caldwell adds.

Marketing by agents could increase acceptance of the Texas Legal Protection Plan, a modified open panel set up by the state bar association and regulated by the state board of insurance in a manner similar to Blue Cross & Blue Shield. It offers three coverage alternatives with monthly family rates ranging from $5.46 to $13.40.

After three years of marketing the program on its own and attracting 1,400 participants in 33 groups, the plan is now being marketed by major insurance brokers in the state, including John L. Wortham & Son of Houston and the Dallas office of Alexander & Alexander.

Consumer Services Organization of Chicago, which began marketing prepaid legal coverage to individuals one year ago, the only plan doing so, has expanded to service groups.

The organization's basic services include use of its consumer complaint telephone hotline, state and federal income tax preparation, unlimited consultation on non-business matters, uncontested divorce, uncontested adoptions, real estate closings, will preparations, basic bankruptcies and name changes.

The closed panel plan, sold to individuals for $225 per year, can be marketed to groups for $120 per person, director Dr. Steven Blutza said.

Midwest Mutual Insurance Co. of Des Moines, believed to be the only insurer actively marketing prepaid legal coverage, remains optimistic about the product's future. "From here on it's up and up," said Debbie Terry, program administrator.

Since 1977, the number of groups insured with Midwest Mutual increased to about 100 from 70. However, the number of persons covered remained at about 20,000. The company markets its modified open panel program in 20 states and is approved in another 17.

About half of Midwest Mutual's plans are union-sponsored, with employers sponsoring most of the balance, Ms. Terry said. Groups range in size from eight to 3,000.

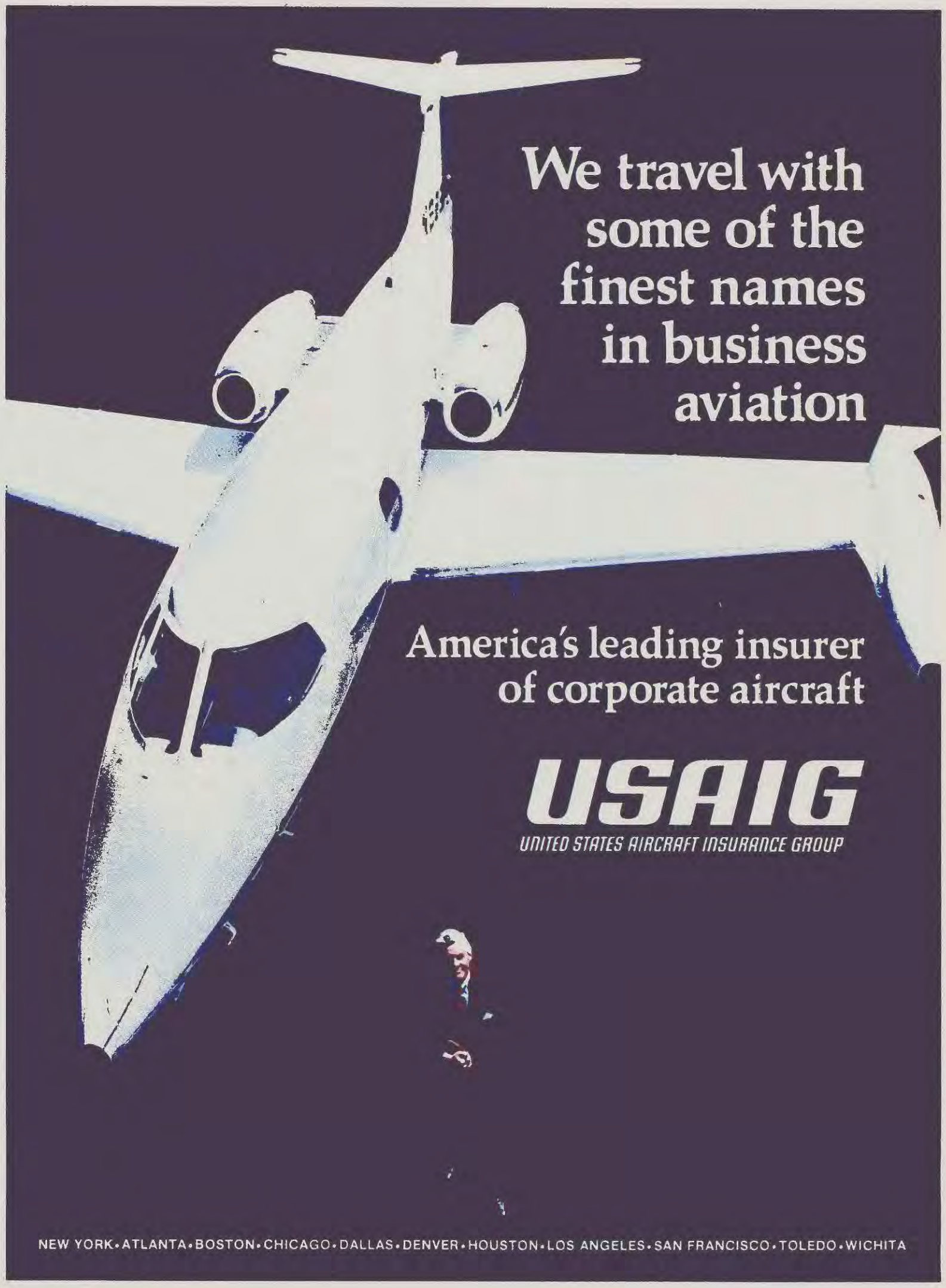
For a monthly premium of $6.92 for individuals and $9.23 for families, Midwest Mutual covers legal expenses from divorces, adoptions, misdemeanors, felonies, wills, traffic charges, guardianship procedures, juvenile court appearances and other needs.

The insurer has a set schedule of benefits that normally pays close to 80% of an attorney's usual fees. The fee schedule will probably be increased during 1980, Ms. Terry noted.

Other insurers, such as Connecticut General and Aetna Life & Casualty, plus Nationwide Mutual, Insurance Co. which has regulatory approval to market legal coverage in 17 states, are either studying the market potential or putting decisions on hold.

Aetna, which is doing a preliminary feasibility study, hopes to have a product developed by the end of 1980, said assistant secretary Susan O. Parent.

"We haven't seen as much demand as everybody expects to see, but prepaid legal still has great potential," she said. ■



Consultants assemble retirement tips

By ELLIS SIMON

Employe Benefits

NEW YORK—Employes don't like to talk about retirement, but employe benefit consultants say they have ways to make workers think about what happens after the gold watch.

Varying preretirement communications consulting services are offered by Alexander & Alexander's Benefacts division, George B. Buck Consultants, Coopers & Lybrand, A.S. Hansen, Hewitt Associates and William M. Mercer. Other consultants, including Johnson & Higgins and Milliman & Robertson, are considering venturing into this field.

Consultants generally assist clients in developing preretirement communications plans from available sources rather than produce books and films.

Benefacts is a notable exception, having developed its own home planning workbook and cassette to be used by clients' older employes. "We're competitors with the other consultants, but we do different things," said Donald F. Pellicano, manager of retirement communications services at Benefacts. "They are in a true consulting stance. My job is to develop a program for companies to use."

Although other consultants will produce materials for clients upon request, they prefer to advise clients on which commercially produced packages are best suited to their needs.

"We try to keep materials as standard as possible to avoid the expense of having to produce new booklets," said Donald Brothers, consulting principal with A.S. Hansen. "The individual in a medium-size company about to retire has the same problems as a guy retiring from, say, Mobil Oil Co., but the medium-size company has the cost problem."

"There's a very good supply of training materials being produced," said Robert A. Jud, assistant vp at William M. Mercer. "The problem is not finding the material, but putting it together in a way to reach the target audience."

Buck Consultants normally produces only communications materials needed to fill gaps in a retirement communications package, said Henry von Wodtke, director of the firm's law department. Such material would be produced if the package were weak on life insurance, investment or other information retirees need.

Consultants capable of producing individualized benefit statements are often called upon to produce more elaborate statements for retirees to demonstrate the effect on income of retiring at different ages or under different options.

For one client, Buck produced a statement covering 20 different retirement options, including provisions for future salary increases and increased Social Security benefits, Mr. von Wodtke noted.

Curiously, enactment of the Age Discrimination in Employment Amendments, which raised the permissible mandatory retirement age to 70 from 65 has not produced a groundswell in demand for preretirement communications consulting services, consultants report.

None of the 45 participants in two workshops on preretirement communications sponsored by Hewitt Associates said their interest was because of ADEA, said Steven Ramsey, a writer/consultant with the firm

Mr. Ramsey suggests preretirement communication for most firms is "a back burner issue that's been moved up."

Several consultants suggested corporations will follow a few leaders. "Once a few big companies get involved, all employers will get interested," said Mr. von Wodtke of Buck.

If a good preretirement communications program leads to more successful retirements for employes, it will provide good public relations for a company and better appreciation of its benefits, said Benefacts' Mr. Pellicano.

Employe resistance must be overcome. Most specialists recommend beginning retirement planning when people are in their mid-50s. Mr. Jud of Mercer noted. But, most people that age are still vigorous and fully engaged in life, he added. "It's difficult for them to recognize that they have to prepare for a new state in life."

The biggest challenge is to find out what employe needs are, said Hewitt's Mr. Ramsey. "Some employes don't want the company to tell them what to do."

Management needs to listen to employes, he continued. However, Mr. Ramsey cautioned against conducting full-scale attitude surveys because of bad past experiences.

Audiovisual devices are useful in retirement planning communications programs, but they're best used to "break the ice and set the mood," noted Mr. Pellicano.

Typically, retirement planning programs consist of an orientation session that may or may not include an audiovisual presentation, home study by the prospective retiree and spouse of written material to select the most suitable options and follow-up sessions.

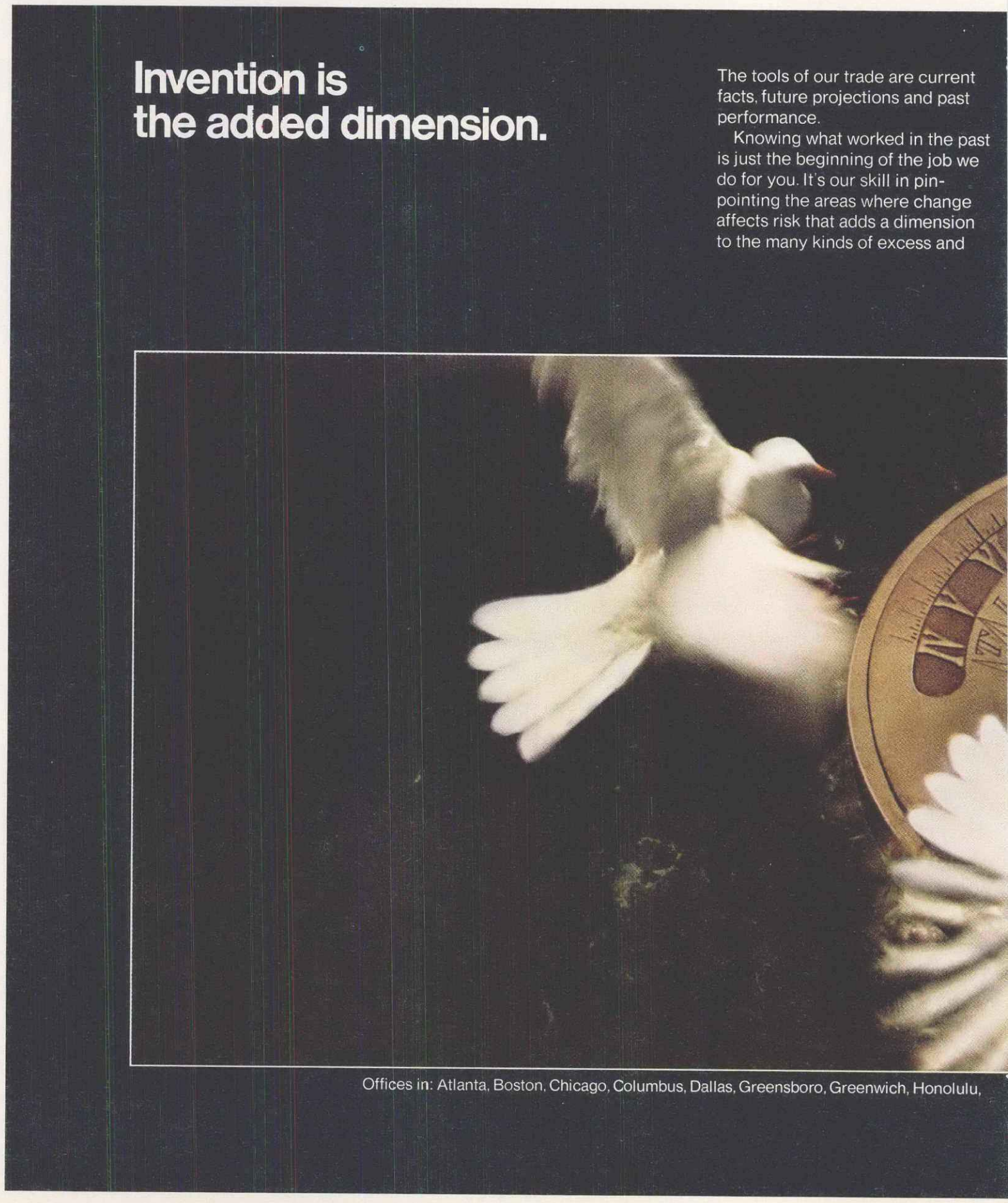
Most consultants provide training for company employes who serve as session leaders. Some consultants conduct the retirement planning sessions.

Leaders should be someone from the employer, Mr. Brothers said. A happily retired ex-employe is the best candidate, he added.

"While everyone is in love with the seminar approach, it reaches a limited audience," Mr. Pellicano said. "Trainers often are one step ahead of the students and, unless they are a special person, they usually don't put zip into their presentations."

Most major corporations cannot afford to send a professional trainer around the country conducting retirement planning seminars, Mr. Pellicano conceded. However, the professionally conducted seminar is the next best alternative to a one-on-one session with an employe, he said.

But Mr. Brothers cautioned that employes participating in one-on-one sessions sometimes believe they are being pushed out. ■



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Insurers promote retirees' life benefit fund

By MARY ELLEN McKEE

CHICAGO—Insurers are peddling a tonic for pumping strength into washed-out life insurance benefits—retired lives reserve—but unsold employers fear it's just patent medicine.

The tax-deductible group term life insurance plans are the medicine retirees need and the prescription firms have been looking for, underwriters of the product contend.

Among the dozen insurers selling RLRs, some are reporting double the business in the last year, among them: First Colony Life Insurance Co., North American Life & Casualty Co., Republic National Life Insurance Co., Security-Connecticut Life Insurance Co., Sentry Life Insurance Co. of New York and Patriot General Life Insurance Co.

CNA got into the business Oct. 1 and has snared 15 cases already. Other insurers including Connecticut General, The Travelers Insurance Cos., Bankers Life Co. of Iowa and The Kemper Group are considering the product.

But an informal survey of 15 Fortune 500 companies revealed many employers are more skeptical than enthusiastic about the product.

"We looked at the retired lives reserve fund concept, but found that bonus plans for top executives were a much more efficient and visible way to reward them," said an administrator in the employe benefits department at Atlantic Richfield Co. in Los Angeles.

Standard Oil of Indiana is planning to implement an RLR program for all employes starting Jan. 1, 1980. "Pre-funding for post-retirement benefits based on an actuarial formula seemed an effective and attractive way to provide an adequate retirement benefit for our employes," said a benefit administrator for the company.

Only American Telephone & Telegraph admitted to maintaining an RLR for its 35 top executives. The tax penalty on the employe for benefits of more than $50,000 is less than under a split-dollar plan and RLR charges don't increase at age 60 as under split-dollar plans, explained an AT&T benefit administrator.

Other benefit managers were either unaware of the product's features or feared RLR is just another "Section 79" product in disguise.

Employe Benefits

A "Section 79" product was a combination of group term and permanent insurance benefits widely marketed until the end of 1976, when the Treasury Department stopped issuing favorable letter rulings on premium allocations between the group term and permanent insurance coverage.

An RLR is a fund maintained by an employer to provide group life insurance benefits to retired employes. The employer annually pays an actuarially determined amount to the fund during the working life of the employe which will pay the premiums on the employe's group life insurance.

The cost to the employer is tax deductible and the employe only pays income tax on the premium for insurance exceeding $50,000 and only prior to retirement, says Peter Hepburn, branch manager of the New York office of Unionmutual, a marketer of RLR. The tax for the employe is significantly less than the taxable income on a permanent life plan, he says.

After retirement, there are no further income tax obligations to the employe, even on benefits of more than $50,000.

"An RLR plan is attractive to the employer because it presents an opportunity to purchase what amounts to permanent coverage for a class of key employes with dollars that are fully deductible," said Richard E. Lewis, assistant vp of life, health and pension distribution at CNA.

The death benefit under an RLR plan, payable to the employe's beneficiary, provides an excellent source of tax-free funds to pay estate and other costs, he added.

While satisfying the requirement for group insurance under Section 79 of the Internal Revenue Service Code, RLR offers an extra punch, says James S. Roberts, a tax attorney with the Miami law firm of DeCarlon & Roberts.

Retirees are assured of life insurance benefits while other plans usually reduce benefits at age 65 and terminate them at 70, he says.

Employers, meanwhile, gain flexibility with RLR in rewarding key executives because as a fund established by an insurance company, it is not qualified by the IRS and can be selective in the classes of employes covered—in corporations where more than 10 employes are covered by an existing pre-retirement group term plan.

The employer determines the employe class to be covered based on salary, years of service or position within the company. All employes that fall within a given class must be covered by the RLR plan.

At age 65, the fund for an employe should contain about $500 for each $1,000 of coverage, said Mr. Roberts of DeCarlon & Roberts. The reserve fund is held by the insurer, where the money earns tax free interest, resulting in a reduced premium cost for the employer.

CNA's Mr. Lewis promotes RLR as an incentive to long-term employment.

"It's also a very effective way to tie a useful employe to an employer for a lifetime career," he says. "If an employe leaves employment before retirement, he loses all interest in the reserve fund for the continuation of his coverage. If an employe stays with the employer until retirement, then the employer must fulfill his end of the RLR obligation by assuring the employe life insurance coverage until his death."

CNA's RLR program offers an individual annual renewable term life insurance policy for active employes and a group term insurance contract for providing post-retirement coverage similar to most RLR products already on the market.

The CNA policy differs from most in its deposit administration fund contract establishing a fund to buy annuities that will pay the group term premiums for retired employes. The contract guarantees a net 7.5% return for the first 10 years and the return is not taxable to employes or employers.

Another selling point of the CNA policy is that it guarantees the maintenance fee to administer the fund will never exceed more than .5% each year, Mr. Lewis said. "I think the absence of these guarantees stunted RLR growth to a great degree," he added. ■

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Employers prod workers to exercise gyms

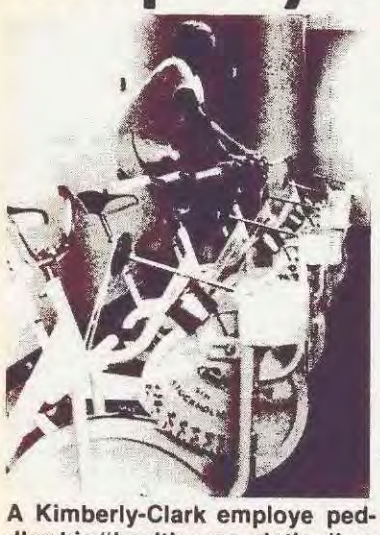


Photo: Kimberly-Clark

A Kimberly-Clark employe peddles his "health prescription" on a cycle.

By MARY ANN MATLOCK

Employe Benefits

NEW YORK—More workers are taking breaks from pushing paper to pump iron—with the blessing of their employers.

Today, more than 500 corporations offer areas for employes to exercise, mostly within their own headquarters and usually without charge, according to the President's Council on Physical Fitness. Matthew Guidry, director of community projects and special projects for the PCPF, estimates 20 companies per month seek advice on developing employe fitness programs, ranging from simple exercise and shower rooms to elaborate gymnasium and diagnostic cardiac testing centers.

Although the heads of corporate fitness centers propound the health benefits of exercise, actual data on the effects of individual programs on worker productivity, absenteeism and accident rates is not available, largely because of the newness of most of the centers and the difficulty in measuring such effects.

"Exercise is the cheapest aspect of health—both physical and mental," Mr. Guidry says, as it increases a person's morale, improves both physical and mental health and helps persons deal with stress. These benefits not only help the individual, but the person's employer, since the employe will be more self-aware, healthy and productive, he says.

A NASA study based on tests conducted between 1968 and 1971 cites the beneficial effects of routine exercising on a person's health. "Participants reported that they could work harder mentally and physically, enjoyed their jobs and found their normal work routine less boring," the study found. "Both the employe and the employer seem to obtain rewards—the one in his physical well-being, life expectancy and mental attitude and the other in the productive capacity of his workers."

"It's too early to determine overall cost-benefit results," says Darwin E. Smith, chairman and chief executive officer at Kimberly-Clark Corp. in Neenah, Wis., which has built an elaborate fitness program for employes. "We know that many individuals have benefited," he adds, and several cases of cancer, high blood pressure and heart disease have been detected in stages early enough for curative treatment.

Kimberly-Clark built its health services center in 1977 for $2.5 million. It consists of multiphasic health testing and physical fitness facilities adjoining one of its office buildings. About $600,000 per year is budgeted to maintain the program.

The program was initially opened to 2,500 salaried employes and was expanded this year to all 4,500 employes. Services include cardiac rehabilitation classes, counseling on alcoholism, drug abuse and special health problems, medical screening, health education classes and the exercise equipment.

The concept of industrial fitness is not new, says Mr. Guidry of PCPF. The Green Bay Packers football team was initially a club team.

The big push for these programs, however, started in the early 1970s because "at that time people were searching for something greater. . . fitness was one way people could change themselves," he says.

Large companies other than Kimberly-Clark that joined this big push were Standard Oil, Prudential, Exxon, Xerox, Mobil, Blue Cross & Blue Shield, Rockwell International and Chase Manhattan.

Other companies also offering exercise facilities, either owned by them or rented for employes' use, include Gould Inc. in Rolling Meadows, Ill., Bonne Bell in Lakewood, Ohio, and Excello Press Inc. in Chicago.

"We feel it's an effective program," Dr. Peter Wolkonsky, medical director at Standard Oil (Indiana), said of the fitness facility on the 38th floor of the Chicago offices.

He estimates the initial investment for exercising equipment at $20,000 to $25,000, exclusive of the stress testing equipment. The facility includes a cardiac stress testing laboratory and fitness facility with 12 exercise stations, individualized exercise programs administered by a trainer and environmental health and medical services. Approximately 150 executives are primary users of the facility, Dr. Wolkonsky says.

Prudential Insurance Co. of America has exercising facilities at its offices in Newark, N.J., and Houston.

"There's little information available relative to the effect of the programs on health," said R. Keith Fogel, fitness director for the company. "We know that it does help, but we have no facts and figures." Variables such as workers' productivity before and after entering such programs is nearly impossible to measure since "it's mainly a subjective thing," he says.

Employes use the facilities primarily during lunch hour and after work. The gym in Newark has been there for 40 years but the Houston facility is only two years old.

Excello Press in Chicago built a racquetball court, shower and exercise room into its warehouse about two-and-a-half years ago, says Thomas Kostka, director of purchasing.

"I know I personally have felt a whole lot better since exercising," Mr. Kostka said. "I have more get up and go. It's a very relaxing way to end the day. I come home in a better mood because of it."

He estimates that 60 to 70 employes out of 200 use the facility, which is open 24 hours a day. "The beauty of it is, it's so convenient," Mr. Kostka said, admitting that before this plant addition, he didn't exercise at all.

Fel-Pro Inc. in Skokie, Ill., is among companies adding exercise facilities. ■

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Immediate vesting

M&M elevates ESOP to sole savings program

Crain News Service

NEW YORK—Employe stock ownership plans are valued so highly by consultants for their incentive value that William M. Mercer Inc. decided to bring an ESOP plan home.

The 10,000 employes of Marsh & McLennan Cos., including William M. Mercer Inc., now have what is considered to be one of the largest ESOPs in the nation.

M&M expanded an existing ESOP in July to replace savings plans for employes allowing contributions to a guaranteed investment contract with The Equitable Life Assurance Society and a Putnam Management Co. fund.

Employes over 55 years old contributing to the old plans can continue doing so or convert their holdings to the ESOP. Other employes, however, now have only the ESOP option, which some employes say has created a bit of discontent, even though the ESOP offers immediate vesting.

M&M financial vp Bruce Schnitzer said the M&M savings plan was amended to reduce "the paternalism" of the old plan.

"Our impression of the savings plans generally is that they started in a different generation as a supplemental retirement plan. Therefore, they had a tendency to have longer vesting requirements. It was a long-term proposition," Mr. Schnitzer said.

"Our view now, in terms of fringe benefits, is that it does not need a supplement and therefore a traditional savings plan does not seem to be needed."

Mr. Schnitzer said the company thinks of itself "as being spiritually a partnership and we'd like to think of the firm as being owned by everyone."

He also stressed that the vesting and withdrawal provisions are "as advantageous to the employes as possible" while still remaining within the law guidelines.

He added that M&M chose the stock program as an incentive, which fits into the company's current development.

The new plan has been "very well received" by the employes who wish to purchase the M&M stock at a 60% discount from the market value, he said.

Critics of the change in benefits, however, labeled the immediate vesting provision "a sweetener," which was inaugurated to compensate for taking away the employe's option of joining one of the other three programs.

However, Gerrard R. Smith, M&M insurance manager, says there has been very little employe opposition to the new plan and more than 85% of the employes have joined the stock ownership plan. ■

Employe Benefits

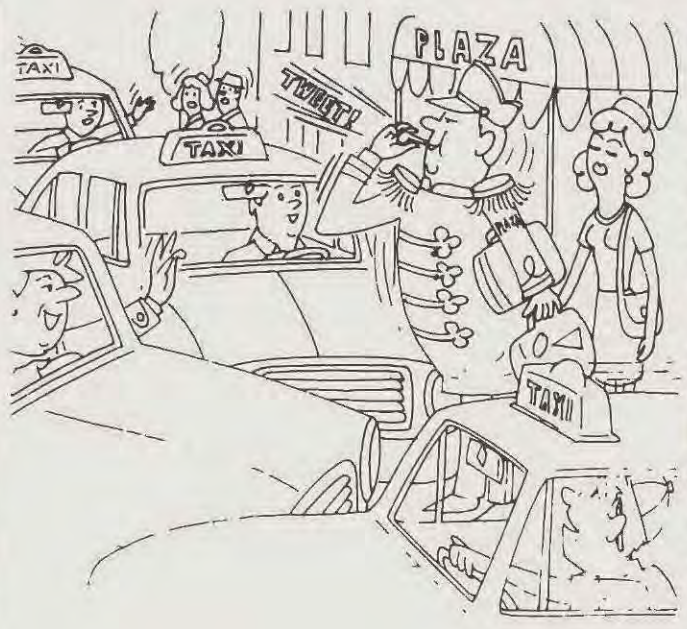
Work comp checks slow

SAN FRANCISCO—The average time it takes a California worker to receive a workers compensation payment after being disabled rose to 17.6 days in the first half of 1979, the longest time lag since 1968, the California Workers Compensation Institute reports.

Fewer than 70% of the disabled in 1979 received their first benefit check within two weeks. In the first six months of 1978, the average time lag was 16.7 days.

Insurers compiled the best time payment record—an average of 17.2 days—but their percentage of first payments dropped to 76%, from 85% earlier in the decade. Self-insurers recorded a 17.3-day average, up more than two full days from last year, and legally uninsured public entities continued to trail at 24.2 days.

But, total first benefit payments declined from the previous year for the first time since 1967, indicating claims are decreasing. ■



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Consultants preach creative planning

By ELLIS SIMON

Employe Benefits

NEW YORK—Employe benefit consultants, finished with putting out ERISA-compliance fires, are preaching future planning to prevent benefit plan problem flare-ups.

"People were paying us to do work resulting from ERISA," said Larry Fisher, president of A.S. Hansen of Lake Bluff, Ill. "Now we're being paid to do work we should be doing, namely pure consulting."

The consultants say they are ready to serve clients in a decade when political, economic and social pressures will force employers to more closely scrutinize benefits and benefit dollars.

"Traditional methods of benefit planning are over," said Douglas Stegner, chairman of Louisville-based Meidinger Associates. "We will have to change from routine services to creative services to make benefits cost effective and get maximum leverage out of the benefit dollar."

Clients are also seeking more work on long-term planning and coordination of benefits, added Rolph Masecar, vp and partner at Tillinghast, Nelson & Warren of Atlanta.

Actuarial and benefit design consulting have replaced ERISA compliance activities as the mainstay of Milliman & Robertson's work in recent months, said James Curtis, president of the Seattle-based firm. "In the past few months, we've caught our breath."

In the future, clients will demand long-term projections on the outlooks for pension plans, Mr. Curtis predicted. "Many companies want to treat pension plans like profit centers and this will result in pressure to improve funding and investment yield."

Public sector pension plans will particularly need improved funding, noted David Hewitt, vp and partner with Hay/Huggins of Philadelphia. These plans will probably have to bring their funding in line with private sector standards and could face the need to comply with legislation similar to ERISA, he explained.

According to a study on employe benefits in the 1980s prepared by William M. Mercer Inc. of New York, the aging of the American workforce and the efforts to eliminate mandatory retirement will guide benefit developments in the coming decade.

An end to mandatory retirement, predicted by many benefit experts, could require sweeping changes in plan design, including a deemphasis of defined benefit pension plans in favor of defined contribution plans and improved life insurance benefits.

Post-retirement benefits will be examined with regard to the needs of retirees and inflation, predicted Clifford R. Simms, chief executive officer at Cleveland-based Wyatt Co. In addition, employers will want to review their total compensation package to determine whether the balance between cash and deferred compensation should be shifted, he said.

Clients will require more "sophisticated data processing resources including computer systems they can operate on their own premises," said William Dreher, partner with Peat, Marwick & Mitchell.

Improved employe data banks are needed partly because of government requirements, added Mr. Simms of Wyatt.

Also in great demand will be advice on health care cost containment, said James G. Harlow, senior vp and partner at New York-based Johnson & Higgins. He expects employers to need help redesigning health plans to discourage use of hospitals.

The end of the rush to bring benefit plans into compliance with ERISA did not flatten demand for benefit consulting services as some had feared. Federal regulation on age and sex discrimination and the health care cost containment drive have picked up some of the post-ERISA slack.

"They all create problems for clients and work for consultants," said Jean Lindberg, vp at George B. Buck Consultants of New York.

But benefit consulting firms will grow more slowly in coming years in part because of the "tapering off of mechanical activity" that marked the ERISA compliance era, said Mr. Fisher of Hansen.

Consultants will have to work at attracting new clients and new business, said Chuck Simons of New York-based Alexander & Alexander.

Employe benefit consultants are continuing to enjoy strong growth, however.

Of the 15 firms reporting employment figures this year, 11 also reported last year (*BI*, May 19, 1978). The combined employment rosters of these 11 firms grew 5% to 9,047 from 8,594 18 months ago.

Frank B. Hall & Co. posted the largest increase in its benefit consulting operation, boosting the staff 83% to 550 from 300. Not far behind was Wyatt Co., boosting its total staff a whopping 50% to 1,050 from 700.

Other gainers were: Hewitt Associates, up 22% to 612 from 500; Mercer, up 4% to 2,400 from 2,300; A&A, up 15% to 575 from 500, and J&H, up 14% to 570 from 500.

Consultants' fees also increased during that period, now ranging from $20 to $150 per hour. Milliman & Robertson's top fee increased 8% to $135 per hour from $125 per hour. Hansen's top hourly rate, which was previously reported as more than $100, is now said to be $150. Meidinger raised its top hourly rate 22% to $110 from $90.

Mercer's entire rate schedule shifted upward, with the range of hourly charges now from $20 to $200. The range 18 months ago was $10 to $150. This reflects a 33% hike at the top end and a 50% increase at the bottom. TPF&C's hourly rates range from $40 to $150 per hour, up from $35 to $100, an increase of 14% at the low end and 50% at the top.

Martin E. Segal Co.'s top rate is down from $200 per hour to $150. The New York-based firm's lowest scale was increased to $30 per hour from $15 per hour, however. ■

Iowa office

The Travelers Insurance Cos. has opened a new commercial lines district office in Cedar Rapids, Iowa. The new district has been formed from the company's Des Moines office and will do business with agents in eastern Iowa. John Van de Voort has been named district manager.

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22 firms profiled

Here's the rundown on who is selling benefit consulting

Employe Benefits

Alexander & Alexander Human Resources Management Division

1211 Avenue of the Americas, New York, N.Y. 10036; 212-840-8500

Alexander & Alexander's human resources management division specializes in actuarial, group insurance and international consulting as well as executive compensation and executive planning services consultation. Its Benefacts communications subsidiary based in Baltimore is known for developing personalized benefit statements and its Atlanta-based administrative services group administers defined contribution benefit plans.

A&A serves more than 10,000 clients, 90% of which are corporate, including about 75 Fortune 500 firms that are principally Benefacts clients. The employe benefits staff numbers about 575, including more than 300 considered professionals.

About 50% of A&A clients use the firm on a retainer basis, but its divisions bill differently. The actuarial division bills strictly on a fee-for-service basis. Benefacts bills for fees plus costs and employe benefit consulting clients can elect to pay an hourly fee or apply commissions against that. Most small clients prefer commissions, noted Chuck Simons, vp of the human resources management division.

Consultants' hourly charges are a direct function of salary, ranging from two-tenths of 1% to three-tenths of 1%. The firm would not reveal its average or top hourly charge. Secretarial support services are billed for separately except where the client elects to pay commissions.

A&A's 1978 employe benefit revenues were $43.2 million with $23.3 million from life and group insurance consulting, $9.3 million from employe benefit communications and $10.6 million from actuarial consulting. Revenues the first nine months of 1979 ran $36.3 million: $21.3 from life and group insurance, $6.7 million from communications and $8.3 million from actuarial consulting.

Human resources management personnel are located in 55 U.S. offices of A&A. An additional 20 offices provide employe benefit services.

George B. Buck Consultants Inc.

2 Penn Plaza, New York, N.Y. 10001; 212-279-4400

Buck Consultants says it is strong in all consulting areas, with its involvement ranging from plan design to tax questions and advising clients on the benefit implications of mergers and acquisitions. It serves 650 clients through offices in New York, Atlanta, Chicago, Pittsburgh, San Francisco, Washington and Toronto. Among its clients are 45 of the 200 largest manufacturing companies, three of the five largest banks and three of the five largest utilities.

The firm's staff of 530 includes about 75 consulting actuaries, associate consulting actuaries and benefit consultants. Buck includes routine support services in its consultants' rates, which it would not discuss. Industry sources believe the firm's average hourly rate is slightly higher than the average because the firm tends to do a greater proportion of actuarial consulting than its competitors.

Coopers & Lybrand

1251 Avenue of the Americas, New

Continued on next page

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3.		JAN 21	Jan 9
4.	Spotlight Report: Workers Compensation	JAN 28	Jan 16
5.		FEB 4	Jan 23
6.		FEB 11	Jan 30
7.	RISK MANAGEMENT SERVICES	FEB 18	Feb 5
8.		FEB 25	Feb 12
9.	Spotlight Report: Computers/Quantitative Techniques	MAR 3	Feb 20
10.		MAR 10	Feb 27
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Employe Benefits

Continued from previous page
York, N.Y. 10020; 212-489-1100

Coopers & Lybrand says its benefit consulting strengths are in retirement plans, total compensation, group life and welfare plans, executive compensation, benefit communications, international benefits and retirement planning. The firm also provides casualty actuarial services for insurance companies and self-insureds. Coopers & Lybrand serves more than 1,200 benefit clients, 80% of which are corporate, including 60 of the Fortune 1,300.

The firm's benefit consulting staff of 250 includes 200 professionals, charging hourly fees ranging from $25 to $125. Secretarial services are billed for separately.

Benefit consulting services are performed in offices in New York, Boston, Chicago, Dallas, Detroit, Los Angeles, San Francisco, Houston, Miami, Atlanta, Syracuse, Columbus, Ohio, Philadelphia and Washington.

Corroon & Black Benefits Inc.

301 Plus Park Blvd., Nashville, Tenn. 37217; 615-367-9707

Corroon & Black Benefits Inc. and its affiliated companies sell advice on administrative services, plan design, estate planning, pension and profit sharing services, self-funding, benefit captives and benefit communications. Its 424 employe benefit staff includes 57 consultants.

C&B benefit specialists charge $25 to $100 per hour, with billing practices for secretarial services varying among offices. Computer time is billed for separately. Employe benefit revenues for 1978 were $15.7 million.

Corroon & Black Benefits, which until 1979 was known as Blair, Follin, Allen & Walker, a subsidiary of Synercon, has offices in: Atlanta; Birmingham; Charlotte, N.C.; Chattanooga; Jackson, Tenn.; Johnson City, Tenn.; Knoxville; Lexington, Ky.; Los Angeles; Louisville; Memphis; Nashville; New Orleans; Owensboro, Ky., and Washington. Benefit consulting services are also provided in 12 property/casualty offices of parent company Corroon & Black Corp. The compensation programs division does profit sharing and pension consulting in offices in Albany and Harrison, N.Y. Other affiliates are: Compensation Programs Inc. in Seattle; C&B Financial Services Inc. in San Diego, San Francisco, Los Angeles and Salt Lake City; Powers, Carpenter & Hall of St. Louis and New Orleans and Professional Planning Consultants Inc. of Columbus, Ohio.

Deloitte, Haskins & Sells

1114 Avenue of the Americas, New York, N.Y. 10036; 212-790-0500

Deloitte, Haskins & Sells offers employe benefit consulting as part of its audit and tax services for clients. The firm performs audits of employe pension and welfare plans, analyzes the tax aspects of plans and consults on systems, plan design and implementation. It doesn't do actuarial evaluation reports. Benefit consulting services are available in approximately 70 of the firm's offices.

Deloitte, Haskins & Sells would not discuss its revenues nor hourly rates, other than to say that secretarial services are built into hourly rates.

Frank B. Hall Consulting Co.

261 Madison Ave., New York, N.Y. 10016; 212-682-7200

Although its staff includes qualified people in all benefit consulting areas, Hall focuses on group benefit plans including health maintenance organizations, special risks such as travel and accident cover and individual life insurance plans deducted from payroll. The firm is also strong in international benefits, benefit communication and executive deferred compensation consulting.

Hall serves 3,000 to 4,000 clients, 85% of which are corporate, but less than 5% pay retainers. The firm works for 150 to 200 of the Fortune 1,300 lists. The worldwide staff of 550 persons, including about 225 consultants, works out of 40 U.S. and 10 foreign offices.

Hourly fees vary with the expertise and title of the consultant performing the work, but are generally in line with the consulting industry's typical range of $35 to $150 per hour. Hall includes secretarial and support services in its fees.

Employe benefit consulting and plan sales produced $19.2 million in revenues in 1978 or 10% of parent company Frank B. Hall & Co. Inc.'s revenues.

A.S. Hansen Inc.

1080 Green Bay Road, Lake Bluff, Ill. 60044; 312-234-3400

A.S. Hansen consults on all employe benefits, including retirement, disability and group health plans, compensation, investment services and communications. Eighty percent of its more than 3,000 clients are corporations. Less than 5% of its clients are billed on a retainer basis.

The staff of 475 includes 125 consultants, whose hourly rates are believed to be in line with the industry average range of $35 to $150. All employes, including secretaries, bill separately for their time. The firm declined to reveal its revenues.

Hansen offices are in New York, Washington, Boston, Houston, Memphis, New Orleans, Atlanta, Columbus, Ga., Montgomery, Tampa, Los Angeles, San Francisco, Dallas, Denver, Fort Worth, Tulsa, Wichita, Chicago, Lake Bluff and Milwaukee.

Hay/Huggins U.S.A.

229 S. 18th St., Philadelphia, Pa. 19103; 215-875-2300

Hay/Huggins lists as its benefit consulting strengths pension actuarial work, benefit evaluations, communications, investment services and surveys. The firm's staff of 170, including 75 consultants, serves 900 clients, two-thirds of which are corporations. Included among those clients are 47 firms on the Fortune 1,300 list.

Hay/Huggins said its hourly rates were slightly below the industry average range of $35 to $150, but the firm bills separately for secretarial and support services. Revenues from benefit consulting run approximately $5.4 million.

Hay/Huggins has benefit consulting offices in Philadelphia, Atlanta, Boston, Chicago, Dallas, Los Angeles, Minneapolis, New York, Pittsburgh, San Francisco and Washington.

Hazlehurst & Associates

235 Peachtree St., Atlanta, Ga. 30303; 404-688-0602

With 35 employes, including 10 consultants and 25 support staff, this small consulting firm tackles all phases of employe benefits, actuarial and investment consulting, president James Pope says. Of its approximately 120 clients, 80% are corporate, including 70 firms on the Fortune 1,300 lists. None of its clients are on a retainer billing. Hourly fees charged Hazlehurst clients range from $20 to $125 and average $60 per hour. All employes bill separately for their time.

In addition to its Atlanta headquarters, Hazlehurst maintains offices in San Francisco and Seattle.

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Hewitt Associates

100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000

Hewitt Associates serves approximately 1,100 clients, 98% of which are corporate, and 650 are on the Fortune 1,300 lists. The company's staff of 612 includes 390 professionals.

Hewitt claims consulting specialties in total compensation planning, actuarial and financial management of employe benefits, total compensation administration and employe communications. The firm also was a pioneer in the field of flexible benefit consulting.

Hourly rates charged by Hewitt consultants range from $32 to $152 and average $70. All employes bill separately for their time. Revenues for the firm's 1979 fiscal year, which ended in October, were $27.5 million.

In addition to its Lincolnshire headquarters and regional headquarters in Stamford, Conn., and Newport Beach, Calif., Hewitt has offices in Atlanta, Chicago, Toronto, Dayton, Houston, Los Angeles, Milwaukee, Minneapolis, New York and San Francisco. Its management consulting services division is based in Scottsdale, Ariz.

Johnson & Higgins

95 Wall St., New York, N.Y. 10005; 212-482-2000

With a staff of approximately 570, including 369 professional consultants and actuaries, Johnson & Higgins's consulting strengths are in the area of financial analysis, cost containment and benefits research, says senior vp James G. Harlow. J&H benefit specialists are trained in both group insurance and pensions.

The firm serves more than 3,000 clients, 90% of which are corporate. Probably half the companies on the Fortune 1,300 lists use J&H benefit consultants in one or more capacities, Mr. Harlow said. J&H works on a fee-for-service basis for more than half its clients and accepts commissions in lieu of fees from the rest. It will, at the client's request, perform regular services for an annual retainer.

J&H would not disclose its annual revenues nor its hourly rates, but said its rates are competitive with other major consulting firms. Secretarial and support services are built into the consultant's fees.

J&H has fully staffed benefit consulting offices in 27 U.S. and seven Canadian cities plus 34 locations around the world.

Kwasha-Lipton

429 Sylvan Ave., Englewood Cliffs, N.J. 07632; 201-567-0001

With one East Coast office, Kwasha Lipton serves 350 clients nationwide. About 98% of these are corporate and they include about 150 Fortune 1,300 list firms. Services provided include defined benefit and defined contribution plan design, actuarial services, defined contribution plan recordkeeping, benefit communications, international benefit consulting, financial services such as money manager selection, and executive and direct compensation consulting. The firm employs 175 persons. Information on its revenues and hourly rates was not available. However, the firm bills separately for secretarial services.

Meidinger & Associates Inc.

2440 Grinstead Drive, Louisville, Ky. 40204; 502-499-1240

Predominant in the Sunbelt and Midwest states, Meidinger & Associates reports strong growth in the asset planning, pension and investment consulting and creative communication consulting areas. Its strengths also include group benefits and self-insurance consulting. The firm serves 1,500 clients, more than 95% of which are corporate. Meidinger's staff of approximately 500 includes about 200 professionals.

With the exception of certain benefit statements, all services are provided on a fee-for-service basis rather than retainer. Meidinger's hourly rates vary from $25 to $110, with secretarial and support services billed separately. Revenues for the 1979-1980 fiscal year are expected to run $21 million, chairman Douglas Stegner says.

The firm has offices in Boston, Philadelphia, Pittsburgh, Atlanta, Baltimore, Birmingham, Charlotte, N.C., Chicago, Cincinnati, Dallas, Indianapolis, Kansas City, Louisville, Memphis, Milwaukee, Richmond and San Antonio.

William M. Mercer Inc.

1211 Avenue of the Americas, New York, N.Y. 10036; 212-997-7171

Continued on next page

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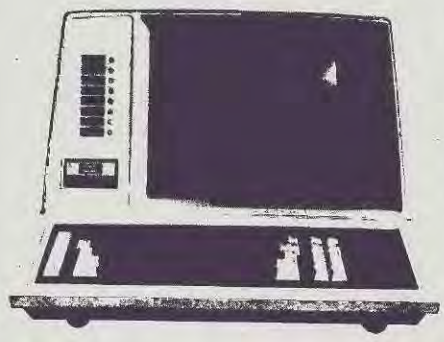
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MAIL STOP _____

System Development Corporation

BI12/10/9

Employe Benefits

Continued from previous page

William M. Mercer, the benefit consulting arm of Marsh & McLennan Cos., serves approximately 5,000 clients through 55 U.S., 18 Canadian and 12 overseas offices. Approximately 90% of its clients are corporations. Mercer's staff of 2,400 includes 800 professionals. The firm claims expertise in all major benefit consulting disciplines on a worldwide basis. Its hourly fees range from $20 to $200, averaging $65. Few consultants bill at the higher end, a spokesman said. Secretarial and support services are billed for separately. Mercer's 1978 revenues were $96.5 million and for the first nine months of 1979 ran $78.1 million.

Milliman & Robertson Inc.

1301 Fifth Ave., Suite 3600, Seattle, Wash. 98101; 206-624-7940

Milliman & Robertson's consulting strengths are in actuarial services, says president James Curtis. A separate company, M&R Services Inc., sells computer services for pension plan administration. Benfo, a division of M&R services, is a benefit communications organization specializing in individualized employe benefit statements. Eighty percent of M&R's clients are corporations, including about 100 Fortune 1,300 list firms. Less than 50 of these clients use M&R on a retainer basis.

The company's staff of 350 includes 130 consultants whose hourly rates range from $16 to $135, averaging between $40 and $45. Secretarial services are billed for separately. The firm expects revenues of $18 million in 1979.

M&R has offices in Seattle, Portland, San Francisco, Phoenix, Denver, Omaha, Milwaukee, Chicago, Philadelphia, New York, Jacksonville, Houston, Indianapolis and Los Angeles. It is affiliated with Eckler, Brown, Segal & Co. Ltd. of Vancouver and Toronto.

Peat, Marwick, Mitchell & Co.

345 Park Ave., New York, N.Y. 10022; 212-758-9700

Peat, Marwick, Mitchell & Co. claims main benefit consulting skills in actuarial work and group insurance benefits. Servicing both insured and self-insured group welfare plans as well as small business planning, the firm offers advice on computer modeling, communications, administration, data processing, accounting, auditing and taxes. Its investment supervision consulting group is one of the largest in the nation. More than half of its 1,400 clients are corporations and about 35% use the firm on a retainer basis.

Peat Marwick's benefit and actuarial consulting staff of 360 includes 240 professionals, whose hourly rates weren't disclosed. Employe benefits work generates revenues of more than $15 million.

Peat Marwick has benefit consulting offices in Albany, Atlanta, Boston, Chicago, Cleveland, Dallas, Hartford, Honolulu, Houston, Kansas City, Los Angeles, Montreal, Newark, New York, Philadelphia, Rochester, San Francisco, St. Louis, Toronto and Vancouver.

Price, Waterhouse & Co.

153 E. 53rd St., New York, N.Y. 10022; 212-371-2000

Price, Waterhouse & Co., the public accounting firm, provides benefit consulting services at its New York, Los Angeles and San Francisco offices. With a total benefits staff of 16, including 12 professionals, the firm will advise on any kind of benefit plan, but it doesn't perform actuarial evaluations. Plan design and compensation consulting are its promoted strengths. Hourly fees charged by Price, Waterhouse professionals range from $40 to $140, averaging $75. Secretarial and support services are billed for separately.

Martin E. Segal Co.

730 Fifth Ave., New York, N.Y. 10019; 212-586-5600

New York-based Martin E. Segal Co. provides consulting services on: group health, dental, disability, life and survivor income benefits; defined benefit and defined contribution retirement and capital accumulation plans; executive compensation; investment manager selection and appraisal; administrative studies, and communications. The firm serves more than 2,500 clients through offices in Atlanta, Boston, Chicago, Cleveland, Dallas, Denver, Hartford, Houston, Los Angeles, New Orleans, New York, Phoenix, San Francisco, Washington and Toronto.

About half of Segal's 430 staff are professionals. Hourly rates charged clients range from $30 to $150, averaging $65, with secretarial and support services built into hourly rates.

Tillinghast, Nelson & Warren Inc.

3340 Peachtree Road N.E., Atlanta, Ga. 30326; 404-261-5420

Tillinghast, Nelson & Warren cites five principal benefit consulting strengths: benefit planning, international benefit consulting, financial management for pensions and group insurance, administration consulting and benefit communications. Between 75% and 80% of the firm's 450 to 500 benefit clients are corporations, including 30 firms on the Fortune 1,300 lists. Tillinghast works on a retainer basis for less than 5% of its clients.

Out of a total staff of 190, 28 consultants and 57 support staff work exclusively in employe benefit plan consulting. The remainder of the workforce is primarily involved in actuarial consulting for insurance companies.

Benefit consulting work is performed in offices in Atlanta, Boston, Dallas, Jacksonville, St. Louis and London.

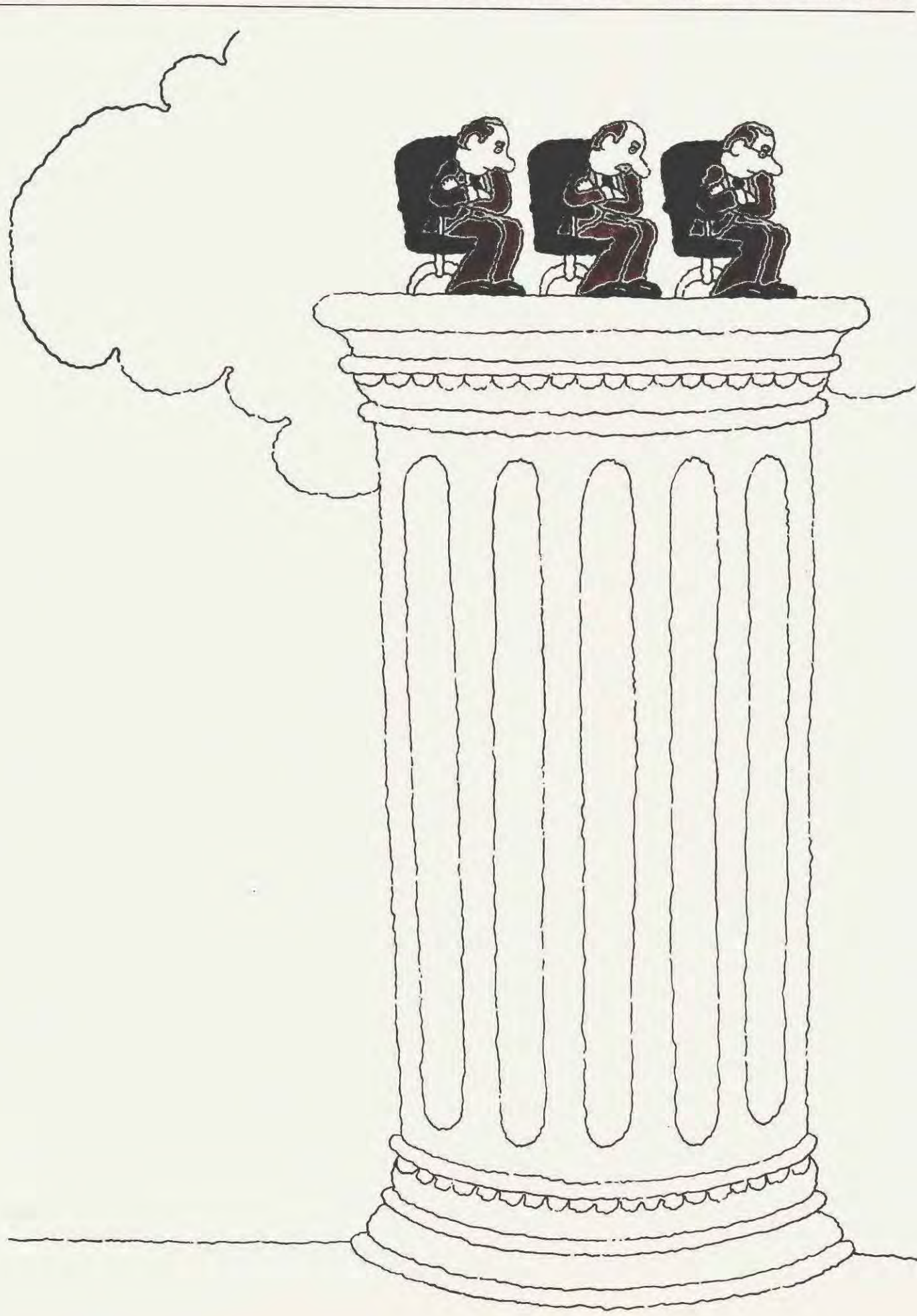
Hourly rates charged by Tillinghast's benefit consultants range from $20 to $125 and average $60. Secretarial and support services are billed for separately. Employe benefit consulting accounts for about 45% of the company's annual $11 million in revenues.

Towers, Perrin, Forster & Crosby Inc.

600 Third Ave., New York, N.Y. 10016; 212-661-5080

Towers, Perrin, Forster & Crosby's employe benefit consulting services are geared to serve the needs of "fairly sophisitcated multinational companies" by providing broad services wherever they might operate, said executive vp Jim Kielly. Actuarial and benefit consulting, employe benefit statements and communications are among its specialties. The firm does not provide financial management services for pension plans nor recordkeeping services, although it assists clients in developing recordkeeping programs.

More than 95% of TPF&C's 2,000-plus clients are corporate, with 350 client firms on the Fortune 1,300 lists. TPF&C's 900 benefit consulting employes include more than 300 professionals, whose hourly charges range from $40 to $150. Secretarial services are billed for separately. Annual benefit consulting revenues are $55 million to $60 million. TPF&C maintains U.S. offices in Boston, New York, Philadelphia, Washington, Atlanta, Tampa, Pittsburgh, Cleveland, Chicago, St. Louis, Dallas,



Minneapolis, Los Angeles and San Francisco. The firm also has three offices in Canada and seven abroad.

Wyatt Co.

1400 Investment Savings Plaza, Cleveland, Ohio 44114; 216-696-6250

Wyatt Co. lists as its consulting specialties: actuarial evaluations; pension and group insurance consulting; risk analyses, such as claims exposure for self-insurers and pools and determination of limits and reserve levels; executive compensation; international benefits; benefit communications; investment performance measurements, and electronic data processing systems. The firm serves more than 7,000 clients, 95% of which are corporate. These include more than 25% of the firms on the Fortune 1,300 lists, says chief executive officer Clifford R. Simms.

Employe Benefits

Among Wyatt's 1,050 employes are 400 actuaries and consultants. The firm has 21 U.S. offices, six in Canada, four in Europe and two in the Far East. Mr. Simms would not disclose Wyatt's fees, only saying they are competitive and that the firm bills separately for secretarial support services. While not revealing the firm's revenues, believed to be $60 million to $70 million, he says Wyatt is the largest "pure" consultant. William M. Mercer Inc. and Towers, Perrin Forster & Crosby have larger total revenues, but Mr. Simms points to Mercer's brokerage clients and TPF&C's reinsurance intermediary business.

Arthur Young & Co.

277 Park Ave., New York, N.Y. 10017; 212-922-2000

Arthur Young & Co. specializes in total compensation and defined contribution plan consulting with emphasis on tax aspects. The firm doesn't do actuarial consulting. The firm's employe benefits staff, numbering about 32, including 22 professionals, works in 22 of the firm's 55 offices. Arthur Young's hourly fees average $70, ranging from $50 for a staff employe to $120 for a full partner. Secretarial services are billed for separately. Revenues were not revealed. ■

Background

The information contained in this directory of employe benefit consultants was compiled by New York-based *Business Insurance* associate editor Ellis Simon, who interviewed the consultants.

Insurer can expect punitive judgments more often: Lawyer

CHICAGO—Insurers can expect to be stung by more punitive damages awards in suits against their claims practices, an attorney warns.

A recent California supreme court decision, Egan vs. Mutual of Omaha (*BI*, Sept. 17), threatens to open the door to more punitive damages judgments, says Frank J. Barrett, executive vp and chief counsel for Mutual of Omaha Insurance Co.

"Punitive damage awards can have a more adverse effect on insurance companies than any other legal concept we face," Mr. Barrett told a recent gathering of the American Council of Life Insurance.

The case, which recognized the concept of punitive damages against insurers, is likely to cause a flurry of activity by attorneys seeing the potential of huge settlements for which insurance companies should be ready, Mr. Barrett warned. "There's a bad faith case out there waiting for your organization."

Although 38 states have recognized punitive damages in such situations, a lot of companies have not yet begun to feel the sting of punitive damage cases that is likely to evolve in the next few years, he said.

The case at issue involved Michael Egan, a Pomona, Calif., roofer who was injured in a 1972 fall. Mr. Egan, who was covered under a disability policy with Mutual of Omaha, filed for and was receiving benefits until the company found him not to be totally disabled under the terms of the disability policy.

Cut off from benefits, Mr. Egan sued Mutual of Omaha, charging the company with bad faith in improperly investigating his case.

The California supreme court overturned a lower court award of $5 million in punitive damages to Mr. Egan, saying the amount was excessive, but upheld the concept of holding insurers liable for punitive damages.

The court affirmed, however, that the company must pay Mr. Egan $123,000 in compensatory damages, which Mr. Barrett said has been paid.

Mutual of Omaha has notified the California high court it intends to challenge the constitutionality of the state punitive damage law with the U.S. Supreme Court, Mr. Barrett said.

The legal community and consumer advocates paint an erroneous picture when they say punitive damages are a victory for the consumer over the profiteering insurance business, Mr. Barrett said. Such awards can actually work to the detriment of the consumer, who is ultimately assessed the cost of the damages, he said.

To cope with the situation, Mr. Barrett said the industry needs a "strong, strong resolve not to let our companies despair at this time." In addition, firms should make sure they have top-notch claims people conducting thorough investigations of each claim to provide "protection against these cases."

Claims and legal personnel should also maintain constant contact to help determine and forecast which claims could develop into punitive damage suits, he said. ■



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london line

Lloyd's launches aircraft grounding cover

By JOHN H. MILLER

LONDON—In the aftermath of the American Airlines DC10 crash near Chicago last May and the subsequent grounding of all DC10s, Lloyd's and the U.K. aviation market are offering coverage for loss of revenue from aircraft grounding.

Sources in London say the plan is likely to have a potential capacity of $50 million to $100 million, especially if other markets decide to support it, but it could be even larger if it appeals to aviation reinsurers.

The Federal Aviation Administration's grounding of all DC10s in the U.S. after the Chicago crash led to more than 270 DC10s being grounded worldwide. Only a small market in grounded aircraft cover existed at the time and applied only to aircraft manufacturers for limited amounts (*BI*, June 25).

Airlines suffered huge losses in revenue and some, including Laker Airways in the U.K., are contemplating a suit against the FAA or other parties. British Caledonian, Lufthansa, and Swissair are also suing the FAA in hopes of establishing that the U.S. authorities acted illegally in refusing to allow foreign DC10s into U.S. airports between June 19 and July 13. British Caledonian lost $2.5 million and the Dutch KLM airline lost $2 million to $3 million because flights had to be rescheduled.

Cover will be placed through a broker consortium of C.T. Bowring, J.H. Minet, Segwick Forbes/Bland Payne, Stewart Wrightson and Willis Faber and Dumas, with Bowring as administrative broker. The proposed coverage will provide daily indemnity ranging from $10,000 to $25,000 per aircraft, according to aircraft type, in the event of future groundings ordered by national safety administrators.

The policy will be available for a 12-month period from an agreed-upon date if enough airlines show interest in it, and will have a common expiration date for underwriting purposes. Premium rates will be based on aircraft type and not on the claims statistics of the airlines.

Proposed indemnities are: $25,000 for Boeing 747; $20,000 for Airbus A300, DC10 and Lockheed Tristar; $15,000 for Boeing 707/727 and DC8; and $10,000 for Boeing 727/737, DC9 and Fokker F28. Maximum coverage time is 30 days in excess of seven days of grounding and acceptance of any one type of aircraft is limited to 25% of the aggregate amount placed.

Under the policy, "Grounding means a complete withdrawal from all flight operations in the interests of safety by the authorities of (a) the country of aircraft or prime manufacturer and (b) the country of registration of the assured's aircraft because of a like condition or suspicion thereof in two or more aircraft whether operated by the assured or others."

If a grounding occurs because of the adoption of maintenance/servicing prodedures differing from those in the manufacturers' manual, no claim will be allowed, and any aircraft being repaired or modified at the time of grounding is subject to a seven-day deductible applicable from time of return.

"The scheme is optional to any airline which wants to take part in it, whether or not it is insured in the London market," said Richard Maylam, one of the Lloyd's underwriters who devised the policy. "We've been working together as an expert unit on this project. The benefit to the London market is that although it is being placed through this group of U.K. brokers, it can be used by all brokers who have interested clients.

"But we're hoping other insurers will come in on the slip, which at the moment is net of reinsurance. Up to the present, reinsurers are not prepared to allow direct underwriters to cede it on their aviation treaties.

"So it is still very difficult to determine what the likely capacity will be, and any figures at the moment are purely speculative," he said. "If a large number of airlines want to take part, then they will have to take their share of available capacity in the first place. Naturally, we're hoping some U.S. insurers, as well as those from other markets, will feel able to support the idea. But it's all very new, so we're now waiting to find the response to it."

New chairman

Leading marine underwriter Peter Green has been elected Lloyd's chairman for 1980.

Mr. Green, who joined Lloyd's as a marine insurer in 1946-47, is one of its specialists in offshore oil risks, protection/indemnity cover and third-party liabilities. He is director of the Hogg Robinson broking group and chairman of the Janson Green syndicate. The syndicate was one of those involved in computer leasing insurance.

During his term of office, Mr. Green will have to handle other major problems as well, including the Sasse Syndicate's $41 million losses and a future report by a special committee under Sir Henry Fisher which is examining Lloyd's whole disciplinary and administrative structure.

Meanwhile, retiring chairman Ian Findlay says Lloyd's security is not threatened by the computer leasing losses because its U.S. premium trust fund has $2.5 billion in reserves. The present estimate of $225 million in losses may be revised when further U.S. computer leasing claims are received.

Tanker collision

The U.K. marine insurance market may be hit with more than $20 million in claims after a collision between the 150,000-ton Romanian tanker Independenta and a Greek freighter, the Evrialy, in the Bosporus Strait outside Istanbul harbor late last month.

The tanker, reinsured in London through the Romanian State Insurance Agency, blew up and lost much of its oil cargo. Turkish naval authorities are revising safety pre-

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cautions for the Bosporus, through which 18,000 ships, mostly of Soviet origin, pass every year.

N.Y. exchange

Lloyd's will not be threatened by the New York Insurance Exchange, but will rather find it one of its most important allies in the U.S. insurance field, said L. Patton Kline, Marsh & McLennan chairman, in London recently.

He told the Insurance Institute of London that the exchange will advance the cause of free trade generally and that substantial commerce will develop between it and the London market.

"There's natural concern over competition, but it seems to me that major insurance companies affiliated with retail and wholesale brokerage firms have greater competitive implications for Lloyd's than the N.Y. exchange will ever have," he said.

"The real future danger may lie in the diminishing of competition when insurers own both the underwriting process and the distribution process."

Praising Lloyd's for its market effectiveness, Mr. Kline forecast that M&M will spend as much of its brokering energy in London as possible, even though it will be driving hard to promote the New York exchange as well.

"Even at the present level of rates, I see no evidence that our position in the London market is diminishing in terms of premium volume and in fact it seems to be growing at the same rate as our overall client revenue," he added.

"I'm tired of comments about what's wrong with Lloyd's. If the London market itself can't contain its criticism, we in the U.S. ought to do so. The energy and realism of Lloyd's has served us well in the U.S. and no one should forget the commercial alternatives it offered in those dark days of 1974 through 1978."

Commercial Union

Commercial Union's U.S. premium income is climbing steadily toward the $1 billion level for this year's operations as a result of intensive restructuring last year (*BI*, Nov. 12).

Premium volume hit $740 million for the first nine months of 1979, more than 14% higher than in the comparable period last year, and the insurer's underwriting experience is improving, particularly in workers compensation and auto lines.

Statutory operating ratio for that period, however, was 103% compared with 99.4% last year. Commercial Union is prepared to wait another 12 months to see whether its improved agent/broker facilities will bring in the full returns it wants, says Cecil Harris, executive director.

"The volume of our business is improving, and now we must wait to find if we're getting the right quality as well," he said. "Our loss ratio is steady, so we expect to find out by the end of 1980 if our judgment of quality, based particularly on the feedback from our strong range of agents, which we've been building up throughout the U.S., turns out to be correct."

Commercial lines represent two-thirds and personal lines one-third of C.U.'s U.S. business income. Hurricanes David and Frederic cost Commercial Union and Royal Insurance $29 million between them, with Royal also suffering bad effects from auto business this year. General Accident lost out on its combined property accounts in the first nine months this year and had hurricane losses of $3 million.

North Sea quakes

Norwegian scientists fear North Sea oil rigs may be hit by powerful earthquakes in the future.

The Royal Norwegian Council for Scientific Research says quakes with a rating of six or more on the Richter scale are certain to rock the Norwegian Continental Shelf, and that drilling is going on in the areas of greatest danger.

Its report, part of an overall safety review for Norwegian North Sea offshore developments, recalls that earthquakes hit the Continental Shelf in 1819 and 1866, and the Dogger Bank, between England and Norway, in 1931.

Persian Gulf

Marine insurers have told representatives of Middle East insurance companies the Persian Gulf will continue to be a war risk zone area (*BI*, Sept. 3). But they will relax the restrictions on insurance cover unless there is a sudden hijacking or similar terrorist outbreak that traps costly tankers in Gulf ports. ■

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legal brief

Court upholds 'claims made' provision

AN ENGINEERING FIRM sought a judgment declaring that an insurer was obligated to provide it professional liability and comprehensive general liability coverage. A Colorado appellate court held that a "claims made" provision in the policy was not contrary to public policy.

James J. Brogger and Associates contracted to provide certain engineering services to the town of Elizabeth. Mr. Brogger was issued a professional liability and comprehensive general liability policy by American Motorists Insurance Co. on March 15, 1973. The policy applied only to occurrences that took place during the policy period if a claim was made or brought during the policy period. Mr. Brogger elected not to renew the policy and it was cancelled March 15, 1974.

In January 1975 an action was filed against Elizabeth, based on the project for which Mr. Brogger had provided engineering services. Elizabeth then filed a claim against Mr. Brogger on March 21, 1975. Mr. Brogger informed American in April 1975, but the insurance company denied coverage. Mr. Brogger sued American but lost in the trial court.

On appeal, Mr. Brogger argued that the "claims made" provision

The abstracts published in this column were prepared by Cases Unlimited Inc., Evanston, Ill.

was contrary to public policy because a policyholder has no control over the date an injured party may decide to assert a claim against the policyholder. Mr. Brogger maintained a policyholder has no choice but to continue the insurance in force and therefore the provision unduly restricts freedom of contract.

The court found no merit in the argument, pointing out that Mr. Brogger was free to contract with any insurer that provided coverage for claims arising before the expiration date of an earlier policy. The court emphasized that Mr. Brogger had made no attempt to establish that such coverage was unavailable. *James J. Brogger, Etc. v. American Motorists Ins.*, Colorado Court of Appeals, May 17, 1979 (BI/01/D.-$4).

Group disability

The issue before an Illinois appellate court was whether supplemental Social Security payments made to a policyholder on behalf of her daughter were "other benefits received" within the language of a group disability policy. The court determined that they were not and that the insurer should not have deducted them from the policyholder's benefits.

Rosie Meeks was covered under a group insurance policy issued to her employer by Mutual of Omaha Insurance Co. Ms. Meeks became totally and permanently disabled. The policy provided that monthly payments would be reduced by the total benefits the employe or any other person on his or her behalf received from Social Security.

Mutual paid Ms. Meeks monthly benefits until it learned that her dependent daughter also received Social Security benefits that were payable to Ms. Meeks on the daughter's behalf. Mutual ceased paying disability benefits. Ms. Meeks sued the insurance company, which countersued her, contending it had overpaid. The trial court ruled for Mutual.

The appellate court said that checks made payable to Ms. Meeks on behalf of her daughter were not benefits received by any other person on Ms. Meeks' behalf. The court emphasized that under the Social Security law, the child's benefit went directly to the child notwithstanding the prerequisite status of the mother. Thus, the court concluded that Ms. Meeks was entitled to recover nearly $2,700 which Mutual wrongfully withheld. *Meeks v. Mutual of Omaha Ins. Co.*, Appellate Court of Illinois, April 26, 1979 (BI/02/D.-$4).

Exclusion inapplicable

The Wisconsin supreme court ruled the economic loss suffered by a company other than the policyholder as a result of negligent repair work by the policyholder on its own product was not excluded from coverage by a standard exclusion in a comprehensive general liability insurance policy.

Sola Basic Industries Inc. was issued the policy by U.S. Fidelity & Guaranty Co. The policy insured Sola against property damage caused by an occurrence. A standard clause excluded recovery for damage to Sola's products or to property damage to work it performed.

Sola sold a transformer to a manufacturing company which malfunctioned. Sola's employe negligently repaired the transformer, necessitating its removal. While the transformer was out for repairs, the manufacturing company could not operate and sued Sola for $60,000 in lost profits and other expenses incidental to the shutdown.

US&G refused to defend Sola in this suit. Sola settled with its customer for $20,000 and sought to recover this sum from US&G. The trial court ruled in favor of Sola.

The appellate court agreed the exclusion here eliminated coverage for injury to or destruction of the product furnished or work completed by Sola. But the court said that if the defect in the furnished product caused damage to other tangible property, there was coverage for such damage.

The court said the term "property damage" to tangible property does not necessarily require physical damage. Tangible property, the court agreed, may be damaged in that it is diminished in value or made useless, irrespective of actual physical injury. The manufacturing company's lowest profits, the court emphasized, were a measure of the dimunition to the plant caused by the malfunctioning

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transformer. *Sola Basic Industries, Inc. v. U.S. Fidelity,* Supreme Court of Wisconsin, June 29, 1979 (BI/03/D-$4).

Loss defined

The Ohio supreme court ruled that "loss," as used in the workers compensation statutes, includes "loss of use" and not merely "loss by severance."

Randal J. Walker, a police officer, was shot by an assailant in July 1975, resulting in his paralysis from the waist down. Mr. Walker's legs were not amputated or otherwise severed. He filed a claim for partial disability workers compensation but was denied. Mr. Walker appealed to the courts but lost there as well.

The appellate court, however, reversed the decision, emphasizing that the compensation law required a liberal construction in favor of employes. For all practical purposes, the court observed, Mr. Walker had lost his legs to the same effect and extent as if they had been amputated.

Furthermore, the court said the permanent impairment of a member without severance generally entitles an injured employe to a compensation award and is regarded as being the same as loss by severance. The court noted that to deny this award would be unjust because it would constitute measuring a claimant's award "by the fortuity of the events contributing to his disability." *State Ex Rel Walker v. Industrial Com'n.*, Supreme Court of Ohio, June 20, 1979 (BI/04/D.-$4).

Group life

A federal appellate court ruled the terms and conditions of an invitation to bid on a group life insurance policy and the bid proposal did not determine the question of coverage. The court said such an approach would ignore the time-tested principle of insurance law that the terms of the policy are controlling.

The question before the court was whether a deceased employe of a Puerto Rican public corporation was covered under a group life insurance policy issued by Crown Life Insurance Co. The invitation to bid indicated the plan would cover new employes without a waiting period. The insurer's proposal provided that an employe not actively at work on the date he normally would become eligible would be eligible upon returning to active full-time work. The proposal was accepted in November 1972 and the group policy was issued on January 29, 1973, retroactive to December 1, 1972, covering all of the corporation's full-time employes.

The deceased started full-time employment in 1969 and worked regularly until October 5, 1972, when he was granted a leave of absence because of illness until December 13, 1972. When his sick leave expired, the employe's status was changed to paid vacation leave. The employe died on December 18, 1972. His beneficiary filed for a death benefit. The insurance company refused. The beneficiary sued but lost in the trial court.

The appellate court was satisfied that under the terms of the policy, since the deceased was absent from work on the effective date of the policy and never returned to work, he was excluded from coverage. The court pointed out that the insurer's proposal did not, in fact, contradict the policy terms.

The court said eligibility terms such as this are not unusual in group life insurance policies. The court said they serve to limit the policy to those who are healthy enough to be employed full-time and exclude those who are unable to work regularly on the effective date of the policy. *Vincente Acavedo Velez v. Crown Life Insurance Co.*, U.S. Court of Appeals for the First Circuit, May 31, 1979 (BI/05/D.-$4).

•

Copies of the entire decision may be obtained by sending a check for $4 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the number for each opinion.

OPIC covers Egypt facility

WASHINGTON—The Overseas Private Investment Corp. has issued a political risk insurance policy to cover an investment in a manufacturing facility in Alexandria, Egypt, by Colgate-Palmolive Co. of New York.

Colgate will provide capital, technology, machinery and management for the plant. The cost of the policy or its limits were not disclosed. ■

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BI-7

book review

New Umbrella Book plugs initial leaks

By SUSAN ALT

The Umbrella Book
Warren, McVeigh & Griffin
1420 Bristol St. N.,
Newport Beach, Calif., 92660
600 pp., $125

When Warren, McVeigh & Griffin published the first Umbrella Book in 1976, analytical information was pulled together in a form previously unavailable and the book became an indispensable tool for any broker or manager negotiating liability policies in the marketplace.

Picking apart policy forms is a monumental job, but picking apart and comparing the umbrella liability policy forms of 49 insurers and comparing them was a feat commonly left to brokers and not infrequently resulting in unsatisfactory judgments about purchases.

Now Warren, McVeigh, a risk management consulting firm, has published the revised edition of The Umbrella Book, a far superior effort building on the strengths and supplanting many of the weaknesses of the first attempt.

The loose leaf tome runs more than 600 pages, three times the size of the first volume published in large size hardback format. It tells buyers, sellers and brokers (and, perhaps, other consultants as well) everything they wanted to know—and more—about these types of policies. Moreover, it offers useful advice to those putting together layered programs of liability insurance who are unsure of how to proceed and what to look for.

James A. Robertson, a CPCU and consultant who was author of the new edition, says he was amazed during his research to find that most insurers said "they'd like a chance to look at" practically any risks needing insurance, indicating the competitiveness of the marketplace today. Unlike a few years ago when insurers had long list of risks they wouldn't touch, most now "seem to be saying they are pretty flexible" and are willing to tailor-make high-limit, broad form liability coverage, Mr. Robertson concludes.

Once the reader makes it through the introduction to The Umbrella Book, practically everything is new, revised and more complete. Even within the introduction, the discussions of how umbrella policies work and the precepts of layered programs are greatly expanded.

Mr. Robertson's key recommendation in the section on underlying insurance coverages is that no primary, excess or umbrella liability program should be nonconcurrent in terms of policy dates, because of the potential problem of gaps in coverage when a loss occurs. All should have the same anniversaries, even if it means amending a policy mid-term, he says.

Umbrella endorsements generally restrict coverage provided by the policy and can have a "dramatic effect" on whether or not a policy will pay when there's a loss, Mr. Robertson notes. Moreover, endorsements aren't standardized among insurers so a buyer has to be careful about how restrictive an exclusion by endorsement really is. Just to write the section on contractor's limitation endorsements, for example, Mr. Robertson scrutinized more than 20 different wordings being used.

His warning to buyers and brokers is: Don't assume anything from the title of an endorsement. Even parts of an endorsement that seem irrelevant, he cautions, may restrict coverage because an insurer doesn't fully understand the buyer's operations.

What sometimes happens in an errors and omissions exclusion, for instance, is that the wording turns out to be so broad it virtually negates all the coverage in the policy. "The problem lies not in the intent but in the actual endorsement wording," says Mr. Robertson, raising the flag of caveat emptor.

Umbrella policies are rated in a variety of ways, based on negotiation ("adjustable rates") or on flat charges for limits required. Mr. Robertson includes in the book a sample of one insurer's rating worksheet which demonstrates how charges are levied and rates calculated. His research led him to the conclusion, not surprisingly, that adjustable rates based on the underwriter's judgment don't always accurately reflect the exposures a company needs to insure against.

The only thing missing from The Umbrella Book is a qualitative summary indicating which insurers offer the best policies and coverage, on a comparative basis. The individual analysis of each company's form (or forms) is present, but regretably, it isn't all pulled together in a quick-and-easy chart telling insurance buyers how the insurers ultimately stack up against each other.

That isn't to say the book lacks charts. Three major charts are included in this volume as in the 1976 edition, indicating specific coverage, defense provisions, definitions, limits, exclusions and conditions, and persons/entities insured for 50 insurers, including Lloyd's of London.

The one chart that's lacking, pulling some conclusions together, will be ready for publication soon, as a supplement to the book, Mr. Robertson says.

The new edition pays more attention to policy terms and conditions often accepted by insured companies without question, such as whether defense costs are included in the coverage, how defense is to be handled and when losses are payable, Mr. Robertson notes.

One of the most helpful additions are the cross references helping the reader go back and forth between the charts and the actual policy forms and analysis contained in the largest section.



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Basically, Mr. Robertson concludes that "the companies doing the best job of providing umbrella liability coverage are the ones who have unique forms that don't simply copy the ISO form and most of its terms," such as CNA, Guaranty National, Allstate, Liberty Mutual, The Hartford Insurance Group and The Travelers.

Ten major insurers refused to provide sample policies to Mr. Robertson, forcing him to obtain the policy forms from brokers. ▪

Preach profits to sell safety plan, author says

By Z'EV KRONISH

Techniques of Safety Management
By Dan Peterson
McGraw-Hill, 1221 Avenue of the Americas,
New York, N.Y. 10020
314 pp., $19.50.

The struggle for safety has slackened, contends Dan Petersen, an author familiar to *BI* readers (Safety By Objectives, *BI*, April 30) and other reports prove him correct.

Part of the solution hinges on top management's active participation. To put teeth into a program, the chief executive and his associates must acknowledge its value and prove their conviction.

Ironically, management needs to be constantly reminded of its self-interest in safety, Mr. Petersen observes. Safety professionals face the delicate task of trying "to motivate their top executives."

How do you win top management's backing? After a loss, especially a major upset, top brass may be jarred into action. But in trying to prevent a loss, part of the safety professional's problem is the ineffectual preaching approach he often utilizes. Sincerely concerned about safety, management is waiting to be sold on an appealing plan, the author writes; talk "profit" and use "dollars" to get your message across.

Preparation of an annual report, he suggests, can enhance the relationship and win you a measure of support. Communication on this level opens the door for an evaluation of the past year's record, projects next year's goals and presents suggestions for management's approval. Goal orientation is an approach management appreciates; the top brass is impressed with performance jargon.

What kind of impact has the Occupational Safety and Health Administration made? A mixed bag, Mr. Petersen says. Safety is on the corporate agenda in a way that was unthinkable 10 years ago, but "for each company that makes a gain in safety because of increased interest by management, generated by the passage of OSHA, we see another industry redirecting its corporate time, effort and money away from safety programming into OSHA compliance."

Mr. Petersen underestimates the necessity for government action. Some firms do initiate excellent safety efforts (and even retraining programs for injured employes), but many more tend to lag.

The safety director has his or her work all cut out. All the props at his or her disposal have to be used—and Mr. Petersen's suggestions are very helpful—but perhaps the most effective leverage with the chief executive is a forceful warning that the government will swarm down on him or her unless the proposal for improvement is adopted.

Safety personnel have a responsibility that neither computer nor insurer can replace. The genius of searching for an explanation for injuries cannot be matched by any computer. The best judgment lies in the plant safety team.

Mr. Petersen's chapters are short and illustrations abound. It's easy to read; because the author feels comfortable with his message, his writing is not stilted. ▪

Z'ev Kronish, who holds an M.B.A. degree from The College of Insurance, has handled corporate risk management and benefits administration. He is now in the claims department at National Health & Welfare Mutual Life Insurance Assn. His reviews of management books appear regularly in BI.

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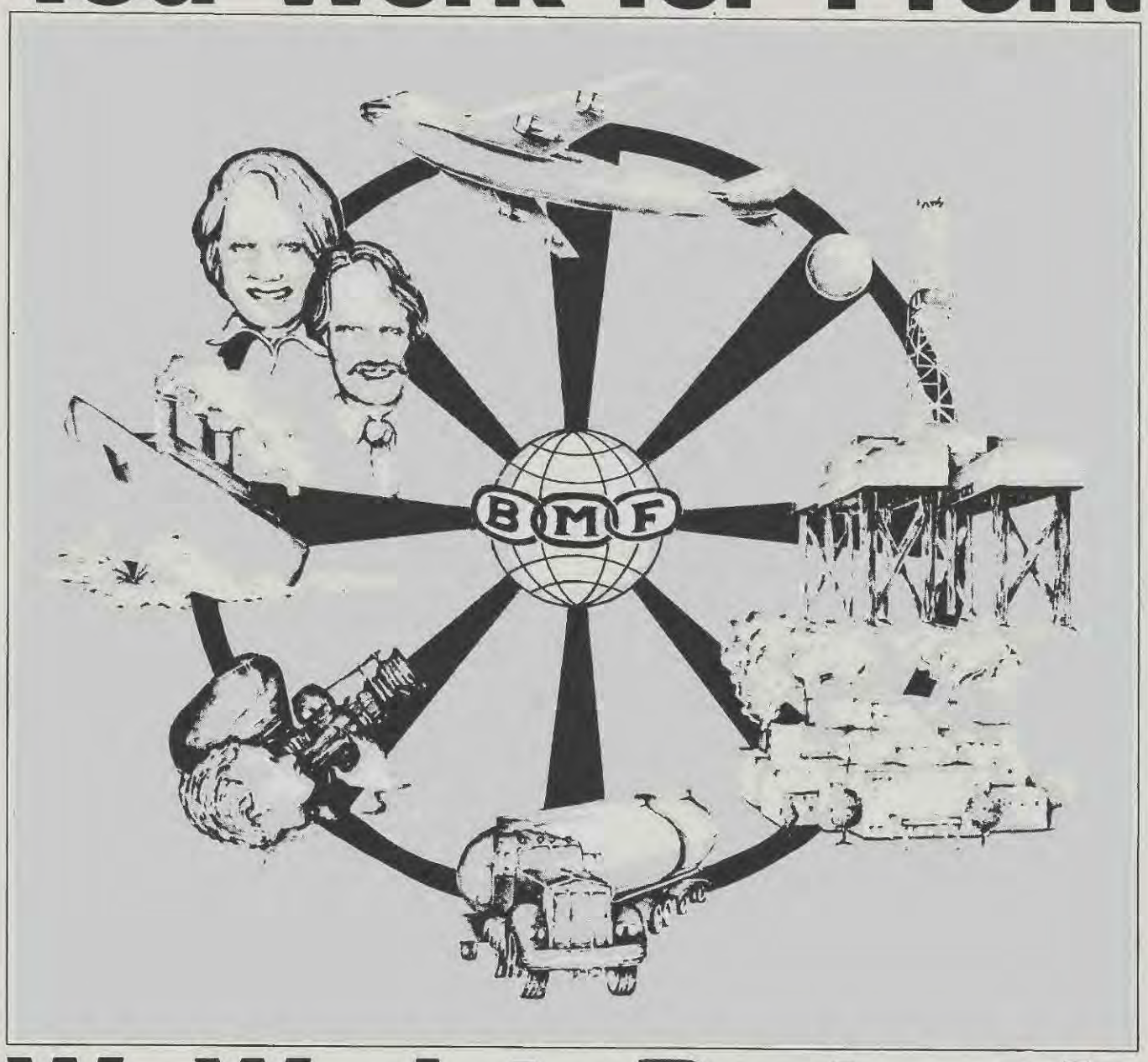
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around the states

Court nixes insurance in brutality case

ALBANY—The New York court of appeals has ruled that an insurer cannot be required to pay any punitive damages to a plaintiff in a police brutality case.

A Hempstead, Long Island, man filed a $100,000 lawsuit against two policemen who, he alleged, struck him with nightsticks. The Hartford Accident & Indemnity Co., liability insurer for the village, disclaimed responsibility for defending or paying because its policy did not cover punitive damages.

The court ruled that although an insurer is responsible for defending a suit in which punitive damages are claimed, allowing such coverage would defeat the deterrent purpose of punitive damages.

$10,000 settlement

SACRAMENTO—A surgeon here has received $10,000 and a note of apology in the settlement of his medical malpractice countersuit.

Dr. Pun F. Yuen filed the countersuit against Bostwick & Rowe of San Jose, charging the firm with malicious prosecution after being named in a suit along with two other physicians. Dr. Yuen assisted the other physicians in an emergency repair procedure after the two had performed colon surgery.

Dr. Yuen filed the countersuit after being dismissed from the case in 1977.

Program extension

TALLAHASSEE—Florida insurance commissioner Bill Gunter is seeking a one-year extension of the payroll limitation transition program for workers compensation insurance, which will expire Jan. 1.

The transition program resulted from a ruling by former commissioner Philip Ashler to use total payroll in computing premiums rather than a maximum base of $100 per week per employe. The temporary program sets a cap on what employers are assessed.

In a letter to the National Council on Compensation Insurance, Mr. Gunter asked that the council limit any premium increases in the extended program to 25% or $50, whichever is higher.

Without the extension, employers who pay higher wages would be hit by significantly higher workers compensation premiums, leading to further depression of the housing and construction industries, the commissioner said.

Increase rejected

ANNAPOLIS—Maryland insurance commissioner Edward Birrane has rejected a request by the National Council on Compensation Insurance for an 18.9% increase in workers compensation rates for employers.

Commissioner Birrane turned his thumbs down on the rate increase because he believed the NCCI's estimate of future losses was based on incorrect assumptions.

Workers compensation rates in Maryland were last boosted Jan. 1, when state employers were hit with an average increase of 24.6%.

Bridge damages

RICHMOND—A federal appeals court last month upheld a lower court ruling that the operators of a sulfur tanker that knocked out a bridge over the James River in a 1977 accident are liable for damages.

The 4th U.S. Circuit Court of Appeals upheld federal judge Richard Kellam's decision that the accident was caused by the unseaworthiness of the tanker.

The state of Virginia has sued for $7.3 million in damages to pay for the cost of repairing the Benjamin Harrison Bridge, which was rammed Feb. 24, 1977, by the 25,000-ton Marine Floridian, a 33-year-old tanker operated by Marine Transport Lines of New York. The loss of the bridge has disrupted marine and land transportation between Richmond and Williamsburg.

The Marine Floridian is insured by a British-based protection and indemnity club, the London Steamship Owners Mutual Insurance Assn. Ltd., for liability coverage, believed to be more than $100 million.

Sovereign immunity

RICHMOND—The Virginia supreme court has refused to consider abolition or revision of the doctrine of sovereign immunity, which frees state government employes from the threat of negligence suits.

The court refused to hear an appeal by a Caroline County woman who said her son was made deaf by negligent treatment at the Medical College of Virginia Hospital when he was 14 months old. Citing sovereign immunity, Richmond circuit court judge James Edward Sheffield threw the suit out earlier this year.

In its refusal, the supreme court said it found "no reversible error" in Sheffield's decision.

The Goodalls' lawyer, J. Madison Mason Jr., had asked the high court to eradicate sovereign immunity as being archaic. Eleven states and the District of Columbia already have done so, he said.

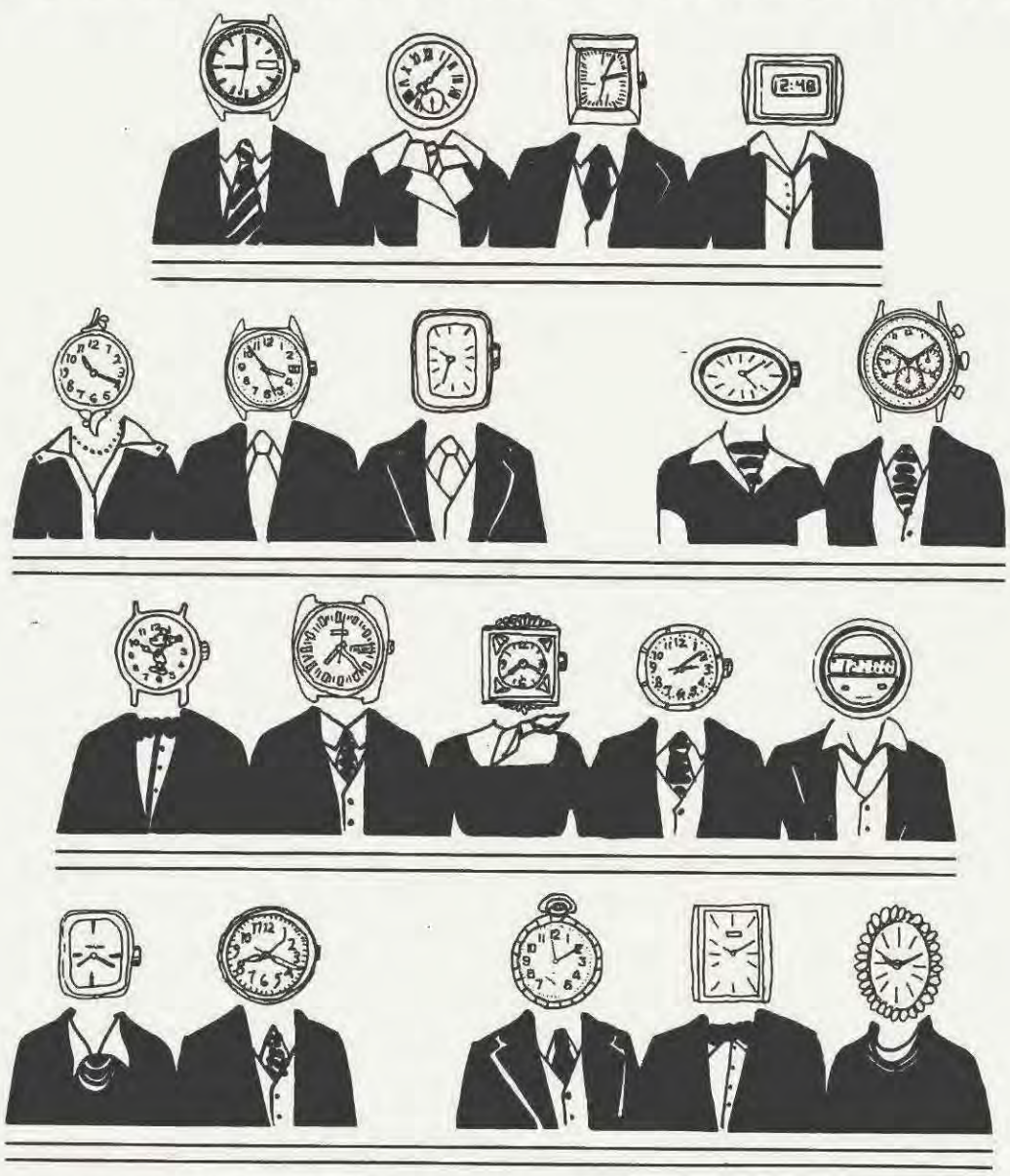
Asbestos suit

SAN FRANCISCO—The California supreme court has agreed to decide if an employe may file suit against an employer who "intentionally" injures a worker by concealing health hazards from asbestos dust.

The high court granted a hearing to Reba Rudkin, who seeks to overturn a Contra Costa County superior court judgment in favor of Johns-Manville Corp. Mr. Rudkin is appealing an Aug. 17 ruling by the court of appeal, which refused to review the matter.

At issue is whether an employer alleged to have intentionally injured an employe through a fraudulent practice can use the California labor code to stop civil court

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action. The code says that in certain instances, the workers compensation act is the exclusive remedy for injury damages.

Mr. Rudkin formerly worked at the Johns-Manville Products Corp. plant in Pittsburg, about 40 miles east of San Francisco. His case is a consolidated proceeding involving several other employes. He filed suit after discovering he was suffering from lung disorders described as asbestosis, an illness caused by inhaling asbestos dust. The disease takes years to develop, but once it begins the effects are irreversible.

Actuary appointed

HARRISBURG—Pennsylvania insurance commissioner Harvey Bartle III has appointed an Atlanta actuarial consultant to conduct a six-month study of the state's workers compensation insurance rating system.

W. James MacGinnitie, 41, a principal and director of Tillinghast, Nelson & Warren, will study the methods used by the Pennsylvania compensation rating bureau in setting workers compensation rates.

The decision to launch the first comprehensive study of workers compensation rating was included in a settlement reached last month on a rate increase proposal filed by the rating bureau. The rating bureau will pay the $100,000 to $200,000 cost of the study.

Work comp law

TALLAHASSEE—The first district court of appeals here will hear arguments Dec. 12 in the first constitutional challenge to Florida's six-month-old workers compensation law.

The law abolished the Tallahassee-based industrial relations commission that used to hear all workers compensation appeals in Florida and transferred that responsibility Oct. 1 to the first district court.

The challenge, which emerged in appeals of two cases, argues that under the state constitution district courts only handle cases that originate in their jurisdictions. If that part of the law is found unconstitutional, the courts and the legislature have to determine where appeals can be heard, likely causing a further backlog of cases.

Assigned risk

SALEM—Oregon insurance commissioner W.W. Fritz has adopted a temporary rule establishing a workers compensation assigned risk plan, including all workers compensation insurers and the state accident insurance fund. About three months will be required to put the legislatively mandated plan into operation.

Rate hike rejected

JEFFERSON CITY—Gov. Joseph Teasdale ordered the Missouri division of insurance to reject a 14.3% rate increase in workers compensation insurance premiums.

The National Council on Compensation Insurance filing would also have altered the traditional system of determining rates.

Citing figures showing workers compensation insurance premiums of $145 million and claims of $109 million in the state in 1978, Gov. Teasdale said, "These figures do not justify an increase."

Tort reform

HARRISBURG—The Pennsylvania house insurance committee this month unanimously approved a major tort reform bill (H.B. 1083).

The bill would bar most product liability suits 12 years after a product is sold and strengthen a manufacturer's defense if the product conformed with government safety standards.

The legislation now goes to the full house where it is given a reasonable chance of passage.

State liable

SAN FRANCISCO—The California supreme court has ruled the state may be held liable for damages for failure to correct dangerous highway conditions.

When officials are aware of such situations, the court declared, the state is vulnerable to negligence suits—even if the conditions are not of the state's own making.

In reaching its 4-3 decision, the justices rejected arguments by state highway officials that they could not afford to construct freeway median barriers and other safety devices every place they might be needed. The question of the cost and practicality of such measures was up to the jury to decide. ■

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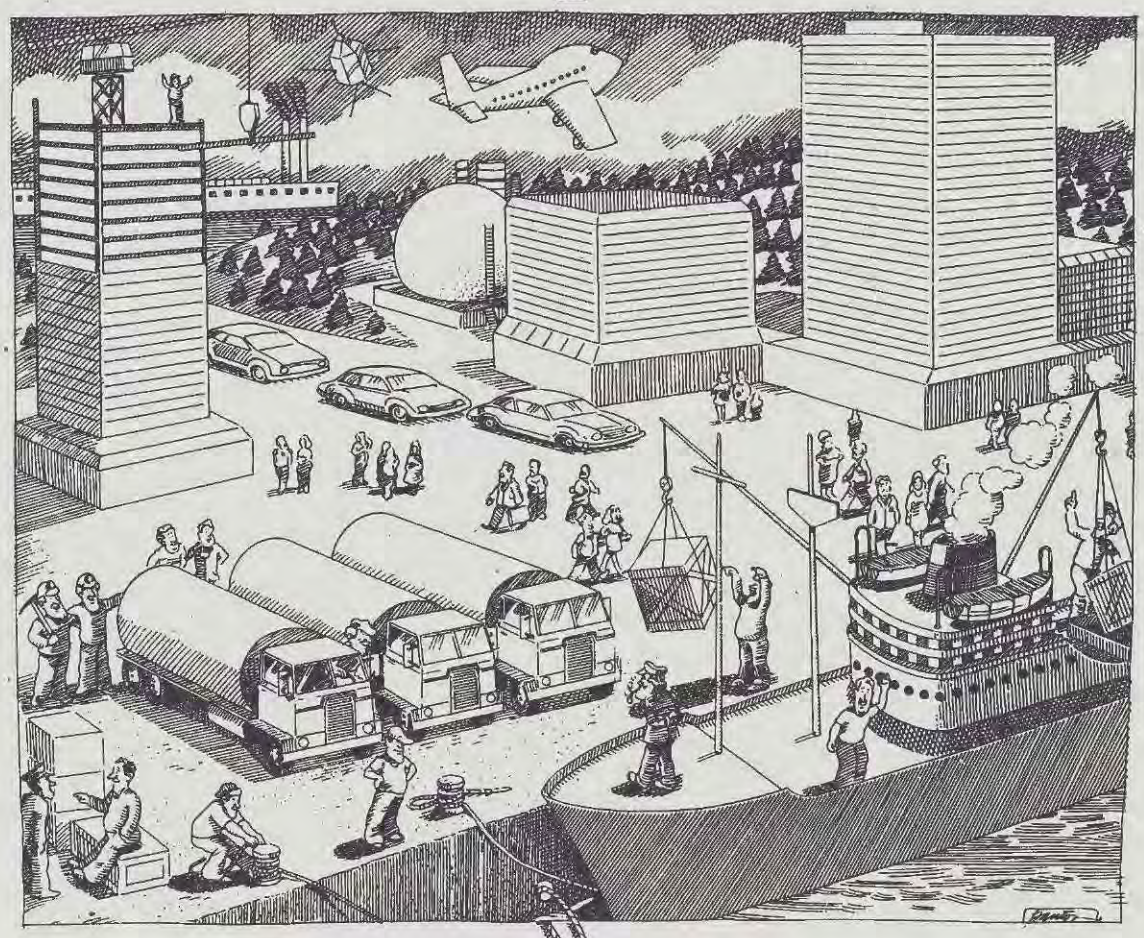
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Midwest work comp report

Vital industry

Little noticed outside the industrial heartland around the Great Lakes, stampers are vital to the automobile, truck, aircraft and appliance industries. The 3,000 stamping companies in the U.S. collectively employ more than 250,000 workers and have annual sales approaching $12 billion, says the American Metal Stamping Assn. in Cleveland.

Stamping company executives were interviewed about workers compensation issues at their recent annual meeting in Palm Beach, Fla., and by telephone afterward.

While all are small businesses, these are among the more prosperous and better operated in the industry. Most get rebates on their workers compensation premiums because their claims experience is good. Some are self-insured.

The premiums they pay vary widely—from $18 per $100 of annual payroll down to $2—not including bonus and penalty rates based on their claims from prior years.

Stamping industry bemoans lack of clout with regulators

By JACK THORNTON

CHICAGO—Executives of small businesses must try harder if they want to correct the abuses of workers compensation that keep pushing up their rates.

That's the consensus of a group of politically active businessmen in the contract metal stamping industry, many of whom are close to despair that state officials will never listen to them.

They insist organized labor opposes any change in workers compensation programs unless it is for speedier and larger benefits. And most stampers say things will not improve as long as legislators remain in the thrall of politically powerful labor groups.

The stampers are typical of U.S. small manufacturers. Most of them employ fewer than 200. They are capital intensive and highly competitive.

Because they are small businesses, usually with only one plant in one state, the stampers lack a national perspective and clout. Their trade associations are geared to working with Congress and federal agencies, not state regulators. State business groups have hundreds of diverse members, each with different priorities.

That leaves stampers and small manufacturers on their own. For them, lobbying is almost a luxury; they not only own the businesses but they also run them on a day-to-day basis. Most say they don't have time for anything that doesn't get more parts out onto the shipping dock.

Stampers' complaints about workers compensation center on administration of the benefit payments. Too many claims are paid for injuries that did not occur at the factory—or at least were questionable, they insist.

Stampers also maintain that those in the Great Lakes and Northeastern states are at a competitive disadvantage with stampers in the Plains and Southeastern states where workers compensation rates are much lower.

Finally, state product liability laws are in such shambles, stampers maintain, they are the targets of third-party and subrogation suits filed by injured workers and machinery builders.

The only way to solve those problems may be on the federal level, says Thurston K. Reid, president of Service Stampings Inc. in Willoughby, Ohio. He agreed a solution from Washington would probably include federalization of workers compensation. None of the stampers wants that.

Mr. Reid says the metalworking industry is partly to blame. Too often its trade associations have lobbied only for their own members' parochial interests, he says.

"We are all going to have to get together on this eventually," Mr. Reid said, including the American Metal Stamping Assn. plus associations representing machinery builders, distributors and tool and die companies.

Small businessmen would win on bills to restrict costly and sloppy claims handling if they lobbied more persuasively, said Marvin R. Wortell, president of Triton Metal Products Inc. in Chicago. His firm pays $16 per $100 of payroll for workers compensation insurance.

He emphasized getting to know state legislators personally—as the labor lobbyists do.

Unlike many others, Mr. Wortell detects a change in attitude in the Illinois capital at Springfield because of business's complaints. "Legislators no longer want to be identified as the people who chased jobs and business out of Illinois," he said.

He pointed to complaints earlier this year by Caterpillar Tractor Co. in Peoria, the state's biggest manufacturer, that expanding in Indiana and Iowa saves on workers compensation costs.

Mr. Reid in Ohio believes in fighting back, "but no matter what the facts are, we lose every case."

He testifies at about three appeals hearings a year. "We protest every case that is questionable and we lose every one," Mr. Reid said. The officials who settle the cases in Ohio's state-operated system "don't even know what a punch






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press is," he complained.

"It's the same old problem in every state, the (poor) administration of the claims service," Mr. Reid charged.

Insurance companies could do more to hold down rates than they do, says Wesley C. Seastrom, vp of Seastrom Manufacturing Co. Inc. in Glendale, Calif. The insurers should "fight harder" when claims are dubious, "but they don't. That way they pay more claims and they can get the increases they want" from state insurance officials, he charged.

Mr. Seastrom is among the majority pessimistic about reform movements. It was tried in California several years ago, he said, "but nothing much ever came of it and there isn't much going on now."

Other stampers complained that workers compensation reform movements are floundering in Michigan, Pennsylvania and Illinois.

A task force created earlier this year in Michigan by the state chamber of commerce and the Michigan Manufacturers Assn. "is floundering badly," a stamper in Saginaw said. "The political climate (in Lansing, the state capital) is just too pro labor," the executive said.

Few Pennsylvania businesses are interested in pushing for reform "because they are going to put their efforts where they can do some good. They know they aren't going to win on this," said A. Stuart Graham Jr., chairman of Fleck Industries Inc. in Willow Grove.

Reform is also hibernating in Ohio. Ohioans for a Free Choice, a political action group seeking to break up the state monopoly on writing coverage for workers compensation, failed last summer (*BI*, April 30).

In Illinois, Gov. James Thompson recently created another six-man, business and labor panel to recommend changes in workers compensation for the next legislative session. Nothing came of last year's so-called "agreed-upon" committee and the legislative watchers in the Illinois Manufacturers Assn. hold little hope for this one, too.

(The "agreed-upon" label comes from the committees' proposals, supposedly agreed upon before presentation to the legislature.)

Bright spots exist in states that have reformed laws on workplace product liability suits, such as Michigan, the stampers say. As those bills with their statutory legal defenses take hold, stampers note fewer third-party lawsuits against machinery builders.

In turn, they explained, that means fewer subrogation claims against stampers for negligence by machinery builders with judgments against them.

But other legislatures have turned down those measures. Ohio's has been stalled for more than a year. Illinois's was watered down to protect only machinery sellers and distributors—leaving the question of builders' liability as vague as ever.

Not all stampers complain about their states' systems.

Stampers can win their cases in Wisconsin "if they have their information on the accident compiled and well documented," reported Frank Loftus, president of Res Manufacturing Co. in Milwaukee.

Generally perceived as a pro labor state, Wisconsin has a workers compensation program "that is fair and well run," Mr. Loftus said. "It has a stronger workers comp code that most other states."

Res's premium rate is $3.98 per $100 "and it has been going down in recent years," Mr. Loftus said. Most firms' premiums have gone only one way: up. "Our claims experience has been good," he said.

The lowest premium rate found in the survey was in Indiana, where Midwest Art Metal Co. in Edinburg pays only $2.04 per $100. Midwest "works hard on safety," reported Charles E. Mitchell, administrative vp.

Midwest Art has installed advanced safety gear on its punch presses, including light curtains. They instantly stop the press if a worker's hands come too near.

Midwest is blessed with a stable work force, Mr. Mitchell added, and until recently did not have a night shift. In general, employes new to their jobs and those on night shifts have higher claims rates than veteran workers on day shifts.

The Connecticut system is "not unduly burdensome," said John Morris, vp of engineering and safety at Cly-Del Manufacturing Co. in Waterbury.

One of the lowest rates in any industrial state is being paid by Heraeus-Volkert Inc., in Queens Village, N.Y.: $5.60 per $100 of payroll. Fred F. Rimmler, president, added he gets a 37% rebate because of good claims experience. ■

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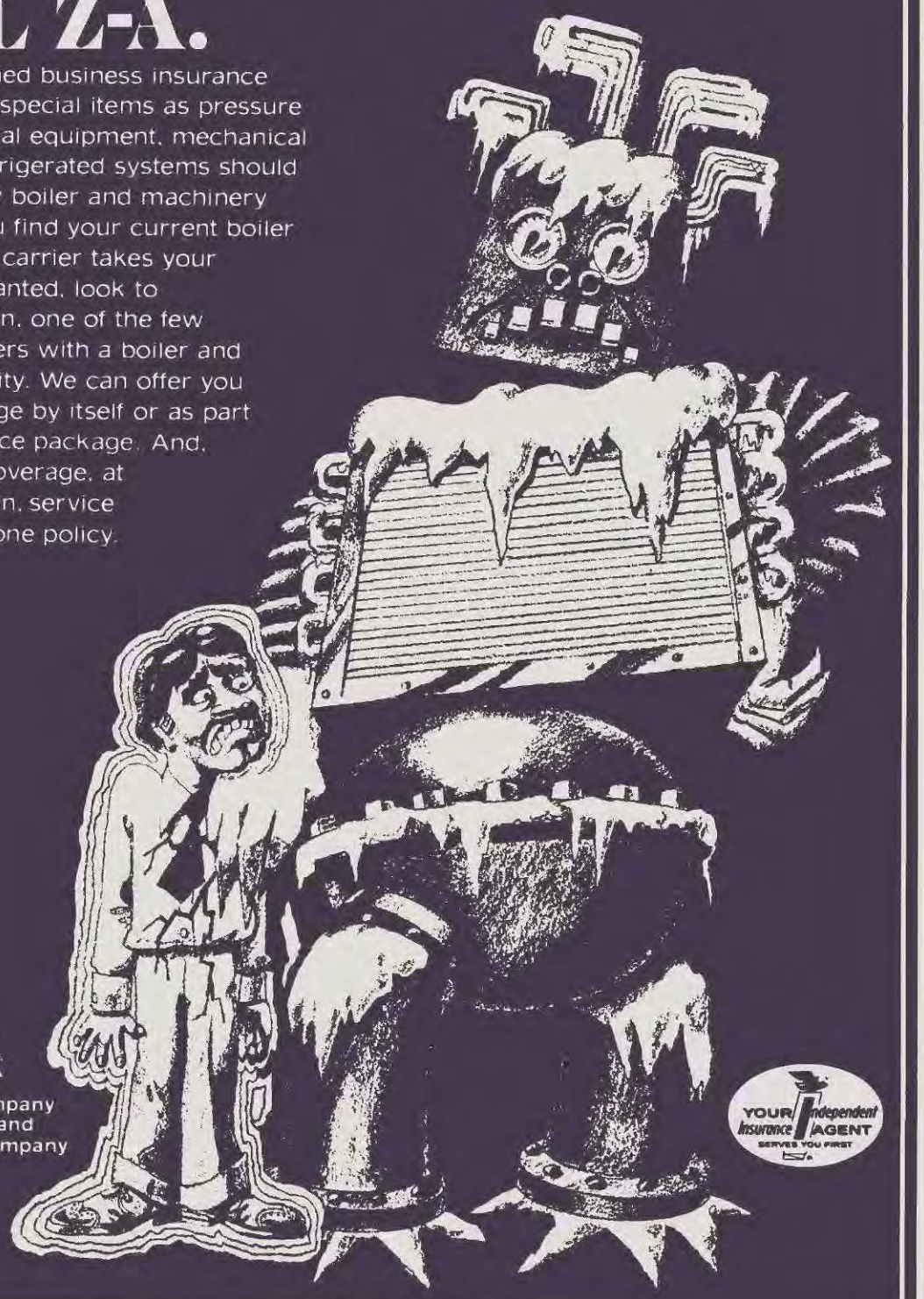
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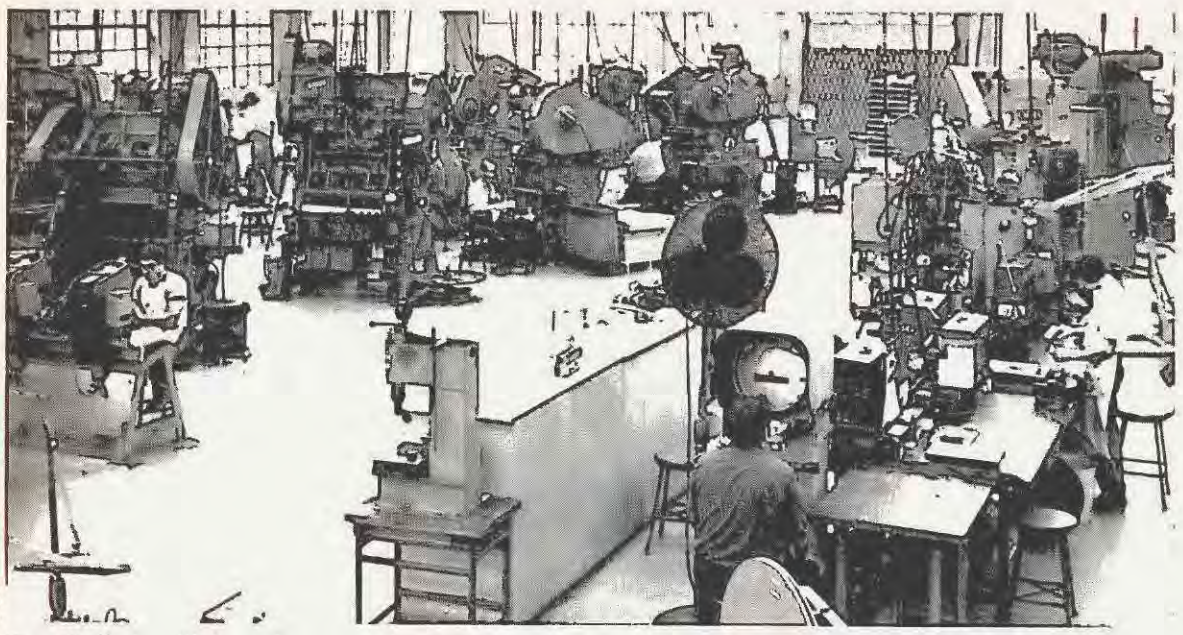


Photo: Heraeus-Volkert

Despite their criticism of state workers compensation systems, stampers oppose a Senate bill (S. 420) that would set federal standards and rates as well as cure some legal woes.

Stampers oppose federal regulation on work comp laws

CHICAGO—Contract metal stampers oppose federal standards for state workers compensation systems on philosophical grounds and because they expect higher rates with no improvements in the system.

Opposition to the federal standards bill (S. 420), proposed by Sen. Harrison Williams (D-N.J.) and Sen. Jacob Javits (R-N.Y.), is strongest where business regards the state system favorably.

But there is also an undercurrent among the more politically active stamping company executives that some form of national standards is inevitable and not necessarily bad. What regulatory burdens will accompany the standards, however, has them worried.

"Watch out for this S. 420," said William Gaskin, government relations staffer for the American Metal Stamping Assn. in Cleveland. AMSA is on record opposing S. 420 and will step up its activities against it.

A survey of AMSA's government relations committee members found them opposed to the bill, as expected, but also mostly unhappy with workers compensation systems in many of the industrial states.

"There is just no way to know what S. 420 will do to our premium rates," said Fred F. Rimmler, president of Heraeus-Volkert Inc. in Queens Village, N.Y. The bill incorporates many features of the existing federal workers compensation program for longshoremen and other dock workers, Mr. Rimmler said. "That thing is horrendous, absolutely horrendous," he said.

But a sort of conditional disapproval came from Chicago stamper Marvin R. Wortell, president of Triton Metal Products Inc. The Williams-Javits proposal would be good "if the government knew how to manage anything," he said, but he doesn't think bureaucrats could do a good job.

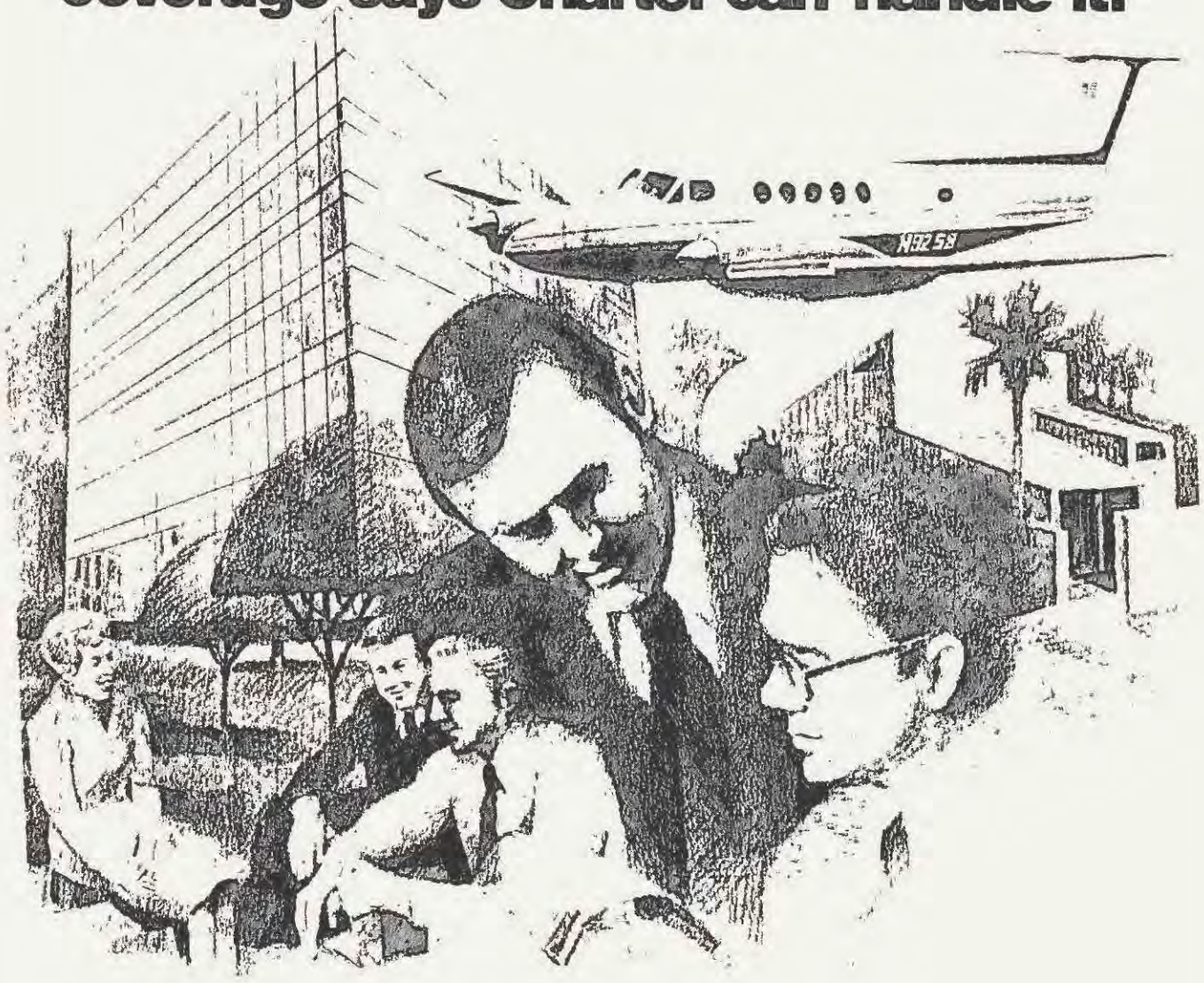
Still, Mr. Wortell added, "I'd love to see companies in Georgia pay the same rates we do."

Thurston K. Reid, president of Service Stampings Inc. in Ohio where workers compensation insurance is a state monopoly, views S. 420 fretfully. He has lobbied against the bill, but concedes, "There are some good things in it."

Aside from setting nationwide standards and rates, the bill would go part way toward curing the stampers' complex legal woes arising from workplace product liability suits against machinery builders. When the machinery builders are held liable they sue the stampers for negligence to recoup. Mr. Reid and many others note this is more than a legal danger; it is a burden because of all the additional legal costs of third-party litigation and subrogation cases.

The Williams-Javits bill would reduce an injured worker's product liability award by the amount of damages the worker received in workers compensation benefits. It also would bar third-party claims against the employer's insurer. ■

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Employers protest proposals to change Ill. work comp rules

By MARCIA STEPANEK
Crain News Service

SPRINGFIELD—Illinois Industrial Commission proposals to change workers compensation regulations have raised the hackles of Illinois business leaders.

Commission chairman Rebecca Schneiderman says the proposed changes—on which the commission is holding hearings here and in Chicago—are designed to help streamline the method by which workers compensation claims are settled.

They also are intended to make it easier for both parties in a workers compensation case to offer medical testimony, she said.

But a controversial proposal in the package would set state hearing-loss guidelines in workers compensation cases. And because those guidelines do not conform to federal Occupational Safety and Health Administration standards, business groups have pledged to fight the proposal.

Under the commission's proposed hearing-loss guidelines, 85 decibels of noise or more over an eight-hour period would constitute prima facie evidence of hearing loss. OSHA guidelines, however, set that level at 90 decibels or more over an eight-hour period.

The Illinois Manufacturers Assn. has come out strongly against this proposal, saying a decrease in the decibel level will hike the number of hearing-loss claims and be costly to manufacturers throughout the state.

"The IMA thinks this hearing loss level should be 90 decibels," said the IMA's Bill Shaw. "A jump back to 85 makes a big difference. Employers are geared to the OSHA guidelines, and when you decrease that level you're increasing liability and costs."

The Illinois State Chamber of Commerce has taken a similar stance, and labor also is wary of the changes proposed by the commission.

The AFL-CIO's Richard Walsh said hearing-loss standards should not be based solely on audiology tests used by both the commission and the federal government to determine hearing loss levels.

Mr. Walsh said such tests are not good indications of a person's ability to communicate in a job where background din is a factor. Such tests also may credit a worker for better hearing than is actually the case because they are based on single tones heard through headphones, he said.

A prior hearing-loss revision proposed by the commission also poses a serious legal question over whether hearing losses occurring before July 1, 1975, will be compensated for in the future, Mr. Walsh said.

Under the proposed revision, "an employer shall be liable for the entire occupational deafness to which his employment contributed unless the employer can establish the extent of the worker's hearing loss prior to July 1, 1975, or prior to the start of his exposure to that noise, whichever is later. If the employer can establish prior hearing loss, the employer shall only be liable for the hearing loss caused by exposure to noise after July 1, 1975."

Mr. Walsh said the proposal raises the question, for example, of whether a worker who lost 40% of his hearing before 1975 and lost 1% of that hearing since 1975 will be compensated for 41% hearing loss or just 1% loss.

But the hearing loss proposal also includes a provision favored by business that would encourage employers to test the hearing of workers.

Other proposals in the commission package would make it easier for parties in a workers compensation case to offer expert medical testimony and require claimants to file a written explanation of how they plan to support themselves before a claim can be formalized.■

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Reforms remain unresolved

Mich. task force finds time running out

By MARY ELLEN McKEE

LANSING—Michigan's legislative task force on workers compensation is back to the drawing board after a two-month hiatus, but its chance of delivering a reform package to the legislature by year-end is remote.

"Task force members have become so frustrated over the lack of progress made in the sessions that they are at a point where they are willing to compromise," said James Barrett, president of the Michigan State Chamber of Commerce.

The major unresolved issues are whether to annually adjust benefits for inflation and how to coordinate workers compensation benefits with other benefits.

Time for compromise is running out. Originally, the task force had aimed to agree upon a reform formula by Dec. 31.

"If the task force members are unable to agree upon a reform package before the end of the year, it will probably be shelved for another year, perhaps longer," said John Thodis, president of the Michigan Manufacturing Assn.

"Next year is an election year, when it will be more difficult than usual to summon up the statesmanship to deal with the complex problem of workers compensation reform and by 1981 the jockeying for the next governor will have begun," Mr. Thodis explained.

"The views of business and labor, equally strong and dynamic groups in the political arena, are too diametrically opposed for a candidate to take up the issue, added Mr. Barrett of the Chamber of Commerce.

Task force members are aware of this, said Mr. Barrett, a non-voting task force member. He says task force members know that if a compromise is delayed, Michigan will lose a great deal of business. "It's costing employers approximately $1 billion a year to keep the system running and any employers contemplating a move into Michigan are going to think twice before they enter a system that costs so much and provides very little," he said.

An annual cost-of-living adjustment in benefits, an issue that drove the group to a two-month stalemate, is the only issue so far where business and labor have not given an inch.

Labor insists a cost-of-living adjustment is a necessary part of workers compensation reform, but business counters it is much too expensive for the already "overburdened" business community, explained Dennis Terrell, an AFL-CIO lobbyist and a longtime observer of the tug-of-war between labor and business interests in Michigan.

That may change in the next few weeks, since the panel is currently haggling over a plan for modest benefit adjustments financed by the state and taxpayers, not by business, said a task force member. Rather than forcing the employer to pay annual adjustments for inflation, a fund of general revenues could be tapped to pay higher benefits to workers disabled for more than two years.

Labor traditionally has been lukewarm to plans to finance workers compensation costs with tax dollars because costs will ultimately be pushed off on the worker, who has to pay taxes to the state, said Mr. Terrell.

Labor is also worried that state spending on workers compensation could take money away from other state programs.

Mr. Terrell also questions the effect the plan could have on safety incentives. "The financial burden on the employers under the current workers compensation system is too great, but this program would totally absolve the employer of any kind of liability," he said. "This could lead to sloppier worker safety programs because employers don't have the financial incentive they had under the old workers compensation system to keep the working environment safe."

"If labor would agree to a statute of limitations on the filing of claims and some kind of provision barring retirees from routinely applying for workers compensation, the business community might be encouraged to give a little on the cost-of-living issue," said Mr. Barrett of Michigan's Chamber of Commerce.

Another option open to the task force and the one most likely for the group to take, according to a Republican lawmaker serving on the task force, is to pass over the differences and tackle the key eligibility questions. ■

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Work comp expenses outpace inflation: U.S.

WASHINGTON—Employers' workers compensation expenses continue to soar with costs far outstripping the rate of inflation, the Social Security Administration reports.

In 1977, the most recent year complete information is available, U.S. companies shelled out more than $14 billion in workers compensation expenses, a whopping 27% more than in 1976.

Workers compensation now costs employers an average of $1.71 per $100 of payroll and is rapidly climbing toward the 2% of payroll mark. In 1940, the first year such figures were tabulated by the government, workers compensation expenses amounted to less than 1% of payroll.

Of the $14 billion employers spent on workers compensation, $9.9 billion went to insurers. Another $2.8 billion was collected by states operating workers compensation funds while employers who self-insured paid out $1.3 billion in benefits and administrative costs.

Injured workers collected more than $8.5 billion in benefits in 1977, about $1 billion or 13% more than the $7.5 billion in benefits paid in 1976.

About $5.8 billion—68% of all workers compensation payments in 1977—represented cash payments to workers, the Social Security Administration says. The remaining $2.7 billion covered medical and hospital care expenses.

Private insurers made 61% of all benefit payments, while state and federal funds accounted for 23% of benefit payments and self-insured employers made the remaining 16% of benefit payments.

For the second year in a row, the number of workers covered under workers compensation programs increased by about 2.5 million, reflecting a rise in employment. ■

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Ohio Delta slashes dentists' voting power

By JOHN MAES

COLUMBUS, Ohio—Dentists' voting power on the board of directors at Delta Dental Plans of Ohio has been slashed to 26% from 60% under an agreement struck by the state attorney general with the Ohio Dental Assn. and Delta Dental.

Delta Dental has reduced to four from nine the number of dental or provider representatives on its 15-member board. The Ohio Dental Assn. also will no longer approve nominations to the Delta Dental of Ohio board.

Provider dominance of many health care organizations is crumbling around the country. Only seven months ago, Ohio's largest Blue Shield plan agreed to relinquish doctor control of its board, which was 80% dominated by the medical profession (*BI*, April 16).

In Michigan, legislation has been proposed by Blue Cross/Blue Shield of Michigan to reduce the size of its board and increase subscriber representation to 75% from 59% (*BI*, Nov. 12).

Attorney general William J. Brown said reform of the Ohio Delta Dental board is a victory for the consumer and resolves antitrust and restraint of trade questions raised by provider domination of the board. Although there was no evidence of wrongdoing, Mr. Brown said, "The economic fact of life is that the dentists and other health professionals have no incentive to engage in price competition so long as they can control the insurance companies that pay their bills."

"It's felt that if these measures had been in effect five years ago, health care costs would have been less in Ohio than they are now," the attorney general's spokesman explained.

But ODA and Delta officials said the changes would have come about even without state intervention because the two organizations had been studying the problem for a long time.

"For the last two years, we've been studying the relationship of the dental community and our organization's dental plans in Ohio," said Albert C. Wagner, president of Delta Dental Plans of Ohio. "We were preparing to make the changes long before the attorney general got his nose involved in our business. So it's quite an empty moral victory for the attorney general."

The board was top-heavy with dentists and dental-oriented workers because few policyholders expressed interest in serving on the panel, Mr. Wagner said. "We had a hard time getting directors who were not dentists. That's how we end up with a majority of dentists being members," he explained.

Ohio law specifies only that at least six of the board's members must not be dentists, but doesn't indicate a maximum representation.

Originally, dentists were the only ones willing to subsidize Delta Dental's first Ohio dental plan in 1960. Loan subsidies through 1968 totaled $115,000 and $80,000 in debt is still outstanding, Mr. Wagner said.

Mr. Wagner denied the dentists dominated board policy or that prices were fixed. "Dentistry is a highly competitive business. All the major insurance carriers are involved in dental payments and it's closely regulated by the Ohio insurance department," he said.

Ohio Delta Dental plan covers about $135,000 Ohio workers and their dependents, but it is not the largest dental insurer in the state. Delta Dental contracts cover many workers in the aerospace and rubber industries, but they do not cover the state's auto workers—the largest single employe group—state employes or steel industry workers, Mr. Wagner said.

The Blue Shield dental plan, which serves more workers than Delta Dental in Ohio, is not provider controlled. ■

Physician control of Blue Shield plan boosts bills: FTC

WASHINGTON—Though Congress is attacking the Federal Trade Commission's freedom to investigate the insurance industry, the FTC continues to research insurance issues.

In a recent study prepared by the commission's bureau of economics, the FTC charged that physician control of Blue Shield plans boosts consumer's doctor bills by as much as $435 million.

Doctors' fees average 16% higher when the local board of a Blue Shield plan is controlled by doctors, according to the study.

"We found evidence that control is associated with significantly higher physician fees," said FTC economists David Kass and Paul Pautler.

BC/BS president Walter McNerney, however, charged the FTC conclusion is "without foundation."

The study "ignores fundamental realities of health care economics which preclude Blue Shield plan board members, including physicians, from increasing health costs," Mr. McNerney said.

Reducing the fees paid by doctor-controlled plans to the level of other health plans could slash medical bills by as much as $435 million, the 84-page FTC study said.

Although the study did not make any recommendations on reducing physician control of Blue Shield, an earlier FTC staff study (*BI*, May 14) recommended a rule be drafted barring medical organizations from controlling Blue Shield plans.

Under the FTC staff proposal, medical societies could not control Blue Shield plans. Doctors would be prohibited from occupying 25% of the seats of a plan's governing board even if they don't represent a medical organization.

According to the FTC, doctors control decisions on fees paid physicians in most of the nation's 70 Blue Shield plans, and physician organizations select the majority of the members of the governing boards of 32 plans.

In 1977, 43% of all Blue Shield participants were enrolled in plans in which physicians comprised at least 50% of the board.

Meanwhile, in another FTC development, the Senate Commerce Committee last month approved legislation barring the FTC from investigating the insurance industry.

"We have to make absolutely certain that the FTC will not investigate the insurance industry," said Sen. John Danforth (R-Mo). "We must see to it that we don't want it to investigate insurance."

Sen. Danforth said FTC involvement in insurance industry activities violates the McCarran-Ferguson Act, the 1945 law that gives insurers immunity from federal antitrust law in favor of state regulation.

Barring the FTC from investigating the insurance industry is part of a broader congressional move to keep the FTC out of such areas as children's advertising and the used car business. ■

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Corporate pension costs jumped 16.2%: J&H study

NEW YORK—Total pension costs for 648 Fortune industrial and non-industrial corporations rose an average of 16.2% to $22.6 billion in 1978, but the increase was consistent with increases in pretax profits and wages and salaries, the 1979 Executive Report by Johnson & Higgins concludes.

The survey of 475 industrial corporations and 173 non-industrial firms found that the average pension cost per employe topped the $1,100 mark, jumping 15.7% for industrials and 17.6% for non-industrials to an average of $1,000 and $1,086, respectively. The surveyed companies employed 20.6 million persons in 1978, although not all employes were plan participants.

Companies cited several factors in the increased costs, including changes in actuarial assumptions to reflect the 1977 amendments to the Social Security Act higher payrolls; actuarial losses; acquisition of new firms; adoption of supplementary plans; switches in types of plans, and improvements.

Pension costs as a percentage of wages and salaries remained fairly consistent, however, rising to 7.2% from 7% in 1977 for the Fortune 500 group and to 7.1% from 6.9% for the non-industrial group. Pension costs as a percentage of pretax profits also showed only a slight increase, to 12.5% in 1978 from 12.2% in 1977 for the Fortune 500, and to 13.3% from 13.2% for the non-industrials, or about one and one-half months of average pretax profits during both years.

Unfunded vested liabilities do not pose a major problem for most companies, the report contends, amounting to an average of 23.6% of 1978 pretax profits for the industrial group and 8% for the non-industrials. Among the Fortune 500, 26% report no unfunded vested liabilities while only 6% had unfunded vested liabilities of 30% or more of net worth. Unfunded vested liabilities averaged 5.9% of net worth for all companies.

Of the 387 companies that reported total (vested plus unvested) unfunded past service liabilities, 90% have such unfunded liabilities amounting to less than 30% of net worth and 7% have no such liabilities. Unfunded past service liabilities dropped 10.9% of net worth in 1978 from 11.4% in 1977.

For industrials, total vested liabilities were 77% funded in 1978, and assets covered 64% of total past service liabilities. Non-industrials showed a 93% funding level for vested liabilities and 71% for past service liabilities.

Overall, 82% of Fortune industrials and 93% of non-industrials would be able to pay all unfunded vested liabilities with less than six months of pretax 1978 profits. Only one industry group, the metal manufacturers, would need more than one year's pretax profits.

Industrial companies with unfunded past service liabilities could, on the average, eliminate them with a little more than five months of pretax 1978 profits. Non-industrials could do so within three and one-half months. Only two industry groups, metal manufacturers and aerospace, would need to call upon more than one year's pretax profits. ■

Proxy statements:

Average contribution is 11.2% of pay: TPF&G

NEW YORK—Pension plan contributions averaged 11.2% of covered pay in 1978 in 79 of the Fortune 100 industrial companies, according to a recent study.

The largest group of employers—18—contributed from 10% to 11.9% of covered pay to pension plans, reports consultants Towers, Perrin, Forster & Crosby.

Fifteen firms contributed 12% to 13.9% of pay; 12 companies contributed 6% to 7.9%; 11 companies contributed 8% to 9.9%; nine firms added 14% to 15.9%; six companies each contributed less than 6% or more than 18% and two firms contributed 16% to 17.9%.

TPF&C analyzed proxy statements filed by the companies in compliance with recent changes in Securities & Exchange Commission disclosure rules. Those changes, for companies filing fiscal reports after Dec. 31, 1978, call for stricter disclosure of pension contributions.

In the proxy statements, 79 companies reported pension contributions as a percentage of covered pay, two reported them as individual allocations and 19 did not report contribution data.

The lack of reporting contribution data for 15 companies was because their fiscal year ended before the new proxy disclosure deadline. Two companies did not have pension plans and two others did not make any statements regarding the contributions, according to the study.

The 79 companies revealing pension contributions used different definitions of covered pay. Twenty-six companies described covered pay for pension purposes as base pay, although some include elements such as bonuses and incentive compensation, while others exclude them. Twenty-five companies specified total pay, which at times included or excluded specific pay elements. For 28 companies there was insufficient evidence to determine the pay base used, according to the study.

But the average pension contribution wasn't greatly affected by the different definitions of covered pay. The average pension contribution was 12% for companies using the base pay, 10.6% for total pay and 10.9% for the undefined covered pay. ■

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Reports can mislead: Hewitt

LINCOLNSHIRE, Ill.—Disclosures about pension plan benefits for directors and officers in proxy statements aren't comparable from one company to another, say consultants Hewitt Associates.

After reviewing the available 1979 proxy statements of the Fortune 500 industrials, 50 banks, 50 retail organizations and 50 utilities, Hewitt concluded that:

- Pension cost percentage footnotes are not comparable from one company to another and are very unreliable measures of either management remuneration or pension size.
- Tables of estimated annual pension benefits make it difficult for the reader to assess the absolute amount of compensation of the executives covered by a plan or to judge the relative compensation being provided through pension plans of different companies.

Attempts to use the information on the proxy statements can be dangerous, the consultant warns in its December 1979 Hewitt Associates Report.

"Trying to compare your own individual pension benefit with that of an executive's in another company can be misleading. And trying to compare your company's pension cost with that of another employer can be even more misleading," the consultant says.

In studying the pension cost footnotes, Hewitt found that pension cost as a percentage of compensation varied greatly, from 2% to over 22%. But the consultant cautions against considering the data useful, because there were too many variables in the way pension costs were figured from plan to plan.

Hewitt considers its analysis of the proxy statements for annual pension benefits to be more reliable than pension costs. The age expected pension for fin erage pay of $100,000, and 30 of service was about $45,000, itt notes. The average expe pension for final average pa $200,000 and 30 years of se was $90,000.

RIMS conference

Finance know-how can help risk exec advance: Expert

By RHONDA RUNDLE

MONTEREY, Calif.—Risk managers are destined to dead-end careers in the middle management doldrums unless they aggressively pursue expertise in financial affairs and polish their management "people" skills, concludes a panel of industry experts.

More women could be caught in the same trap as they move into risk management ranks.

"I call these phenomena the 'double-F impact'—financial and female," Richard T. Bergsund, a management consultant with Leon A. Farley Associates in San Francisco, told the RIMS Western Regional Conference meeting here late last month.

"I don't want to be a doomsayer," Mr. Bergsund said, "but it doesn't appear likely that risk management will break out of its 'velvet rut' in the corporate hierarchy." That's why ambitious risk managers should beef up their financial know-how to advance their careers, perhaps through an M.B.A. degree, he said.



Photo: Rhonda Rundle

"It doesn't appear likely that risk management will break out of its 'velvet rut,' " says Richard Bergsund.

Most risk managers today are insurance people, Mr. Bergsund observed. To reach the top management circle, however, they must learn more about data processing, corporate communications, finance, accounting and personnel management.

Even the risk manager of the 1980s will be more challenged, however, suggested Emmet F. Monaghan, director of insurance management and administration for Kaiser Aluminum & Chemical Corp. Security, safety and benefits management may belong under the risk manager's umbrella, he said.

Companies that deal in high risk services and commodities—specifically drugs and aircraft—will face proportionately higher risk costs, he predicted. In those companies the risk manager's role will be upgraded into a top management job, he added, requiring more emphasis on really managing risks and less on the technicalities of insurance.

Putting a new concept into action early translates into super savings, Mr. Monaghan says. Self-insurance and captives were better bets when they were new than they are today, he said.

The top-flight risk manager must have the wisdom and courage to separate the wheat from the chaff among new risk tools, he added.

"Keeping your company one step ahead of the pack spells danger," he admitted. "But anyone who takes a lot of responsibility always risks a wrong decision—that's what you get paid for."

Mr. Monaghan also hailed the "female phenomenon" in risk management. "Half of the smartest people in the world are women," he quipped, "and we are obviously underutilizing them because few are visible in the corporate world."

This is changing, he notes. The insurance brokerage houses, for instance, are spawning grounds of intelligent women who will cross the bridge into corporate management in increasing numbers.

Douglas Temple, dean of the school of risk management and insurance at Golden Gate University in San Francisco, heartily endorsed an emphasis on financial expertise in the risk manager's career.

"Understudy the financial manager in your company," he urged. "This way you will understand where you fit into the scheme of things and what you need to know to step into the shoes of the chief financial officer—perhaps on the way to the company presidency."

Risk managers have a unique view of the overall operations of a large company, he pointed out. They visit plant facilities and study operations, to pinpoint loss exposures. They merely need to upgrade their credentials to qualify for a line management job, the risk management dean said.

Mr. Douglas recommends an M.B.A. program with an emphasis on finance in an accredited community institution of higher learning. "Cash flow forecasting and capital budgeting are topics you need to explore," he told the audience of risk managers predominantly from the Western states and Canada.

But changing companies isn't necessary to advance in risk management, the panelists agreed. "I don't think mobility is either an indicator or a means to success," Mr. Monaghan said. "There is, naturally, a big difference among companies."

"I don't think anyone should move just for the sake of moving," said Herb Cunningham, vp at Transamerica Corp. "If you change companies, you should be solving a specific problem in your old position," he said. ■

M&M opens 2 new offices

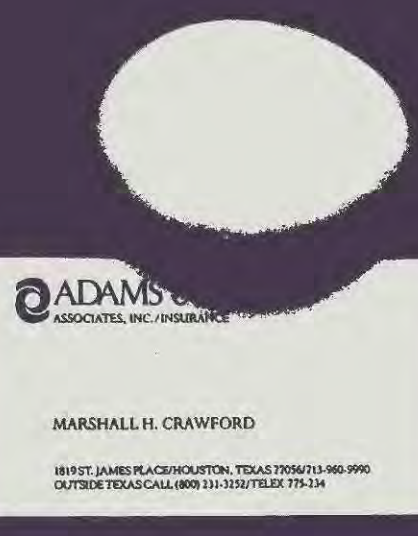
NEW YORK—Marsh & McLennan Inc. has opened offices in Tucson, Ariz., and San Jose, Calif.

Economic growth in the two regions prompted the new offices. M&M officials cited growth in the leisure, tourism and recreation industries in Tucson. The nation's largest broker is eyeing expansion of electronics industry, contracting and retailing accounts in San Jose.

Both offices will offer financial services including insurance brokerage, risk analysis, claims management, insurance company management, multinational insurance consulting and loss prevention counseling.

William T. Taylor, formerly an account executive in M&M's Phoenix office, has been appointed manager of the Tucson operation. Ralph O. Hanley, in the past a profit-center manager in M&M's San Francisco office, is the new San Jose office manager. ■

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Letters column . . .

Continued from page 12

Incorrect headline

To the editor: Thank you for your coverage of our recent changes in risk management at Itel (*BI*, Oct. 15). There is one thing I would like to correct, concerning the headline which stated we had canceled a contract with our broker for risk managing. In fact, there was no contract with Fred S. James & Co.; therefore, we did not cancel any contract with them when we established our risk management department.

Stephen A. Hause, CPCU

Director of risk management, Itel Corp., San Francisco, Calif.

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Unfair editorial

To the editor: Re: "Resting on their laurels" (Oct. 29).

Your editorial has "more than a little" disturbed me because it is obviously intended to and does create the impression that many CPCUs are opposed to the principle of continuing education.

The too-many members of the society that you speak about are made up of people who have a CPCU degree and who, by their own investment of time and money, have assiduously for the good of our industry spent many days and nights away from their offices and homes on society business. These people willing to "rest on their laurels" come from all segments of the insurance industry.

The fact that the society organized the blue ribbon committee is proof that it considers continuing education as a top priority. As a former member of the board of directors, I can certainly understand the reluctance of some members to endorse the entire report at this time. The dramatic change suggested by the blue ribbon committee does require some time to be disseminated to the membership so that objections that might arise can be dealt with.

I regret, just as you do, that the board of the Society of CPCU has rejected our recommendations, but as you rightfully state, "the issue is hardly closed for all time." I firmly believe that in time, the society will eventually arrive at the right formula.

Alan S. Samuels
Senior vp, Frenkel & Co. Inc., New York

Resounding amen

To the editor: Re: the editorial Oct. 29 ("Resting on their laurels"). I'd like to add a resounding amen! It's been my feeling for many years that a great many CPCU completers seem to feel that they're so superior to others and that they sit back on their laurels, forgetting that it "ain't what you got, it's how you use it" that counts.

John J. Ellen, CPCU, ARM
Senior account executive, Arthur A. Watson & Co. Inc., Wethersfield, Conn.

Falling into trap

To the editor: Your editorial of Oct. 29, "Resting on their laurels," seems a little hard on my fellow CPCUs, all of whom, you would have us believe, "don't want to have to do any more work themselves to stay on the cutting edge of their business."

Proudly, I served on the Blue Ribbon Committee, although for many reasons I did not support the final proposition put to the board of directors for passage.

Don't fall in the trap of thinking that by not approving this program, CPCUs "oppose updating their educational achievements periodically."

I would not swap my day-to-day experience in this business ("on-the-job training") for any sheepskin or certficate of compliance from a prescribed program.

We CPCUs are not in the business of education—we are in the business of insurance, committed to continuing education, and we must continue our educations in a manner best suited to our individual needs and goals.

Mitchell Gwinn
Executive vp, The Insurance House, Atlanta, Ga.

Consultant's reply

To the editor: Re: Alan Pearce's remarks at the Institute of Risk Management Consultants, Oct. 1 issue of *Business Insurance*.

First, I agree that self-insurance is often more cost-effective than using a captive and always more cost-effective for casualty coverage unless the casualty premium is tax deductible. In any event, all risk financing devices should be considered. A qualified risk manager cannot afford to favor one device over others without objectively studying each possible device or combination of devices for each program.

Second, the use of a captive can often result in reduced commissions, but seldom result in less commission than a self-insurance program. The other point Mr. Pearce makes regards the excessive fees charged by the management companies can be valid. The risk manager has the same responsibility to carefully evaluate commissions or fees to make sure he is paying an adequate but not excessive amount for the time the service company or broker spends servicing his account.

Third, I seriously doubt that captives are either overrated or overutilized to the extent indicated by Mr. Pearce. Most of the captive situations that I know of are actually underutilized and a number of Fortune 500 companies without a captive should have one. The captive is another risk financing tool that each company should have available to use with other retention programs and various risk transfer devices.

Fourth, I object to Mr. Pearce's remarks regarding CIRCL.

CIRCL never was and never will be a political football. It was and is a fine cooperative effort by a number of major U.S. corporations There are presently 14 participants.

Wm. S. Mortimer
Principal, Risk Management Consultants Inc., Laguna Beach, Calif.

Intermediary role

To the editor: My attention was caught by Alan Pearce's comments in *Business Insurance*, Sept. 17 ("Risk exec slams E/S lines").

A retail broker does not always have a choice about going to a wholesaler if he wishes to reach certain markets which may be important to the handling of your risk. The majority of surplus lines insurance carriers writing industrial and commercial or specialized lines of insurance prefer to limit the number of producers they must deal with.

Most such insurers seem to have recognized the important role the intermediary plays in sorting out the specific types of risk which he is interested in seeing.

By representing a variety of specialized insurers, the surplus lines broker also has the ability to direct a given problem to an insurer who will solve it. A broker is not showing weakness by using an intermediary broker, but rather is tying into a system which creates an advantage for him in getting to the right market.

James H. Bryson
Vp, National Assn. of Professional Surplus Lines Offices, Jenkintown, Pa.

Incomplete quotes

To the editor: In the Sept. 17 article, "Liability penalties drive scared Wilson out of helmet game," I find quotes attributed to myself that are incomplete.

I'm quoted as having said that Spalding removed itself from the helmet business in 1973. . . "also because of product liability risks and high costs of insurance." I actually said that when we considered these factors in connection with the fact that the line was not providing us a sufficient return, we decided to abandon that portion of the market.

I did not say we had been sued "a couple of times" for product liability in helmets. I mentioned rather that we were currently involved in one such suit which to the best of my knowledge was the only one in which we'd been involved. Additionally, I responded to your question by saying that, yes, lacking factual evidence at the time, we might have at some time in the past been sued a couple of times, but that I could neither confirm nor deny that during our brief conversation.

John E. Lacey
Product manager, team sports, Spalding, Chicopee, Mass.

Proper name

To the editor: In the Oct. 29 article entitled "Panel to review herbicide claims," reference was made to "Affiliated Factory Mutual."

Although in connection with a recent hearing, our company more often than not was referred to as "Affiliated Factory Mutual Insurance Co.," the proper name of our company is Affiliated FM Insurance Co.

David L. Johnson
Vp-general counsel, Allendale Mutual Insurance Co., Johnston, R.I.

Striking a nerve

To the editor: Your page 1 story Oct. 29 on the ERISA fiduciary liability lawsuit by an Eastern Airlines pilot contained a paragraph that struck a nerve with me. The line was " . . . and ALPA representatives on the retirement committee are Eastern Airlines employes and covered by the airline's fiduciary policy, ALPA is not likely to be found to have liability," said Marshall Rattner, president of Professional Indemnity Agency.

Sharing of pension investment decisions with a union is common, often mandated by contract. I would have guessed that most companies feel their fiduciary policies cover employes who act in a fiduciary capacity as a part of their assigned jobs. I doubt if the company or its insurers contemplate coverage on employes whose duties are totally foreign to their duties on the pension committee and who are selected and assigned to this role by the union.

Since these designees are the union watchdogs on the company's activities, they generally run toward an adversary role.

Seems odd to bracket them under the company policy.

Waller B. Smith
Vp, Rollins Burdick Hunter Co., Chicago

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Former consultant Boylan steps to new job with Grace

W.R. Grace & Co., in New York has appointed **Charles J. Boylan** corporate director of benefits within the company's corporate administration group. Mr. Boylan, 35, was formerly senior employe benefits consultant for Coopers & Lybrand in New York, where his duties included the design and development of pension, profit sharing, group insurance, personal estate planning and executive incentive programs for major corporate clients. He has a B.S. degree in mathematics and physics from Catholic University, an M.S. degree in statistics from the University of Alabama and an M.B.A. in accounting and finance from The Wharton School, University of Pennsylvania. In addition, Mr. Boylan has an L.L.B. degree from Seton Hall University and was admitted to the New York and New Jersey bar associations.

* * *

Cyril W. Jakubowski has been appointed to the newly-created position of corporate safety manager at Boehringer Ingelheim Ltd. in Ridgefield, Conn. He will be responsible for the formulation, implementation and administration of all corporate safety, employe environmental health and loss control policies, procedures and employe training for all BIL facilities and the coordination of similar activities for divisions and subsidiary companies. Mr. Jakubowski, who will report to Lawrence J. Salerno, director of corporate insurance and safety, was previously responsible for safety and loss control at Essex Chemical Corp. in Clifton, N.J. A replacement is being sought for him there. He has a B.S. degree in chemistry from Fairleigh Dickinson University, pursued his M.S. degree in chemistry at Rutgers University and recently completed an M.A. degree in occupational safety and health at New York University.

* * *

A.O. Smith Corp. in Milwaukee, Wis., has named **Jon R. Mittler** employe benefit analyst. He replaces Fran Birchhill, who left the company. Mr. Mittler, 31, will be primarily responsible for pension plans and organizing an employe benefits communications package. He has a bachelor of arts degree in communications from North Park College in Chicago and a master of arts degree in communications from Purdue University. Mr. Mittler, who will report to Ron Meissner, director of employe benefits, was previously senior plan administrator in the trust department of Continental Illinois National Bank.

* * *

Richmond W. Marshall CPCU, ARM, has been named risk and insurance manager at Fidelity Financial Corp. in San Francisco, a holding company for Fidelity Savings & Loan Assn. in Oakland, Calif. Mr. Marshall, who reports to Karen M. Manning, executive vp of administration, was formerly employed by Continental Insurance Cos. and Design Professionals Insurance Co. in San Francisco. He has held a variety of positions including casualty and property liability underwriter. He has a bachelor of science degree in mechanical engineering from Washington State University.

* * *

The Continental Corp. has appointed **William J. Barron**, 57, assistant vp and director for insurance and safety engineering in its New York corporate real estate department. His responsibilities include safety engineering, compliance with federal, state and local safety codes in all Continental facilities as well as risk management and contingency planning. Mr. Barron joined Continental in 1958. He has a bachelor's degree in economics from Columbia University and a M.B.A. from New York University Graduate School of Business. He reports to George W. Reeder, director of real estate.

* * *

Instrument Systems Corp. in Huntington, N.Y., has named **Harry P. Mirijanian** corporate director of insurance and safety. This position is a consolidation of two previous positions at the firm: director of insurance and employe benefits and corporate safety manager. **Mark C. Sysler,** former director of insurance, is now employed by City Stores Co. in New York, and **Gordon Reid**, former corporate safety manager, is now working for Kane Miller in Tarreytown, N.Y. Mr. Mirijanian came to Instrument Systems from Fred S. James & Co. in New York. He has a master's degree in occupational safety and health from New York University. He reports to Edward Garrett, chairman of the board.

* * *

Martin T. Fox, 31, has joined Whittaker Corp. in Los Angeles as an insurance analyst. Mr. Fox was previously assistant to the president of Intercontinental Reinsurance Inc. He has a bachelor's degree in finance from St. Norbert College in Wisconsin and a law degree from Hamline University in St. Paul, Minn. He reports to Dick Bruno, corporate risk manager.

* * *

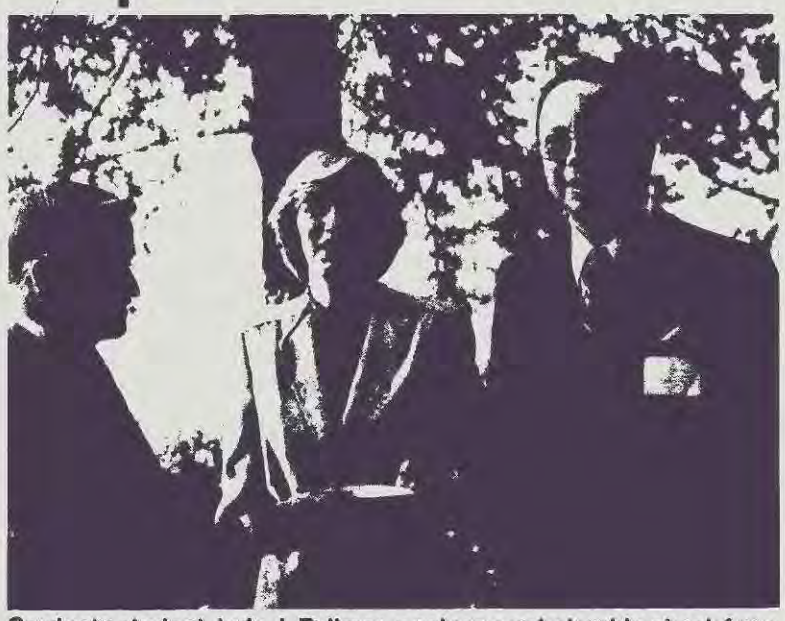
Donald T. Browne, vp and manager of the insurance division of First Atlanta Corp., has been appointed chairman for 1979-1980 of the executive committee of the Insurance and Protection Division of the American Bankers Assn. Mr. Browne has held his present position with First Atlanta, parent company of the First National Bank of Atlanta, since December 1972. He is a 1956 graduate of Georgia Tech and attended graduate school at Florida State University. Mr. Browne is also national treasurer and a member of the executive committee of the Risk & Insurance Management Society and is past president of the Atlanta Chapter of RIMS.

* * *

Judy J. Fullmer, a student at the graduate school of business administration at the University of Southern California, has received a $1,500 scholarship from the Los Angeles chapter of the Risk & Insurance Management Society. Ms. Fullmer is a Phi Beta Kappa and is planning a career in employe benefits. The scholarship program was instituted by the chapter in 1978 to encourage advanced studies in risk management. It is open to M.B.A. candidates at USC who are studying risk management.

•

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to Mary Ann Matlock, Business Insurance, 708 Third Ave., N.Y., N.Y., 10017 or call 212-986-5000. We'd also like to receive pictures of the people involved.



Graduate student Judy J. Fullmer receives a scholarship check from Jack Pierce, left, and Bob Wilkinson of L.A. RIMS.

BCSP schedules examination dates

CHAMPAIGN, Ill.—The Board of Certified Safety Professionals has set the 1980 Certified Safety Professional Examinations for May 17, 1980, and Oct. 18, 1980.

For new applicants, the deadlines for receipt of complete applications for the May and October examinations will be Feb, 1 and June 2, 1980, respectively.

Examination locations will be based on the geographical distribution of the examinees.

For further information or applications, contact the BCSP at 501 South 6th St., Suite 101, Champaign, Ill. 61820, or telephone (217) 359-9263. ▪

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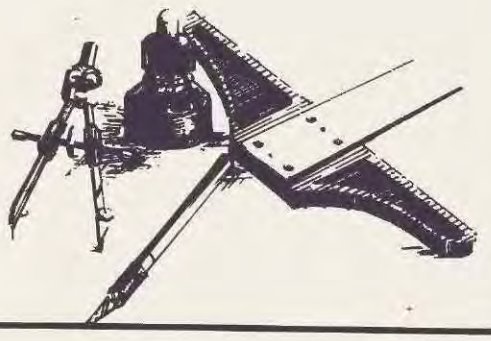
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Calif. stops work comp retros

Continued from page 1

about the California insurance department's review, reports Marcus Ramsey, chief of the rate regulation section.

"We hope to meet informally and face-to-face with representatives of companies that have marketed those plans to express our concerns and theirs. No date has been set for such hearings but we're aiming for mid-December," he says.

Industry sources say sales of paid-loss retro plans have stopped cold in California. Fireman's Fund and INA voluntarily stopped quoting and issuing them last month pending a ruling on their legality from the insurance commissioner.

"We are contacting two or three other companies that may have written similar policies," Mr. Marcus notes.

Best of both

If given the option, some companies might select paid-loss retros over captives or self-insurance because they offer the best of both worlds: the financial advantages of self-insurance with the security and services of insurance, suggests a risk manager at a major California company.

"We use these cash-flow plans in every other state and there's no problem," says Bill Lachner, regional vp with INA Special Risks in San Francisco.

"We requested a hearing to get all the facts on the table and we're ready to appear whenever the department is ready." Since preparations must be made on both sides, however, he expressed doubt that hearings could begin in less than 90 days.

Mr. Lachner believes the INA plan is misunderstood. "Our plan is like any California retro," he said. "The only difference is the way in which premiums are collected."

After a deposit premium is paid, the policyholder issues a promissory note with an "irrevocable letter of credit" in lieu of cash for the difference between the standard premium and the deposit.

"It's almost like a loan," Mr. Lachner says. "The insurer gets 15% to 20% up front and a note for the rest."

This arrangement differs from other paid-loss retros which defer full premium payment but do not require a letter of credit, Mr. Lachner maintains. In the past, the California insurance department ruled against those plans because the insurer is exposed to default on premiums by the policyholder. A letter of credit is a financial guarantee against this catastrophe, Mr. Lachner says.

INA has underwritten three or four cash-flow retros in California this year, Mr. Lachner revealed, all for companies paying more than $500,000 in premiums. The business isn't significant now, but with a favorable ruling from the insurance department it might be, he says.

This approval seems unlikely, however. Most risk managers and brokers believe the state's insurance authorities nixed cash-flow plans about eight years ago and chances are slim they will reverse that ruling. Spokesmen at several California-chartered insurance companies said their companies do not write those plans because "they are illegal."

Natural attraction

"The department is just awakening to the fact that in spite of its prohibitions, companies are looking for ways to improve their cash flow," observes Charles E. Hiatt of the Hiatt Co., a risk management consulting firm in Malibu, Calif. This attraction is natural in times of tight money and high interest rates, he points out.

Mr. Hiatt suggests such plans are a way for corporations to "self-insure through the back door." In other words, they circumvent legal state requirements for self-insurance under the guide of buying insurance. This can be dangerous, he says, when policyholders issue promissory notes without collateral to back them up.

These plans are especially popular in Texas, Mr. Hiatt says, because self-insurance of workers compensation is not permitted there.

"I would venture there are 20 to 30 insurers underwriting such plans for between 200 and 300 companies in Texas," INA's Mr. Lachner estimates. ■

Harvester seeks second trial

Continued from page 2

• The judge improperly permitted evidence from previous tractor fire cases into the record, including allegations of fraud in the discovery process (the withholding of relevant company documents from the plaintiff's lawyers). This created a "punitive" climate against Harvester.

• Mr. Cook "deliberately and willfully" made "vituperative" and inflammatory remarks in court.

• Mr. Cook's closing arguments to the jury were "so extreme, so intentionally prejudicial, so inflammatory and so inciting to passion and prejudice as to evidence utter disregard of . . . the court, the jury and the judicial system."

• Harvester should have been granted a change of venue because of prejudicial pretrial publicity stemming from the Gauges settlement. Mr. Owen's brief cited Mr. Cook's statements to local newspapers before the Stambaugh trial.

• Mr. Stambaugh's 1963 Model Farmall tractor was built without defects; Harvester had had no control over it in the 12 years before the accident; it had been partially rebuilt; Mr. Stambaugh had purchased it used and he continued to use it after the fire.

• The jury's verdict disregarded proof that the accident could not have happened by the gas tank cap blowing off, as Mr. Stambaugh said. IH still makes those caps and sells them to some of its competitors.

• The jury was "contaminated" because instead of being sequestered, the 12 jurors deliberated for six hours in Judge Goldenhersh's courtroom where they had access to Mr. Cook's personal files on the case.

Contentious point

This point could prove to be the most contentious.

The jury room of Judge Goldenhersh's court is reportedly small and stuffy and jurors routinely deliberate in the courtroom. The jury room reportedly is too small to accommodate the files and evidence from the Stambaugh case. One exhibit is a complete tractor fuel system identical to the one on Mr. Stambaugh's Farmall.

The issue of what the jurors might have seen in the courtroom was raised after their verdict. Each of the 12 was questioned on the stand and each denied he or she looked at any evidence not ruled admissible in the trial.

Because the jurors deliberated in the presence of Mr. Cook's notes—lying open on the judge's bench—Harvester contends they could have in that way learned the extent of its insurance coverage and the damages demanded by Mr. Stambaugh.

No damage sum was ever mentioned in the trial, Harvester contends. Mr. Cook says he argued for both $10 million and $20 million.

Many lawsuits

Even sources at Royal Globe concur that Harvester has an unusual number of tractor fire lawsuits against it. Some fires are inevitable, Harvester says privately, because of farmers' own negligence.

In a mid-November statement after the verdict, Harvester said its research shows one tractor fire occurs for about every one billion hours of operation. Assuming the "average" tractor is operated 500 hours a year, a high figure, that means a fire occurs for every two million tractors in service.

Mr. Cook draws parallels between the Harvester tractors and Ford Motor Co.'s Pintos. In a controversial Indianapolis case this year, Ford's Pintos were alleged to be designed so as to be susceptible to fuel tank fires in rear-end collisions. Mr. Cook contends Harvester, like Ford, knew of the defects and did nothing to correct them.

"There are 40 to 50 other tractor fires that I personally know of," Mr. Cook asserted. "The only way they won the one case was by not letting anyone know about the other fires." ■

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Detroit RIMS elects officers

DETROIT—The Detroit chapter of the Risk & Insurance Management Society elected new officers for 1979-80.

President is A. Herbert Johnson, Detroit Edison; first vp, Ronald W. Stasch, Federal-Mogul Corp.; second vp, Charles T. Cozier, American Natural Services Co.; secretary, Dennis L. Bennice, Dana Corp., and treasurer, Thomas V. Hallett, General Motors Corp. ■

Nuclear firms to fight liability increase

Continued from page 1
crease in liability, setting a limit on liability losses at $1.3 billion instead of $560 million.

Even at current liability limits, it's expected insurance premiums for the nation's nuclear power plants will increase by a third next year. And there's concern that underwriters might hesitate to renew insurance policies in the face of $560 million class action suits against the owners of Three Mile Island.

If Congress increases nuclear power plants' liability for accidents, utility companies would have to increase their liability insurance limits. In addition, the current $5 million per reactor that would now be assessed each utility in the event of an accident at any of the nation's plants would have to be increased from $20 million per reactor (the Senate) to between $50 million and $100 million per reactor (the House).

Tough fight

The utility companies are the target for the increased financial responsibilities because congressional officials are convinced the private insurance industry will not take more risk for the plants than it now holds.

Congress is considering also involving the suppliers and architects of nuclear power plants in the insurance pooling arrangement, but it seems to have little chance of passing, according to several knowledgeable sources.

Indeed, congressional staff members say they expect a tough fight in getting any increases in the liability for nuclear accidents.

"The utility companies are pretty unhappy. They say this legislation will be the Achilles' heel of the nuclear power industry," explained Barry Glaser, a staff member of the Senate nuclear regulatory subcommittee. "They will probably accept some raise in their liability, but getting rid of the limit or raising it so high that it really drives up their risk causes them a lot of worry."

During the few hearings held by the House Interior Committee on proposals to raise the limits set by the Price-Anderson Act, industry officials refused to agree that changes in the law were needed.

"They said they were happy with the way things are now," said Deborah Sliz, staff counsel to the committee.

Burt Proom, president of American Nuclear Insurers, the pool that provides liability and property insurance for the nation's nuclear plants, has been to Washington several times to oppose efforts to raise the limits. He acknowledges that he expects some increase in liability to be passed by Congress in the next year, but is adamant that the increased liability cannot be covered by insurance companies.

"We have all the capacity right now that we can get," Mr. Proom said of the $160 million insurance provided by the pool out of the total $560 million of liability nuclear plants face. To raise just $160 million, Mr. Proom said, foreign reinsurers had to be brought in to cover 49%. The pool has almost nowhere else to go for increased capacity, he said.

Increasing capacity by assessing suppliers of nuclear power plants a portion of the liability for accidents would not work, say Mr. Proom and others.

Forcing suppliers to take part of the risk "would push our suppliers out of the business," Mr. Proom said. Mr. Glaser said Senate staffers realized the proposal would have little chance of going through when told by suppliers that "a lot of them would say 'The hell with it. Why should we take a risk on this business?' Westinghouse has 40 lines of business, why should it keep one of them that would cause them all this trouble?"

While almost all nuclear industry officials are fighting to keep their liability exposure from increasing at all, more important to them is keeping at least some cap on the overall liability for a nuclear accident. The efforts to completely repeal Price-Anderson are seen as dangerous, and possibly fatal, to nuclear power.

Philip J. Brown, a vp at Marsh & McLennan, says, "If Price-Anderson, or something like it, isn't there, the utilities would have trouble raising the finances they need to build power plants and operate." Repeal, he said, "would be a problem."

Financial losses

Utility company officials have also warned they would all have trouble coming up with their share of the losses if the proposed liability limit of $1.3 billion being discussed in the Senate is ever imposed, particularly since they would all be trying to scrape it up at the same time.

Even under the current liability limits, some industry observers see financial problems caused by Three Mile Island.

The estimated $200 million in property damage at Three Mile Island—covered under a $300 million property policy with ANI—comes close to wiping out the reserved losses set aside by the ANI under its property policies. Mr. Proom said he expects the pool will raise property premium rates at least a third next year because of the drain on reserves.

Others are worried about what will happen if the liability losses reach $560 million, damages asked in several class-action suits filed against the utility companies.

"If the class-action suits filed in the wake of Three Mile Island succeed—which I don't think they will—it would cause somewhat of a disruption in the markets," said Mr. Brown. "The insurance industry would certainly consider whether to underwrite the risks (again). The question right now is whether to reinstate the coverage (when renewals come up)."

Lorne Palmason, also a M&M vp, said that even if the suits don't succeed, the market might be affected.

"The risks of nuclear plants are definitely being reassessed by insurers," he said. "The Three Mile Island and the fact that we can never again say that a serious accident can't happen, because one has happened, will definitely affect premiums and the prices of insurance."

"Prices will rise 10% to 25% over the near term," Mr. Palmason predicted. Hikes would probably be closest to 20%, "but that's pure speculation," he said.

While insurers worry about the rates and availability of policies and utility companies worry about keeping their plants operating, other industry officials are pushing safety efforts in hopes of preventing future losses.

Safety programs

Mostly in response to sharply critical Kemeny Report conclusions on safety and operator training programs by the plants, several groups are beefing up their activity in these two areas.

ANI expects to increase its engineering capabilities by about 50% in the next few years. The pool will add about 19 more engineers in the next three or four years and will make its first forays into operator training, Mr. Proom said.

The Atomic Industrial Forum, a trade association, is also forming a group next year that will provide training facilities for operators of nuclear power plants and set safety standards for member companies. The group was formed in part because of assertions in the Kemeny Report that most of the problems at Three Mile Island could be tied to human errors.

Utility companies would be encouraged to follow the guidelines of the group and allow its inspectors to regularly check their facilities by a mutual insurance plan formed by the utilities to provide a form of business interruption insurance not available to them (*BI*, Nov. 29). The coverage would be available only for those utilities that followed the safety and training procedures, an AIF spokesman said.

The AIF was particularly stung by criticism in the special Presidential commission's report that many of the errors at Three Mile Island were simple ones that should have been corrected long before they aggravated the leak at the nuclear plant. ■

Nuclear plant operators need better training: Panel

WASHINGTON—Nuclear power plant operators need to be better trained, according to the Presidential commission that investigated the nuclear accident at Three Mile Island.

Many factors created the March 28 accident that cleared out the surrounding Pennsylvania towns and dominated the nation's headlines for more than a week, but perhaps the most crucial of all, says the recently released report by the special commission, was the fault of the plant operators to follow much-needed safety procedures and correct minor errors that turned into major problems.

Design problems were also blamed for some of the operators' errors.

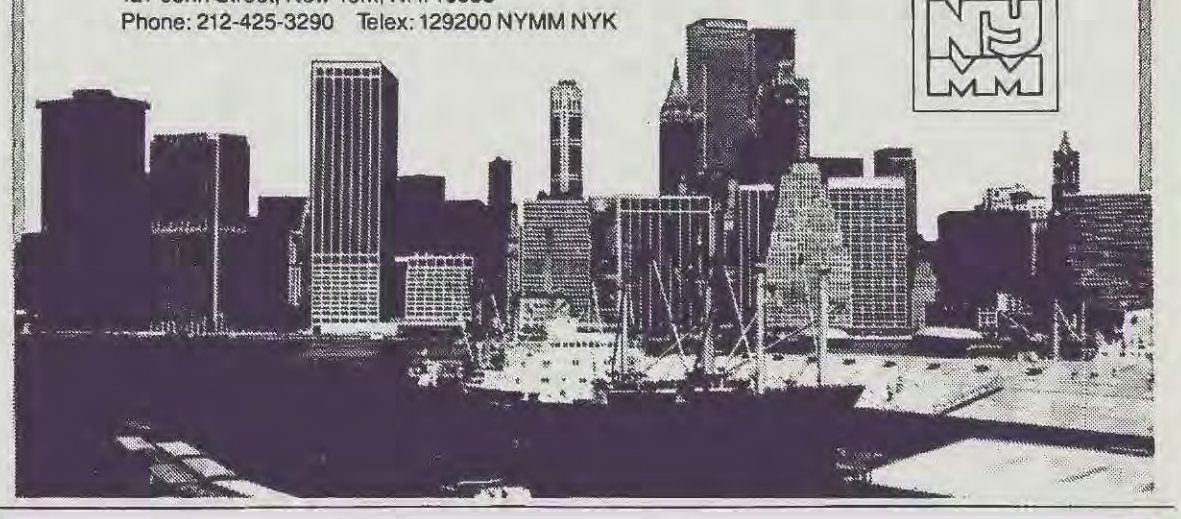
A control panel had 100 alarms that could be triggered by one incident. There was no way to suppress the unimportant ones so the operators could rapidly respond to the important ones, the report said. Some of the alarms were also out of the viewing range of the operators, the report added.

Metropolitan Edison and General Public Utilities, owners of the plant, and Babcock & Wilcox, the plant's designers, were also blamed for ignoring safety problems that had been brought to their attention either at TMI or at similar plants. ■

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Group health bills to continue climb in '80s

Continued from page 1

William Montgomery, group sales manager at Kemper Insurance Group in Long Grove, Ill. "Inflation and increased utilization will do a number on costs and that's a fact of life now in the employe benefits field.

"Rates are increasing, however, at a much slower rate than we saw in 1974 and 1975 and I think this trend will carry over into the 1980s," Mr. Montgomery said.

This story is based on reporting by Business Insurance editors Stuart Emmrich, Jerry Geisel, Margaret LeRoux, John Maes, Mary Ann Matlock, Kathryn McIntyre, Mary Ellen McKee, Rhonda Rundle, Ellis Simon and Len Strazewski. It was written by Mr. Strazewski.

In addition to inflation, factors causing rates to jump from year to year in group health insurance plans are: longer hospital confinements, increasing frequency of hospital confinements, the amount of testing done on each individual patient and the "cover yourself" defensive medicine being practiced by many doctors, Mr. Montgomery said.

" 'Cover yourself' medicine is causing doctors to require more tests than they would have a few years ago, to keep people in hospitals longer than they had before and, in general, not to practice any kind of cost control," Mr. Montgomery explained.

Lower rates

Unlike most employe benefit programs, however, group term life insurance rates are down, especially when compared with individual ordinary life insurance, Mr. Montgomery said.

Although group life insurance rates tend to move up or down more slowly than the rates for other employe benefits like dental and health insurance, Mr. Montgomery says group life insurance rates are at least 20% lower than they were 10 years ago.

Life insurance rates dipped while the cost of other benefit programs such as major medical and dental climbed because underwriters wanted to sell their group health insurance clients group

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term life insurance, too.

"The current aggressive market conditions exist because underwriters need a hedge against the cost of providing group health insurance," Mr. Montgomery said. Under the old manual rates, a wide profit margin was built into the rates, but since underwriters have gone volume happy, the profit margins are much narrower, he added.

Still, Kemper is averaging 4% to 5% in profits on its group life insurance business, "a quite acceptable profit margin," Mr. Montgomery remarked.

Leon Moskowitz, vp for group insurance marketing at Metropolitan Life, however, downplayed increased use of medical services as a reason for group health policy increases.

"Inflation has had an impact on group insurance programs. Prices of medical care are up about 10% to 15% over last year." And prices next year won't depend so much on what happens in the health care industry, he said, as on the state of economy as a whole.

"I don't see that the pattern for health costs—and the prices for employe benefits—will severely deviate from general inflationary trends. If the cost of living starts to stabilize, I don't think you will see the continued jump in health costs," Mr. Moskowitz said.

Potential turnaround

Meanwhile, the industry has to look to other influences besides its own for some relief on increased prices, such as Washington, state and local governments and labor wage scales, he suggested.

Several insurers reported a potential turnaround in escalating medical costs. Cost containment measures, including second surgical opinions and peer review boards, they say, have kept medical care costs rising at a rate less than the increase in the Consumer Price Index.

Connecticut General, for example, is initiating a nationwide cost containment program incorporating a second surgical opinion benefit and hospital budget and utilization reviews. A pilot program has been successful in Connecticut and Maryland, the insurer says.

A 10% to 14% increase in medical insurance costs in the last year at Connecticut General reflects increased charges by hospitals and doctors and an erosion of fixed deductible levels, said John Leonard, director of marketing. "It's easier to get above the $100 deductible today and that means a high increase in the number of claims," he explained.

Health insurance costs will continue to rise in 1980 at a rate close to the CPI, Mr. Leonard said, but medical cost inflation is actually being reduced slightly while the cost of everything else is going out of sight.

"Medical costs previously rose at a pace four to five points higher than the Consumer Price Index. Now it's just below the CPI," he said.

Premiums for disability income and life insurance should remain stable as they have in the last year, Mr. Leonard noted, predicting inflation will only slightly affect rates.

Self-insurance and high deductible plans are employers' strongest counterpunch to inflation, the insurers said. To prevent all the premium dollars from slipping away, most of the insurers contacted by *Business Insurance* reported stepped-up sales of administrative service only contracts and new benefit products, including vision and dental care, group auto and group legal plans.

Although traditionally viewed as best used by large corporations for funding health insurance, self-insurance plans and insured flexible funding arrangements are also attracting smaller employers. Brokers are touting the concept and insurers are trying to meet self-funders halfway.

In 1980, for example, Unionmutual plans to introduce a split-funded approach for long term disability insurance. It will mix self-insurance and indemnification based on duration of the claim: The insurers will indemnify the first few years of coverage and the employer will pay the rest.

Self-insurance

Provident Life & Accident Insurance Co. now has nearly 40% of its business in "premium equivalent" or minimum plans, said Ted Dunn, vp-actuarial and underwriting. The percentage is expected to increase to 70% in the next two or three years, he says.

"It's both good and bad for the insurer," he explained. "It takes away the risk of loss, but our experience has been good. Its advantage to the policyholder is that it reduces cost because it eliminates state premium tax in almost all jurisdictions."

The brokers who often negotiate on behalf of employers in establishing coinsurance plans report booming self-funding aided and abetted by the insurers.

"Insurance companies are changing their attitudes, becoming more pliable," observes Mansford Barnes, vp-employe benefits for Bayly, Martin & Fay in Los Angeles. "For imaginative brokers and consultants," he adds, "that means more business for them and lower costs for their clients."

Tough competition in the industry has forced insurers into more flexible contracts, says Mr. Barnes, creating a special role for sophisticated brokers and buyers who demand maximum value at the lowest cost.

Consumerist forces

The same consumerist forces affect the brokerage business, too. At BMF, says Mr. Barnes, straight fee compensation on totally insured business is becoming more common. "Some clients prefer to negotiate your fees for you rather than letting you negotiate with insurers," he explains. "Smart buyers are fanatic about controlling costs.

"Nearly 45% of our employe benefits billing is already on a fee basis," Mr. Barnes reveals, "a sure sign of the gaining strength of self-insurance."

BMF was a pioneer in the self-funding area, writing its first such contract in 1947. Mr. Barnes predicts that within the next five years well more than half his firm's business will be consulting and designing self-insured contracts.

Many clients are close to self-insurance already, says Mr. Barnes, since the larger underwriters like Prudential, Aetna and John Hancock are offering alternate methods of funding group insurance contracts. These underwriting giants, although slow to do so, now will release reserves to the policyholder, grant premium delays or require minimum premiums with a retrospective agreement. "It doesn't take the client long to figure he can pick up another 2% to 4% by self-insuring," Mr. Barnes says.

Special products

Brokers Fred S. James & Co., Arthur J. Gallagher & Co., Corroon & Black Benefits Inc., Albert M. Bender & Co. and others all reported dramatic increases in self-insuring of benefits that will continue into 1980.

In addition, both brokers and insurers reported increasing interest in special products, even though employers are very cost conscious.

In Texas, for example, the Carter administration's voluntary wage guidelines have severely inhibited the growth of employe benefits, reports Doug Magee, manager of the employe benefits department of John L. Wortham & Son, a Houston-based brokerage with about $80.3 million premium volume last year. "The petroleum industry sets the pace here," he says, "and is adhering pretty strictly to Carter's restrictions."

When constraints loosen, however, Mr. Magee looks for a strong move by medium and large employers to add dental plans. "That's pretty new to Texas," he says, "and perhaps throughout the South."

Mr. Magee also sees some activity in the group legal market. Recently, he observes, the Texas state bar association adopted an excellent plan modeled on a health maintenance organization concept.

Union demands

"We've done some marketing of group legal in medium-sized professional companies," Mr. Magee noted.

Union demands are expected to push vision, group legal, group auto and group homeowners plans, insurers say, "but such a benefit program would have to be won by one of the nation's major labor unions in a contract before there's widespread acceptance of these plans," observed Jae L. Wittlich, vp of group sales and underwriting at CNA.

Dental plans, he said, echoing the consensus of brokers and insurers, are one of the hottest benefits around and are expected to continue to boom in 1980.

Though highly competitive, dental plan prices may increase slightly, as insurers rerate the plans to match loss experience and take lumps from a lack of cost containment moves in the dental ring.

Underpriced dental

Kemper's dental insurance program, for example, started three and one-half years ago, grew 100% each year and so far this year has leaped 60% to 70% more than last year. Despite this tremendous growth, Kemper is planning to "tighten up a little bit in the 1980s" to restructure the plan, says its group underwriting manager.

"When Kemper, as well as other companies, entered the dental insurance market to make its benefit packages more competitive, lack of statistical information made it impossible to price the product correctly," said Mr. Michael C. Love, group underwriting manager. As a result, many companies, including Kemper, underpriced the product. Mr. Love admits Kemper underrated its dental program by about 12% to 15%.

Several additional factors have also made dental insurance a difficult product to price, Mr. Love said. "The lack of statistical information obviously posed problems. And insurance companies had not prepared for the intense utilization



Health plan premium hikes will track increases in the CPI, says John Leonard of Connecticut General.

of plans in their first year in operation and employers, employes and insurance companies were not prepared to deal with a medical person so different from the physician—the dentist," he joked.

New to the world of prepaid dental, dentists resisted the insurance company's need for complete information before a claim could be paid. "Also, dentists have absolutely no conception of what cost containment is," Mr. Love said. "They think nothing of encouraging the employe to opt for gold fillings rather than the cheaper and just as effective platinum fillings.

"Another problem is that claims people were very unfamiliar with dental terminology and claims took longer to process." ■

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dates for buyers

JAN. 22-25. The Colorado Committee on Hazardous Materials Safety and the Nashville Hazardous Risk Advisory Committee are sponsoring a seminar on **hazardous materials** to be held in Nashville. The seminar will cover new techniques in hazardous material safety, and demonstrate various techniques of transporting hazardous material by air and waterways. Cost is $75. Contact Darrel J. Behrendsen, chairman of the training unit, Colorado Committee on Hazardous Materials Safety, P.O. Box 22533, Welshire Station, Denver, Colo. 80222; phone 303-575-5722.

JAN. 22-23. Captive Insurance: The Decisions for 1980 is the name of a seminar to be held in Los Angeles sponsored by AMR International Inc. The seminar will discuss how to analyze the **financial strength of a captive,** what can be expected from the Internal Revenue Service this year, offshore investment strategy and how outside underwriting profits can be achieved. Cost is $595. Contact AMR International Inc., Advanced Management Research, 1370 Avenue of the Americas, New York, N.Y. 10019; phone 212-974-0800.

JAN. 28-31. A University of Dallas seminar on financial costing in **risk management** will be held on the campus. The impact and timing of risk management accounting decisions, the accounting needs of risk management, budgeting, self-insurance, FAS No. 5 and the new requirements for replacement cost disclosures are just some of the topics to be covered. Cost is $345 for RIMS deputy members and $375 for others. Contact the University of Dallas, Professor Bruce Evans, executive director, The Risk Management Institute, Irving, Tex. 75061; phone 214-438-1123, ext. 360, or 214-438-5765 for seminar assistance. ■

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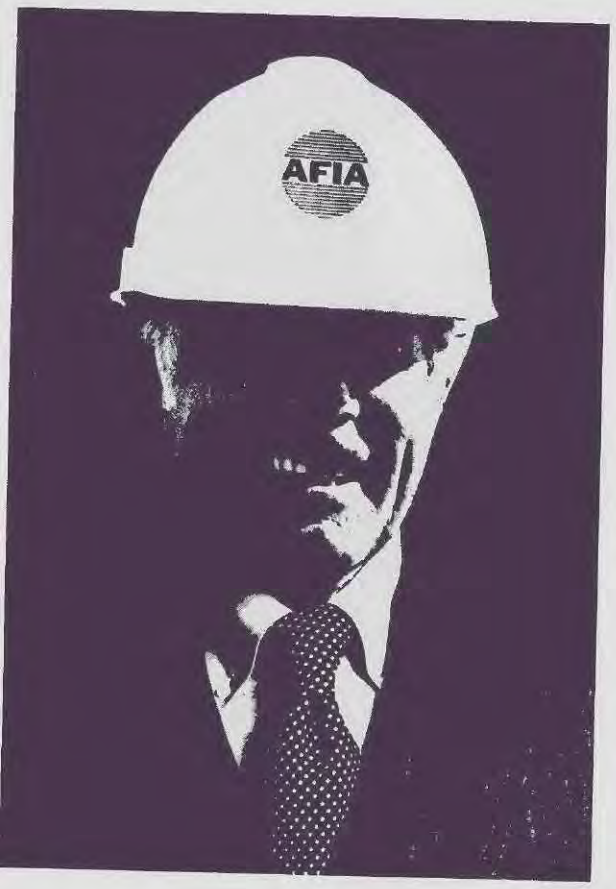
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