

# Employee Benefits: Special Report

## HMO bandwagon

The HMO bandwagon is rolling again, pushed by renewed government support and new interest by business. In a series of stories beginning on page 13 and continuing on pages 50 to 58, associate editor Kathryn McIntyre Roberts and correspondent Margaret LeRoux investigate the new effort (13), report how corporations are responding and the cost of HMOs and other health plans (13), profile the granddad of HMOs (50) and describe a conflict in federal legislation (52).

## Benefit management

More and more companies are making benefit management part of the personnel function, associate editor Ellis Simon found after talking with benefit managers and consultants. Page 13. Many members of our Benefit Board oppose mixing risk management and benefits. Page 31.

## Washington report

Government action and federal legislation play an ever increasing role in employee benefits. Washington editor Jerry Geisel discovered a bewildering array of groups competing for influence on employee benefits. Page 13. And he has put together some hard figures on what benefits are costing employers. Page 37. Another Washington story reports that national health insurance is stalled while Carter ponders what to do (18).

## Updates

In a new feature, in this issue, *Business Insurance* editors have gone back to check up on stories in last year's employee benefits issue. The reports include second looks at a minority reinsurance plan (20), health screening (22), TRESOPs (23), the Blue Cross discount (24), 501(c)(9) trusts and prepaid legal insurance (42).

## Other benefit stories

- **BENEFIT BOARD** gives consultants mostly good grades, but finds the price high. Page 16.
- **EXECUTIVES STORM** public forums to fight increasing medical costs. Page 27.
- **JOB SECURITY** will be a key issue in union negotiations next year. Page 39.
- **BROKER** paves the way in mental health care with a low cost program. Page 59.

## Elsewhere:

- **AMA** panel calls for new price consciousness in medical treatment. Page 2.
- **WE'VE TRACED** further inflated product liability claims. Page 4.
- **THE DEADLINE** nears for *Business Insurance's* Risk Manager of the Year award. Page 74.
- **BOATING INDUSTRY** Assn. parts the waves and paves the way on product liability. Page 68.

## Clients demand broker reporting

By JOANNE GAMLIN

LOS ANGELES—"I would sue my broker if he didn't report a claim of my company."

That's the view of Bruce Gibson, insurance manager at Arcata National in Menlo Park, Calif. His comment was typical of a large majority of California risk managers asked whether a broker has an obligation to report pending claims to an underwriter about to provide coverage and whether a broker should report partial quotes to a client when arranging coverage.

Those two issues were at the heart of a recent lawsuit brought by Mattel Inc. against Marsh &

McLennan. Present and past executives of M&M's Los Angeles office testified that they did not believe it was their obligation to tell insurance companies of a pending claim against Mattel and that they did not communicate partial renewal quotes to clients.

The lawsuit by Mattel ended in late October in a compromise settlement. Mattel is expected to reveal the total amount of the settlement in a filing with the SEC this month.

Risk and insurance managers interviewed by *Business Insurance* generally came down hard against the positions taken by Marsh & McLennan.

The responsibility for disclosing "bad news" to an oncoming carrier, Mr. Gibson said, lies unequivocally with the broker.

If it doesn't, "what is the purpose of a broker's claims department?" he asked.

Pointing out that his one-man operation does not allow the time to deal with an insurer, he said that risk managers traditionally have not been allowed to negotiate contracts with insurers.

A risk manager would be in a pretty tight spot if he could not trust his broker to keep the insurer informed about claims information, he said.

However, Mr. Gibson adopted a more lenient stance on the question of whether a broker has a duty to disclose partial quotes. Partial quotes are often "not very helpful," he argued, explaining:

"I will call my broker if we are 30 days or less to expiration and still without assured coverage."

Brokers are not always at fault, he continued, if an expiration date draws dangerously close without the risk manager knowing if he will even have renewal coverage, much less its cost.

The insurance market itself is often to blame for tardy quotes, he believes.

"Insurance companies, including some of the biggest names, are damn bad at getting them

*Continued on page 72*

# business insurance

Week of December 12, 1977

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

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## Work comp costs climb; self-insuring, pools grow

By JERRY GEISEL

WASHINGTON—While product liability and medical malpractice attracted most of the insurance headlines over the past several years, employers have faced a continuing escalation in workers compensation costs.

Major improvement in benefits in state workers compensation programs have increased costs twice as fast as the increase in the general cost of living.

Employers spent \$8.9 billion in 1975, the last year information is available, to insure or self-insure their workers compensation programs, according to the U.S. Department of Health, Education and Welfare. That's up by \$1 billion or 12% from the year before.

In some states, the surge in benefit improvements has been far more dramatic. In Alaska, for example, a worker injured in 1970 received a maximum of \$82.55 in weekly workers compensation benefits. Seven years later, the weekly benefit level had shot up to \$551.86, a 569% increase.

And costs could increase much more under legislation introduced in the U.S. House of Representatives by Rep. Joseph Gaydos (D-Penn.). Rep. Gaydos has proposed that four years after his bill is enacted into law, minimum weekly benefits would have to be at least 200% of the statewide average wage. Currently, only the District of Columbia has a 200% average wage minimum though

benefits in Alaska, Iowa and Maine are slated to climb that high by 1981.

Sen. Harrison A. Williams (D-N.J.) also is expected to introduce a similar bill establishing national minimum standards early next year. While his aides decline to predict if the bill will reach the Senate floor, they believe the measure will clear the Human Resources Committee—something that has never happened before.

While the drive for national minimum standards will be an

uphill battle due to the united opposition of the insurance industry, the real action in workers compensation has been at the state level.

South Carolina, South Dakota and Vermont have passed legislation increasing maximum weekly benefits to 100% of the average weekly wage. South Carolina's and Vermont's benefit increases took effect this year, while South Dakota's hike to 100% will occur July 1, 1979.

In Iowa, the period for receiving compensation for the partial

*Continued on page 69*

## Riddell helmet cleared; other lawsuits to fade?

By KATHRYN McINTYRE ROBERTS

PHOENIX—Riddell Inc., the nation's leading manufacturer of football helmets, successfully defended a \$2.5 million product liability lawsuit here in Arizona superior court.

During the six-week trial that ended Nov. 9, Riddell fought with the determination of a team up against bad odds. The company produced a wealth of information on football helmets and head injuries that Riddell's attorney predicts will benefit not only Riddell in future lawsuits but also the helmet industry.

"I'm convinced Riddell will win its next case with this extensive information," said Phoenix attorney Richard Black. Two suits are pending against Riddell in Illinois and "more than we'd like" are pending elsewhere, said a spokesman for Riddell's parent company, Wynn's International Inc.

Moreover, evidence presented by the defense during the trial, including the results of tests conducted on the helmet and expert testimony, "jelled thinking in the helmet industry about what helmets should and should not be able to do," Mr. Black said.

The helmet industry has been one of the most visible targets of

*Continued on page 70*

The people column  
page 78

# Raise price consciousness, control health costs, suggests AMA panel

CHICAGO—Employers should offer their employees a number of health care choices, providing the same company contribution for all options, urges a panel of health care experts formed by the American Medical Assn.

The panel of 27 individuals, representing doctors, hospitals, insurers, unions and corporations, says the best hope for controlling medical costs is by strengthening price consciousness in the medical system.

The panel opposes new government regulations to control health care costs, arguing government regulation is inefficient and costly. However, it admits the health care system cannot operate completely free of regulation.

AMA executive vp James H. Sammons called the report "controversial" and said many of the panel's suggestions differed with positions held by the AMA. "I want to emphasize that the commission has been, and is, an entity unto itself," he said. "The report at this point is just that: the report of the commission."

The panel urges employers to offer new employees a choice of health care programs and to give current employees periodic opportunities to switch from one system to another. Employers should provide the same company contribution for all options, thus encouraging employees to use the least costly, the panel says.

Employees should also share in health care costs at the time services are delivered through deductibles and coinsurance payments, the panel recommends. Out-of-pocket expenses must be balanced to provide incentives for price consciousness without deterring access to preventive care, it warns.

The current tax exemption for employer contributions for health care costs should be replaced with a flat dollar tax credit or deduction, the panel suggests.

The panel says health maintenance organizations have shown an ability to inject price consciousness into the health care system and urges a neutral public policy between HMOs and fee-for-service arrangements. However, the panel says HMOs cannot be expected to solve the health care cost spiral in the short-term because HMOs require large scale restructuring of the health care delivery system.

Two alternatives to encourage cost control are suggested, health care alliances and variable cost insurance, which would experience-rate groups of physicians and hospitals.

A main thrust of the commission's recommendations involves making available more information on fees and services. Regional directories of physicians and fees and more cost informa-

tion for employees from employers and insurers are proposed. Continued state regulation of insurance companies and other health care plans is supported.

While rejecting mandatory federal cost control programs, the commission suggests voluntary cost control efforts by providers, consumers and third-party payers. These should include prospective reimbursement arrangements and payment restrictions imposed by third-party payers on providers.

The panel says, however, that increased federal regulation is needed to increase the consumer's role in medical decision making—a role that is needed if price consciousness is to be strengthened.

The panel supports current health care planning and certificate of need (CON) programs, even suggesting that the CON program be extended to doctors' offices if it proves to be cost effective. Also encouraged by the panel are development of regional centers for high-cost, specialized technologies.

But the commission specifically opposes the Carter Administration's proposed cost ceiling on hospitals. And it ignores national health insurance proposals.

Doctors and hospitals should arrange to share diagnostic tests to reduce costs, strengthen disciplinary measures to weed out unqualified physicians, encourage the use of para-professionals and investigate ways to resolve medical malpractice disputes outside the legal system.

But the panel has little enthusiasm for second opinion surgery programs though it does seem more in favor of continued experimentation with multiphasic health screening. ■

## for your information...

### Congressman throws support behind self-insured reserve tax deduction

WASHINGTON—Rep. John LaFlace at a House committee meeting threw his support last month to tax breaks for companies that self-insure their product liability risks.

Companies would receive the same tax deductions for reserves set aside for product liability losses that they now receive for premiums paid to purchase insurance.

However, the New York Democrat rejected direct federal insurance or reinsurance to solve the product liability problem.

Meanwhile, administration officials said they are preparing an "option paper" outlining appropriate federal action on product liability. The report should be completed early next year.

### Pregnant women must keep seniority

WASHINGTON—The U.S. Supreme Court ruled unanimously this month that employers may not deny seniority rights to women who have taken maternity leave. The court said pregnant women may not be denied seniority if a company allows seniority to continue for other types of leave.

Denying seniority to women on pregnancy leave would violate the 1964 Civil Rights Act, the court said. However, the court reaffirmed last year's ruling that employers did not have to provide medical or disability benefits to pregnant women.

### Property/casualty underwriting profit

NEW YORK—The nation's property and casualty insurance companies achieved an underwriting profit of \$355 million in the first nine months of 1977, according to an estimate from the Insurance Information Institute.

The Institute estimated a statutory underwriting profit of \$867 million, which was reduced by \$512 million in policyholder dividends. The industry reported an underwriting loss of more than \$2.2 billion during the first nine months of 1976. Premiums for the first nine months were estimated at \$47.1 billion, up from \$40.7 billion.

### OSHA to abolish 1,100 regulations

WASHINGTON—Taking their battle against "nit-picking" safety rules one step further, Occupational Safety & Health Administration (OSHA) officials this month targeted for extinction 1,100 safety regulations that have no direct effect on worker safety or health.

Some of the rules that will be abolished include guidelines on toilet seat size and specifications for fire extinguisher mounts.

"Thousands of working people suffer serious accidents and illnesses each year, yet to the best of our knowledge none has been caused by the shape of a toilet seat or because a fire extinguisher was two inches too low," said Labor Secretary Ray Marshall.

OSHA intends to refocus its enforcement efforts on serious hazards rather than on "picayune regulations," Mr. Marshall said.

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## errors & omissions

• A typographical error resulted in an incorrect figure in Kenneth Keene's perspective page column on mandatory retirement legislation in the Nov. 28 issue. Inflation has averaged about 6% compounded yearly in the past 10 years, not 8% as the story stated.

• In a Nov. 14 story about risk management consultants' own difficulties in obtaining E&O insurance against lawsuits by clients, First Risk Management Co. in Wyncote, Pa., was incorrectly identified. The firm changed its name last summer from First Insurance Management Co.

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Taking the Risk out of Business

# the benefit beat

## Slow Social Security reforms, Congress urged

**HEWITT ASSOCIATES**, increasingly concerned with the benefit design and financing trends in Social Security, has entered the public arena to urge Congress to move slowly on long term changes in the system. Last month Hewitt expressed those views in an open letter to Congress in the Washington Post, the first time the consulting firm has paid for space in a newspaper.

A year ago the firm put together a group of seven employees with diverse political backgrounds to work on solutions to Social Security problems that would be in the public interest, said chief executive officer Peter Friedas. This fall Hewitt approached members of the House Ways and Means Committee and Senate Finance Committee, urging Congress deal with the short term deficits in the system but reconsider any major changes that could create as many long term problems as the changes solved.

But as Social Security legislation began rushing through Congress this fall it became apparent that effort "wasn't getting us anywhere," said Mr. Friedas. So Hewitt purchased the advertisement and then sent copies to every senator and congressman. "Our hope was that our ideas would match those of a few congressmen and senators and we would be able to influence them to move at a slower pace." So far Hewitt has received 20 responses, some requesting additional information.

**MAX FACTOR & CO.** in Hollywood, Calif., has installed a new, non-contributory dental program emphasizing preventive care. John McKenna, director of compensation and benefits, said the program will pay 100% of the cost of an initial visit to a dentist. The program, however, requires that employees visit a dentist for a checkup every six months if employees are to receive full coverage. Under the incentive system, the insurance covers 60% of the cost of treatment the first year, 70% the second year and 80% the third year. If an employe or dependent fails to visit the dentist every six months, Max Factor will only pay 60% of treatment. The program is underwritten by Metropolitan Life, but McKenna declined to reveal its projected cost.

**THE IRS** is apparently waiving penalties for plan administrators who are filing Form 5500 late, says Hewitt Associates. Some plan administrators are receiving form letters that say the \$10 per day late penalty will be waived if the Form 5500 is filed by Feb. 1, 1978. Hewitt points out that the penalty waiver will not be certain until the IRS issues a press release announcing the new policy.

**PUBLIC SERVICE Electric & Gas Co.**, as part of a major effort to encourage participation in the four HMOs it offers its employees, has prepared a 16-page summary plan description for one of the HMOs. The booklet describes in easy-to-understand language what an HMO is, how it works, what benefits are available, what costs the employe might incur and what rights the employe has under ERISA. The utility's Richard D. Quinn said the booklet is part of an effort that has paid off with 10% to 13% participation in the HMOs, far higher than the participation reported by most other

companies. In addition to the booklet, PSE&G has company officials on four HMO boards, surveys its members who join the HMOs about problems they encounter and holds group meetings to explain the option.

**PREPAID LEGAL** insurance will be available in Indiana from a joint effort of the state bar association and Indiana Blue Cross/Blue Shield. The program will be available to companies with 50 or more employees at a cost of \$5.90 per employe per month. Dependent coverage is included in the \$5.90 fee. Services are divided into four areas—preventive law, civil and criminal defense, marital relations and general legal services such

as bankruptcies and estate planning. Maximum annual benefits are \$265 for preventive services, \$1,500 for defense, \$500 for marital relations and \$500 for general services. Participants may use any lawyer of their choice, but they may not use benefits to begin legal action.

**CUMMINS ENGINE CO.** in Columbus has extended until 1979 its contract with Systems Development Corp. for computer processing of health claims. Cummins first adopted the SDC system for its self-funded health insurance plan in 1973. Cummins processes claims for more than 13,000 employees and 30,000 dependents, said Cummins' Malcolm Heuss.

**DELTA DENTAL PLAN** of South Dakota will administer a dental insurance program for 50,000 American Indians in the Dakotas, Iowa and Nebraska. The program provides 100% coverage for preventive, restorative, periodontic and prosthodontic services on a usual, customary and reasonable fee basis. Previously, Indians had to visit dentists holding individual contracts with the Indian Health Service. The Delta system allows Indians to visit any dentist.

**AMERICANS ARE** not enthused about the federal government taking responsibility for their life insurance and pension needs, according to a survey conducted by the American Council of Life In-

urance. Asked if they wanted the government to assume this function by raising taxes, 40% of the respondents said no and only 26% said yes. Half the respondents said they want private insurance companies to play a major role in fulfilling life and health insurance needs while 15% said they should not.

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## Lawn mower story remains a mystery

## Inflated product liability claim traced to '69

By JERRY GEISEL

WASHINGTON—That legendary product liability case in which a man picked up a lawn mower, was injured and successfully sued the manufacturer continues to be a mystery.

But *Business Insurance* has been able to trace further the use of inflated estimates of the number of product liability claims filed annually.

*Business Insurance*, in an Oct. 31 story, traced the origin of the claim that one million product liability claims are being filed annually to a 1975 speech by T. Lawrence Jones, president of the American Insurance Assn. Mr. Jones said product liability claims

had increased from 500,000 in 1970 "to perhaps a million today."

The author of the Mr. Jones' speech, AIA vp of communications Ronald Krauss, said he obtained the estimate from a presentation several years earlier by Jerry Maatman, vp and director of corporate planning and research at the Kemper Insurance Cos.

Mr. Maatman told *Business Insurance* he had actually put the estimate of the number of product liability claims filed annually at 500,000 based on a published report. Kemper was unable to locate the source before the *BI* story was published.

After the story was published, Mr. Maatman located his source: A March 10, 1969, report by the

Research Institute of America, a New York-based management advisory firm.

The report said, "An estimated 500,000 product liability suits are now filed annually, double the 1963 figure."

The report said annual product liability claims were expected to increase from 50,000 in 1963 to 500,000 in 1969.

When asked how the Research Institute came up with the 500,000 estimate, Mary Jane McKinney, an editor with the firm, said: "I have no idea. It didn't come out of any research we did . . . but came from what we thought was a reliable source."

Ms. McKinney did not disclose

who that source was and added that it would be impossible to find out since so many years have passed since the report was published. The Research Institute no longer uses the 500,000 figure.

Meanwhile, Aetna Life & Casualty Co. has deleted a footnote in an advertisement that read: "Product liability cases alone have increased from 50,000 a year in the 1960s to almost a million now."

Its new footnote, in an ad which otherwise has not been changed, says a 1976 study in California found that the number of personal injury and property damage suits filed in that state is increasing at five times the rate of population growth.

The title of that study, which is

not mentioned in the ad, is "Writing the Liability Balance." The bulk of the funding for the year-long, \$800,000 study came from the California Medical Assn.

The study found that while California population has increased about 1% between 1975 and 1976, the number of personal injury and property damage suits increased about 6%, according to Ed Hamilton, executive director of the California Citizens Commission on Tort Reform, an ad-hoc, 22-member group that directed the study.

But the administrative office of the U.S. courts found that the number of product liability cases filed in federal court in California in the last two years has not increased.

Between June 30, 1975, and June 30, 1976, 133 product liability cases were filed in federal court in California. One hundred thirty-three cases were also filed between June 30, 1976, and June 30, 1977, the administrative office said in its annual report. These figures, of course, do not reflect product liability suits that were filed in California state courts.

Meanwhile, no fresh evidence has turned up to prove that the famous successful product liability lawsuit involving the misuse of a lawn mower ever happened.

Alvin D. Herrington, the Wichita, Kan., attorney who said he read in a newspaper about such a lawsuit, still has not been able to find a copy of the newspaper where the article appeared.

During an earlier interview, Mr. Herrington said he told the lawn mower story to Robert J. Bevenour, executive vp of Nissen Corp. in Cedar Rapids, Iowa.

Mr. Bevenour then retold the story when he testified before the Senate Select Committee on Small Business but said that the suit against the lawn mower firm was successful and that the case occurred in California.

During his first interview with *Business Insurance*, Mr. Herrington said Mr. Bevenour "misunderstood" him. "It sounded like Bob was saying the manufacturer lost. I don't know that. I never said that." But in an interview after the *Business Insurance* Oct. 31 article was published, Mr. Herrington said it was possible that he told Mr. Bevenour that the case occurred in California and that the suit was successful, but he wasn't sure. ■

## Chemical industry forms coalition

NEW YORK—The chemical industry has formed a coalition to assist the Occupational Safety and Health Administration develop rational regulations on carcinogens in the workplace.

The coalition, composed of 34 chemical companies and six companies outside the chemical industry, has objected to OSHA's "unscientific" method of determining carcinogenic risks. Industry spokesmen have also said OSHA isn't giving the industry sufficient time to respond to the proposed regulations.

In response to this complaint, OSHA has moved the hearing on the proposed regulations to April 4, 1978, from March 14. Deadline for submitting material for testimony at the hearing was also extended to Feb. 28, 1978, from Jan. 9. The date for companies to submit requests for attending the hearings was extended from Dec. 8 to Jan. 30, 1978. ■

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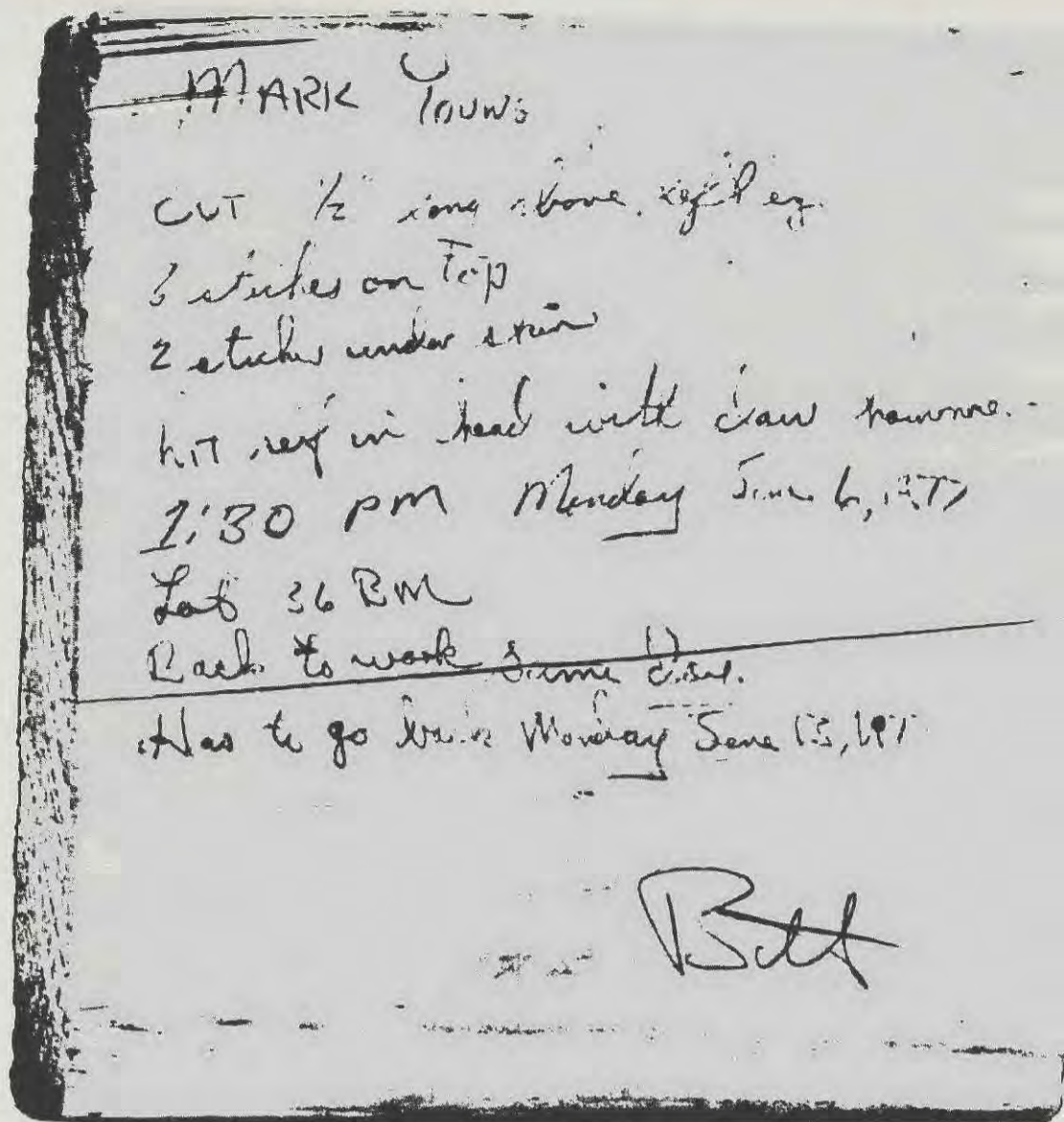
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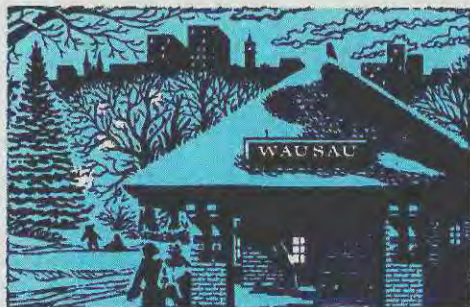
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From the Partnership People

EMPLOYERS INSURANCE OF WAUSAU Wausau Wisconsin

## Total payout between \$70 and \$80 million

# Last DC-10 lawsuit settled but appeals linger

By JOANNE GAMLIN

LOS ANGELES—All of the more than 300 lawsuits stemming from the 1974 crash of a Turkish Airlines DC-10 outside Paris have been settled with an award of \$187,000 to three children of an advertising executive killed in the accident.

However, three of the cases have been taken to the federal appeals court, leaving the door open for further litigation.

"What happens now is in the hands of the 9th Circuit Court of Appeals," said an assistant to federal judge Pierson Hall, who presided over the lawsuits with federal judge Manuel L. Real. The total amount of the set-

tlements has been estimated at \$70 million to \$80 million.

The crash of the DC-10 outside Paris killed 345 persons and was known as the worst disaster in aviation history until the collision this spring of two 747s on the Spanish island of Tenerife. Five hundred seventy-nine persons died in that crash.

The most significant case now being appealed involves a decision by Judge Real that the victims may sue for punitive damages. The decision overturned a California law prohibiting suits for punitive damages in wrongful death cases.

The crash of the DC-10 was caused when a cargo door came

loose, creating a sudden decompression which buckled the floor and rendered the controls unusable. There have been numerous allegations that McDonnell-Douglas, manufacturer of the DC-10, knew of the problem but failed to correct it.

McDonnell-Douglas attorney James FitzSimons said opening briefs will be filed with the 9th Circuit on Dec. 19. Arguments on the appeal may be heard some time in the first half of 1978, he added.

Mr. FitzSimons said the defense is also appealing the 1976 Kween verdict, the first and most publicized award in the long case. A jury awarded \$1.5 million to two children of a couple who

perished in the crash. The parents of the deceased couple also shared in the award.

The third case before the appeals court involves the death of Nancy Kalinsky, 22, of New York, who was living in Europe at the time of her death. A three-day compensatory damage trial yielded a verdict of only \$25,000.

Attorney David Noble who represents the plaintiffs, said he is appealing the compensatory damage verdict on the grounds that the trial was held on a day when his side was not prepared. He also indicated dissatisfaction with the award.

If the 9th Circuit upholds

Judge Real's decision that punitive damages can be sought in wrongful death cases, Mr. Noble said the Kalinsky case will go to trial on the issue of the defendants' liability for the crash.

Marshall Morgan, another plaintiff's attorney in the case, said that one of his cases, the Flannagan case, has also been saved to go to trial if Judge Real is affirmed.

However, Mr. Morgan said that the chances are good that Judge Real will be reversed. "Judge Real has been reversed many times," he observed.

Exact awards in the settlements have been kept secret by the federal court, as has the agreement between McDonnell-Douglas, General Dynamics, Turkish Airlines and the U.S. government on how the award payments will be divided.

As for what the attorneys see as the major lessons of the case, Stuart Speiser, whose firm of Speiser, Krause, Madole handled 164 of the suits, said that the most important fact to emerge from the lawsuits, "is the right of foreign nationals to sue in the United States in a crash that may have no real connection with the United States."

Noting that less than 10% of the plaintiffs were Americans, Mr. FitzSimons said the case pointed out the "international flavor" of the plaintiffs' bar in representing foreign nationals in American courts.

## The Multi-Assumption Projection System.

# If we didn't own ourselves, maybe we wouldn't have created it.

This new Johnson & Higgins system is an advanced pension plan cost forecasting tool that "maps" where your pension costs might be five, ten or even more years down the road. Frankly, it's an eye-popper for many corporations.

The system works via complex computer techniques using a variety of possible scenarios. It's like watching a movie instead of looking at the static snapshot the usual actuarial valuation represents.

One corporation employed the system to help decide investment policy for pension funding. But after the future costs of benefit improvements already scheduled

were revealed, the company's original thinking was immediately modified. A re-evaluation of basic pricing policies followed.

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Consulting Actuaries George Budd [left] and Bob Bein of J&H New York and Russ Millman [center] of J&H Cleveland, review a Multi-Assumption Projection System print-out.



Forecasting today requires more precision than "Guesstimating" or using rules of thumb.

## Social Security knowledge low

WASHINGTON—Despite the steady growth of the Social Security system, surveys by the American Council of Life Insurance have found public knowledgeability of the system to be low.

In 1973 and 1976 surveys, about 50% of the American public said they considered themselves not very well informed or not at all informed about the Social Security system. And although knowledgeability of the system is, as expected, greater among older respondents, only 17% of those age 65 and over considered themselves to be "very well informed" about Social Security in 1976.

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## editorial opinions

# HMOs are an idea whose time has come

EVIDENTLY, corporate managers concerned with employee benefits have at long last dug out of the ERISA trenches and are shifting their attention to other pressing issues in the benefit field. Such as preventive medicine.

At the same time, it's apparent HEW Secretary Califano will do what he can to fertilize the slow but persistent growth of HMOs. He's called 800 corporate representatives to a Feb. 27 meeting to discuss what he clearly considers an important national need. Predictions are he'll ask the business community to lend support (probably in the form of capital) to the HMO movement. (It also looks as if he'll draw a larger audience than anticipated, having already received 1,000 responses to the initial notice.)

As a series of stories in this issue illustrate, there are quite a number of companies taking an initiative on HMOs, either offering HMO enrollment to their employees, looking to establish group practices for their own workers to use, or—as in the case of Ford Motor Co.—embarking on extensive feasibility studies to find out if employers can spearhead development of HMOs.

Health maintenance organizations are nothing new, but

### DUNAGIN'S PEOPLE



they're now being viewed as vehicles to help bring more competition and perhaps some logic to the health care delivery system. If nothing else, those who use medical services are beginning to ask questions about the exorbitant cost of medical treatment and to think about better ways of delivering care to patients.

Cartoon: Field Newspaper Syndicate

erating care to patients.

Some doctors and hospitals will continue to fight HMOs, trying to protect for themselves the virtual corner they've had on the market for so long. But HMOs involve an idea whose time has come, despite the years of ups and downs for supporters of the concept.

Employers are wisely involving themselves in the activity surrounding HMOs. They can be most valuable in assuring that the HMOs established in their communities are financially sound, efficiently run and workable additions to the health care system.

There was a time when HMOs were suspiciously viewed as the first step on the road to national health insurance, a euphemism for socialized medicine. Since the burden of soaring health care costs falls heavily on employers providing medical benefits, HMOs suddenly seem much more attractive.

The idea of using efficient, centralized clinics to provide medical services paid for in advance isn't simply a foray into socialized medicine. HMOs are being given the chance they need to develop into a practical method of delivering better care to more people at a lower cost over the long haul.

## How much to retain?

HOW CAN A COMPANY determine what it can "afford" to self-insure?

That's a question we are often asked and we often hear asked of brokers and consultants. There have, of course, been various yardsticks used, including percentages of net worth, for example.

But we recently heard a new variation on the theme of guidelines for risk retention, unrelated to the older rules of thumb, citing the amount of premium discounts available, the "don't-risk-a-lot-for-a-little" rule, or the percentage of sales or net worth.

"Figure that you should retain everything you can, up to the point where the company will feel pain," advised a risk management consultant.

The threshold of financial pain . . . surely a guideline for self-insurance that would encourage companies to take an entirely new look at the losses they could afford to pay out of their own pockets.

## Psychological pain

HYPPOCHONDRIA pays.

In fact, it pays so well, we may soon have a nation of professional hypochondriacs. The Montana supreme court ruled recently that a steelworker who imagined he was still in pain from 1973 workplace injury should receive work comp benefits from the employer's insurer as if the employee were suffering from real pain.

A psychologist and other doctors testified in a case involving Empire Steel Manufacturing Co. of Helena, Mont., and Employers of Wausau, the insurer, that the worker's suffering was psychosomatic and that his psychological problem was worsening. Though the pain was in his mind, they said, it was a result of the work-related injury and was very real to the employee.

The judge in the case said a final lump sum payment to the worker would be appropriate, along with coverage for his psychiatric treatments as reasonable physician services. (The amount was to be determined later.)

## 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 Magazine, 740 N. Rush St., Chicago, Ill. 60611.

### CPCUs

To the editor: You published a letter from Robert G. Walters (Nov. 14) that I believe will generate a flood of reactions from the many responsible risk managers throughout the United States who hold a CPCU designation and/or who may have gained a portion of their education, training and experiences in the agency end of the insurance industry.

His statement that "Finding a risk manager in a health care administrator is about as far fetched as finding one in a CPCU or even worse than that agents" is both unfounded in fact as well as irresponsible.

There are, of course, varying degrees of competency and professionalism evident in the ranks of CPCU agents and risk managers throughout the country. At times it requires a review of someone's published commentary to ascertain his apparent position (or lack thereof) in the scheme of things.

Risk management includes, but should not be limited to "claims management." Claims usually arise from errors in judgment, mistakes, unsafe acts, or the existence of unsafe conditions in the hospital. Claims can be considered as the tail of the malpractice monster and from Mr. Walters' commentary it would seem that he has been working too close to that end of the "monster" animal.

I suggest that the CPCU designation letters in this case might mean "can pass—can you?" Mr. Walters.

Wayne H. Pearson

CPCU/ARM, vp & General Manager, Financial Guardian Insurance Agency, Chicago, Ill.

### National health

To the editor: In response to Jack Love's letter (Nov. 14), even on my most opinionated days I do not automatically assume that a national health plan in the United States will fail, but I do think that there is a strong probability such a plan will create massive political and economic difficulties which won't be easily resolved, not to mention moral problems.

As for plans in countries other  
Continued on page 73

## business insurance

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## N.J. public liability plan eyes reinsurance

By ELLIS SIMON

TRENTON—New Jersey's public entity liability insurance crisis may be eased if measures proposed by the insurance industry and state insurance department are implemented.

Insurance commissioner James J. Sheeran announced this month plans to introduce legislation calling for the formation of a reinsurance facility which would guarantee liability coverage to the state's municipalities, school districts and other public agencies.

At the same time, he gave his support to an industry proposal calling for creation of a market assistance committee composed

of underwriters, agents and brokers, which would also act to place coverage for public entities facing difficulty.

The market assistance committee proposal was presented by American Insurance Assn. regional vp Grover Czech at a public hearing prior to Mr. Sheeran's announcement.

After that hearing, assistant commissioner Herman Hanssler said the commissioner would probably reject the committee proposal and go ahead with plans for implementing a six-month moratorium preventing insurers from canceling public entity liability policies.

However, Mr. Hanssler said a meeting with Gov. Brendan Byrne was held shortly after that at which time the decision was made to support the AIA proposal and seek legislation establishing a reinsurance facility.

Mr. Sheeran had requested moratorium legislation in mid-October after carriers writing coverage for 23 school districts filed requests for higher rates with increases averaging 723.1%.

The moratorium, which would have been retroactive to Oct. 1, would have allowed time for the insurance department to analyze three alternative solutions to the crisis—the reinsurance facility, a state insurance fund and a mutual insurance fund for municipalities.

A bill to establish the insurance fund is also to be introduced when the legislature meets Dec. 15.

If approved, the reinsurance facility would probably be an interim solution to the crisis, Mr. Hanssler said. However, he added that if successful, the reinsurance facility could become permanent.

Although details of the reinsurance proposal are currently being worked out, Mr. Hanssler said the proposal would probably take a form similar to the state's Medical Malpractice Liability Insurance Act which set up the Medical Malpractice Insurance Assn. to cover doctors who cannot find insurance.

Mr. Czech said that with a reinsurance facility, all companies licensed to provide public entity liability coverage would have to accept some of the risks, regardless of whether they are currently participating in the line.

"No matter how you divide up who will pay the losses, you are still paying out the same number of dollars," he explained. "It won't change the cost factor, it will just shift those costs."

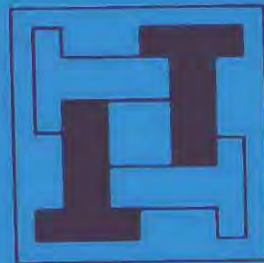
Mr. Czech said the industry would probably prefer a proposal calling for establishment of a state insurance fund under which public entities would contribute between 2% and 5% of their premiums to cover losses above \$250,000. That proposal deals with cost, he explained.

The AIA's market assistance committee will probably be the first dedicated to solving public entity liability problems, Mr. Czech said. The committee would probably take a form similar to market assistance groups set up for product liability.

If the committee is successful, the AIA hopes to convince the insurance commission that a reinsurance facility will not be necessary since availability problems are being handled by the market assistance group, Mr. Czech said.

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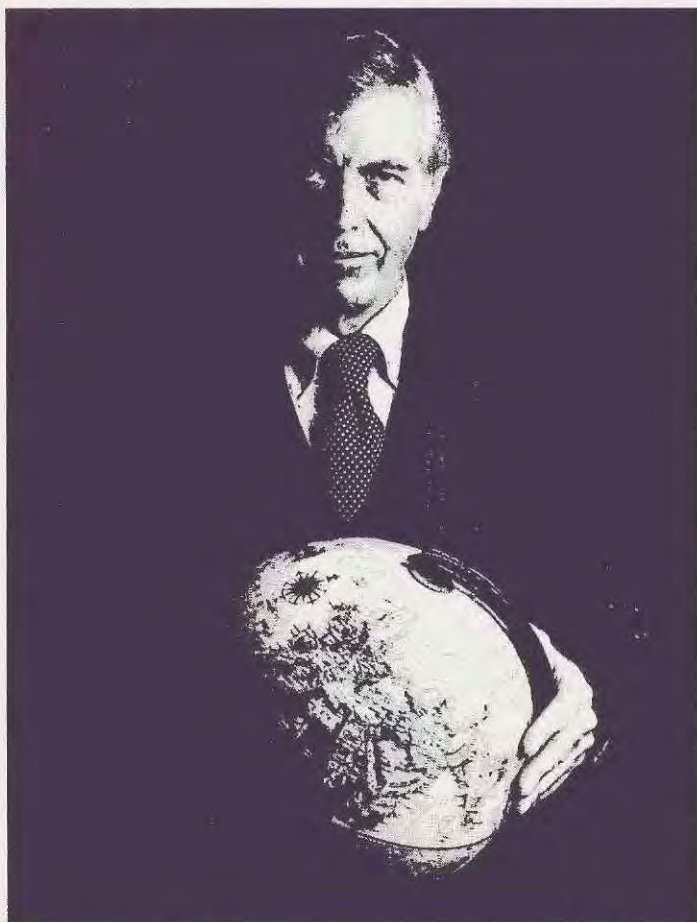
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# Employee Benefits

## HMO bandwagon renews its uphill climb

By KATHRYN McINTYRE ROBERTS

CHICAGO—The HMO movement is flaring up again.

Stoked with new enthusiasm from the federal government, interest expressed by business and power provided by the mandatory dual choice option, the HMO movement is promising it will burn brighter than ever before.

"The HMO's time has come, gone and come again," says Dr. Paul Ellwood Jr., president of Interstudy in Minneapolis and originator of the term health maintenance organization. "Those of us that have stuck with it are convinced it's going to take off," he says with assurance.

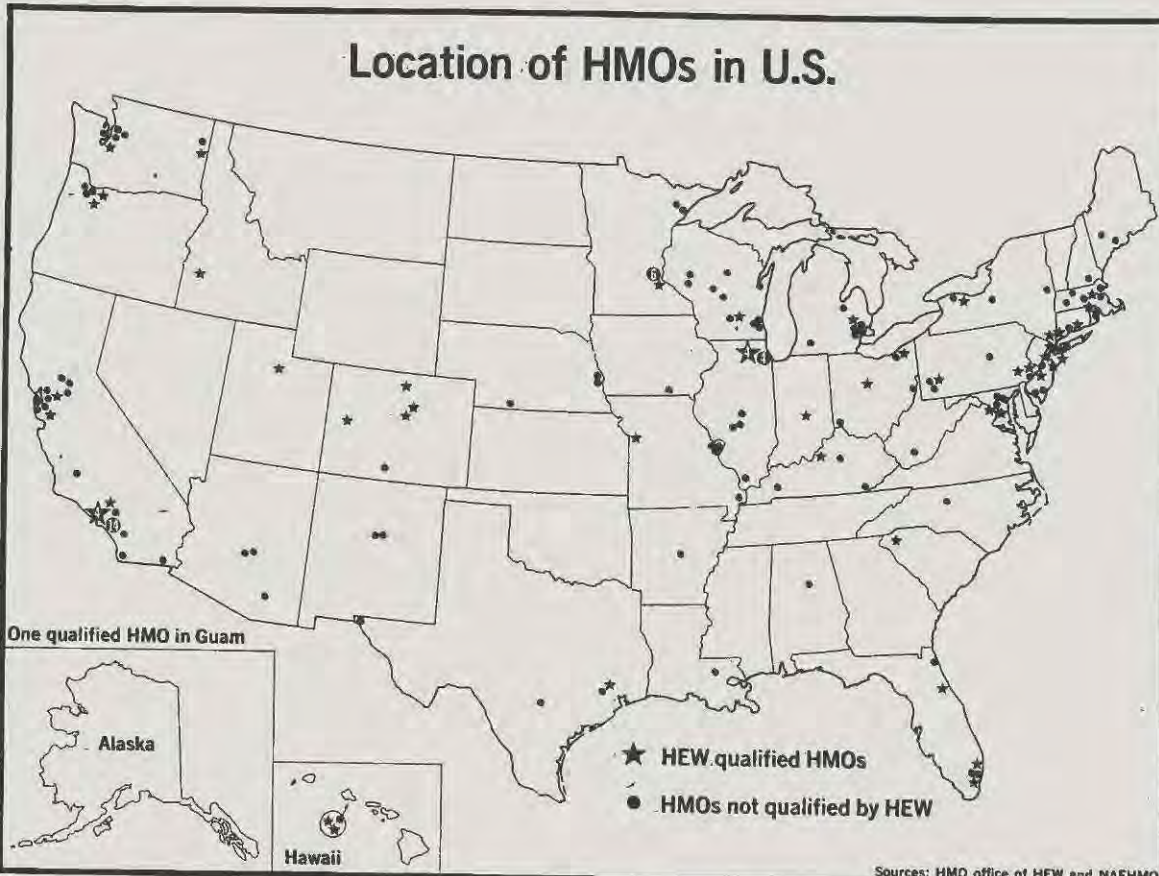
Others recognize that the movement has been ignited again, after smoldering since passage five years ago of federal legislation designed to stimulate HMO development. Not everyone, however, is convinced there's enough fuel to keep the movement going.

"They're jumping on the bandwagon all over again," observes General Motors benefits and policy director Victor Zink. "It didn't go the first time and it won't go anywhere this time just because we're all jumping on it."

His comments aren't to be interpreted as opposition to development of HMOs; his interest is in "keeping some rationality" this time around in assessing the prepaid medical delivery system.

Federal legislation passed in the early '70s was designed to promote the alternative health care delivery system, a system that focuses on preventive care by providing a wide range of benefits for a predetermined fee. Such lofty goals as 450 HMOs operating in 1973 and 1,700 operating in 1976 were set.

But in 1973, there were only 132 HMOs serving 3.6 million persons. And, in July 1977, the date of the last HMO census, there were only 165 operating HMOs serving 6.3 million people—125 group practice HMOs and 40 individual practice associations.



Just 3% of all Americans receive their medical care through a health maintenance organization.

Rekindling the HMO effort, however, are some impressive developments:

- Renewed commitment to the development of HMOs in the Department of Health, Education and Welfare.
- Federal qualification of Kaiser-Permanente Health Plans, the largest and most respected HMO in the country.
- Corporate sponsorship of feasibility studies on developing new HMOs and a surge in interest in offering HMOs and educating employees about the option.
- Invocation of the mandatory dual choice option by the increasing number of federally qualified

HMOs, forcing the hand of corporations once reluctant to offer HMOs.

HEW is moving on several fronts to stir up the embers of a movement it has been mandated to encourage. Secretary Joseph Califano has admitted publicly that much of the blame for languishing development of HMOs can be placed with HEW.

"When we arrived at HEW, the federal government seemed to be doing all it could to make it difficult, if not impossible, to qualify as an HMO," he said recently.

Requirements had become too cumbersome, paperwork was unwieldy and the HMO staff was fragmented and too small, he said. Streamlined qualification procedures, more staff and a reorganized HMO office under the

administration of a director are to change all that, he promised.

The secretary personally signed the papers qualifying Kaiser-Permanente Health Plans, saying, "In many ways, it marks the coming of age of the qualification program." Qualification of the Kaiser plans boosted enrollment in federally qualified HMOs to an impressive 3.8 million people compared with a mere 615,000 before Kaiser joined the fold.

The HEW chief also used the Kaiser announcement to invite representatives of the nation's top 500 industrial corporations to a Feb. 27 meeting on HMOs. The invitation list has been expanded to 800.

Willis B. Goldbeck, director of the Washington Business Group

Continued on page 55

★ ★ ★

## Corporations pull a share of the load

CHICAGO—Employee benefit managers differ on how much additional work there is to offering the HMO option to their employees.

The weight of administration—reviewing HMOs, preparing communication materials, organizing enrollments, providing for payroll deductions and payments to HMOs and listening to complaints from dissatisfied employees—sets heavier on some shoulders than others.

Employee benefit managers interviewed by *Business Insurance*, however, despite the administrative burden, agreed employees should be given a choice of health care delivery systems and prepaid health plans should be given a chance to prove they control costs and keep employees healthy.

"We have 12 separate HMO plans in place and we're looking at requests from an additional 35," said Ford Motor Co.'s Jack K. Shelton. "Our experience has been good with cost and delivery because we've been selective. Our biggest problem is we can't get employees to participate—excluding the Kaiser plans."

On a national average, just 5% of the eligible employees elect an HMO, Mr. Shelton said, with participation ranging from a low of 3% in Detroit to a high of 40% in California.

Mr. Shelton suspects location of facilities, attitudes of the plan providers, the type of benefits offered and the availability of primary care physicians contribute to the low figure.

In Detroit, where participation is low, Mr. Shelton notes the HMO is located in the inner-city.

Continued on page 57

## Benefit lobby: Diverse groups strive for impact

By JERRY GEISEL

WASHINGTON—When hearings were held this spring on a bill that would require firms to cover pregnancy in their benefit plans, the U.S. Chamber of Commerce told a congressional committee that the measure could cost employers \$1.7 billion annually.

"The Chamber's position was a gross exaggeration of the facts," said a key Hill staffer. "They gave a cost estimate that I thought was unsupported. I don't know how to put it more tactfully: They simply were exaggerating to a degree that destroyed their credibility with me."

A loss of credibility means a loss of influence and that is something the bewildering array of interest groups that maintain staffs in Washington to monitor and influence legislation that affects employee benefits try to avoid.

One group that not only has kept its credibility but is viewed by one Hill staffer "as the most effective lobbying interest" in the health legislation field, is the Federation of American Hospitals, which represents about 1,000 for-profit hospitals.



WBGH's Willis Goldbeck can give an up-to-the-minute report on health bills, says one admirer.

The effectiveness of the Federation in influencing the course of legislation is due to its executive director, Michael Bromberg, who has intimate ties to key members of congressional health subcommittees.

Both the Federation and the American Hospital Assn., the other big hospital trade association that represents 6,500 private and public hospitals, are credited with derailing the administration's hospital

Continued on page 14

## Many firms now place benefits in personnel

By ELLIS SIMON

NEW YORK—Employee benefits are being increasingly aligned under the personnel function in the corporate structure, but it is not unusual for the finance department to retain some control.

While benefit managers and management consultants recognize or are part of this movement at large corporations, the shift has not been total.

In many cases, benefit design and administration are personnel functions, funding of benefits has been retained by the treasurer's office and the risk management department has been brought in to handle the purchase of group insurance.

A few corporate benefit managers reported that decisions concerning benefits are made at the joint recommendation of the benefit manager and the risk manager.

That is the case at Polaroid Corp., where employee benefits involve the benefit manager who is in the personnel department and is in charge

Many Benefit Board members oppose mixing benefits and risk management. See our latest survey, page 31.

of administration and employee contact, the insurance manager who handles insured plans and the manager of banking and investment who looks after financial control and investment of funds.

These three administrators sit on the plan management committee and collaborate on benefit design, noted Ralph Law, a corporate international personnel administrator who formerly was benefit manager.

In addition, the executives to whom these administrators report comprise the benefit committee which reviews proposals and acts as fiduciary, he explained.

Similarly, at Eltra Corp., a New York-based conglomerate, the benefit function is split between a benefit manager in Toledo, who is in the industrial relations department and handles design and administration

Continued on page 30

# Benefit lobbying . . .

Continued from preceding page  
cost control ceiling through massive lobbying of congressmen controlling that measure.

Powerful covering fire in the cost control battle also came from the massive (245,000 members) American Medical Assn., which was concerned that placing a ceiling on hospital expenses might be followed by legislation controlling physicians' fees.

Unlike the hospital and medical trade associations, the Washington Business Group on Health does not attempt to influence the course of legislation.

Instead, the three-year-old organization, whose 153 members include the nation's largest corporations, provides an array of policy and legislative analysis services on health-related issues.

Since his arrival, WBGH di-

## Employee Benefits

rector Willis B. Goldbeck has appeared before a plethora of congressional committees and discussed national health insurance as well as the impact of the HMO amendments of 1976 on employers.

"Bill Goldbeck is the guy who can give an up-to-the-minute account of what is going on in the area of health legislation," said one admirer.

But the 90-year-old National Assn. of Manufacturers does try to influence legislation that affects employee benefits. Four key NAM policy groups stay on top of employee benefits legislation: labor relations, occupational safety and health administration, employee benefits and com-

pensation.

During the debate on the pregnancy bill, NAM's task force worked closely with Sen. Orrin Hatch (R-Utah) in developing several amendments to make the measure less costly to employers.

But all but one of the Hatch amendments failed during the debate on the bill on the Senate floor. And like the Chamber of Commerce, NAM also had a credibility problem with Hill staffers when it asked the Congress to give companies more time to comply with the legislation.

"If the NAM had come to us with facts indicating why employers needed more time to change their benefit plans to comply with the legislation, we would have listened," one staffer said.

"But they (NAM) had no facts to back up their request for a delay in compliance. As a result,

we thought it was pretty clear that their tactic was if you can't beat a bill, delay it as long as you can."

While the 14,000-member NAM represents both large and small manufacturers, the Chamber of Commerce's 60,000-membership roster is made up mainly of small and medium-sized companies.

The Chamber's legislative policy committees correspond roughly to the components of the federal government. A separate legislative staff of "generalists" make the determination on what issues the Chamber should devote the bulk of its resources, said Jan Ozga, associate director for health care.

The passage of the Employee Retirement Income Security Act (ERISA) in 1974 with its incredibly complex regulations stimulated the establishment of what have become several influential pension interest groups.

The most influential of the

pension groups is possibly the National Coordinating Council of Multiemployer Plans which represents about 50 trade unions and their multiemployer pension plans.

One pension expert who frequently has clashed with the NCCMP describes the group's effectiveness this way: "They talk to the right people. They get things done fast."

Part of NCCMP success is due to its top-notch professional counsel including legal experts from Arnold and Porter, a prestigious Washington law firm, and tax experts from the Martin Segal Co.

Since it was founded in 1974, the NCCMP has secured a number of class exemptions from prohibited transactions for multi-employer plans.

Another influential group that often finds itself on the same side of the table as the NCCMP is the ERISA Industry Committee (ERIC), representing 80 of the nation's biggest corporations and pension plans that cover about seven million workers.

ERIC's basic thrust is on regulation—trying to ease the difficulties of large companies in complying with ERISA, said legal counsel George Pantos. ERIC, for example, has filed about 40 comments in response to proposed Labor Department regulations.

A group that sometimes finds itself at odds with ERIC and the NCCMP is the Ralph Nader-backed Pension Rights Center whose aim is to get the federal agencies "to act as advocates for employees," said director Karen Ferguson.

"Other pension groups (ERIC) representing employers did an effective job of convincing the agencies to rewrite ERISA to cutback on the new (pension) rights. Obviously, there was a need for an advocate on the other side," Ms. Ferguson said.

Caught between the employer and employee interest groups is the Assn. of Private Pension and Welfare Plans. The APPWP represents about 600 accountants, actuaries, lawyers and contract administrators.

In April, the APPWP, which one Labor Department official calls "the voice of the pension administrator," set the foundation for taking a more active role in the pension world by establishing a policy committee that will be looking into possible changes to ERISA.

The size of an association is often less important than its ties to members of Congress and officials in the regulatory agencies. Steven Schanes, the first director of the PBGC and now head of his own five-person consulting firm, is known around Washington as an effective advocate.

"When Steve Schanes calls Matt Lind (now head of PBGC) or Ian Lanoff, his calls are returned," said one Washington observer.

The two big insurance trade associations in Washington that keep their eye out on employee benefits legislation are the American Council of Life Insurance and the Health Insurance Assn.

While the Council would like to be the voice of the country's life insurance companies, that evidently has not happened yet. Several Hill staffers complained that the insurance companies have failed to unite and often lobby individually.

"One company says one thing. Another company says something different," said a member of a Senate committee. "The result is that our staff becomes very confused."

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## But Benefit Board reports they aren't cheap

# Consultants get mostly good grades

By SUSAN ALT

CHICAGO—Corporate benefit managers purchase a lot of different services from employe benefit consultants, are generally pleased with the consultants' performance and plan to use consultants more in the future.

These were some highlights of *Business Insurance's* latest survey of 70 Employe Benefit Board members, who revealed a wide range of projects they hire outside experts to undertake.

Nearly all of the corporate benefit chiefs responding to the survey said they'd used a consultant at least once (65 out of 70), most often for benefit communications projects, audits or studies of group

health insurance programs and actuarial services for pension plans.

Of the 65 who've used consultants, 61 said they were pleased with what they got in return for the money spent, which many benefit managers commented was considerable. Consultants seldom come cheap, we would conclude from the comments about consulting fees.

The 65 firms that have used consultants have dealt with an average of two firms each. A total of 29 firms were named by the benefit managers as having been used, with Hewitt Associates leading the pack (30 mentions). Other firms frequently named by benefit managers were Towers, Perrin, Forster & Crosby (20), Johnson & Higgins

## Employe Benefits

(13), Alexander & Alexander/Benefacts (10), Marsh & McLennan/William M. Mercer (10), Wyatt Co. (six), Kwasha Lipton (six), A. S. Hansen (five), Martin E. Segal (four) and Bloomquist, Batte & Campbell (three). Other firms were mentioned only once or twice.

Of the eight corporate benefit chiefs who said they weren't entirely happy with the job the consultant did for them, two gave bad marks to Hewitt Associates, two voted negatively on Johnson & Higgins and single comments were volunteered about Bloomquist, Batte & Campbell; Towers, Perrin,

Forster & Crosby; Marsh & McLennan/William M. Mercer, and Kwasha Lipton.

The reasons for displeasure varied, although many seemed to focus on the expense involved in using a consulting firm, as weighted against the quality of the services. Seven comments from corporate benefit managers indicated they didn't think they got their money's worth.

Three comments were specific enough to indicate that benefit managers intending to use consultants had best be very sure of what they want from the consultant:

- "Despite a carefully worded work plan, the consultant went way beyond the scope of the pro-

posal to suggest significant changes in our pension, savings, group life and short-term disability plan."

- "Was overpriced and we had to rewrite all of their copy."

- "Recommendations were made without adequate supporting facts, client is expected to take them at their face value."

Only one benefit chief said he wouldn't use a consultant again, because of the results not measuring up to the costs. All of the other panelists said they would use consultants again.

**Professional qualifications** were the leading factor in the choice of a particular firm said the panelists, pointing out that references were also important as a guide to the kind of work the consulting firm had previously done.

Price played a role in the choice of a benefit consulting firm for nine managers, while another nine followed the recommendations of other corporate benefit administrators. The size of the consulting firm's professional staff influenced seven benefit managers in their choice.

Other benefit managers chose their consultants based on:

- Experience in handling self-funded medical and life insurance plans.

- Flexibility and adaptability.

- Previous friendships with some consultants in the firms.

- Previous use of the firm for actuarial valuations, so they already had the necessary records for a pension design study.

- Proposals submitted by a number of firms, with a comparison of proposals resulting in the choice.

- General reputation.

Even a few of the satisfied benefit managers spoke up when it came to a question about whether the consultants charge reasonable fees. Yes, said 52 of our panelists. No, said 16 panelists. (There were some multiple answers from benefit executives using several consulting firms who might have thought fees charged by one firm used were reasonable, but fees charged by another firm used were too high.)

Nearly all of the benefit managers who had used consultants paid for services provided on a "project" basis. Only 10 managers on the Benefit Board said they'd received quotations of hourly rates, which varied from \$30 an hour up to a high of \$400 an hour, depending on the individual consultant doing the work, his position in the firm and the nature of the work to be performed.

Most of the hourly rates cited were between \$50 and \$125 an hour.

Aside from the group benefit studies consultants commonly do, some projects benefit managers looked to consultants to perform included a study of a medical claim referral service, a study of the impact on benefits of a change in the mandatory retirement law, study of comparative benefits at companies in an industry, a TRESOP study, feasibility study to establish a 501(c)(9) trust, relocation benefit program analysis and evaluation and a study of health maintenance organizations for one company's employees to use. ■

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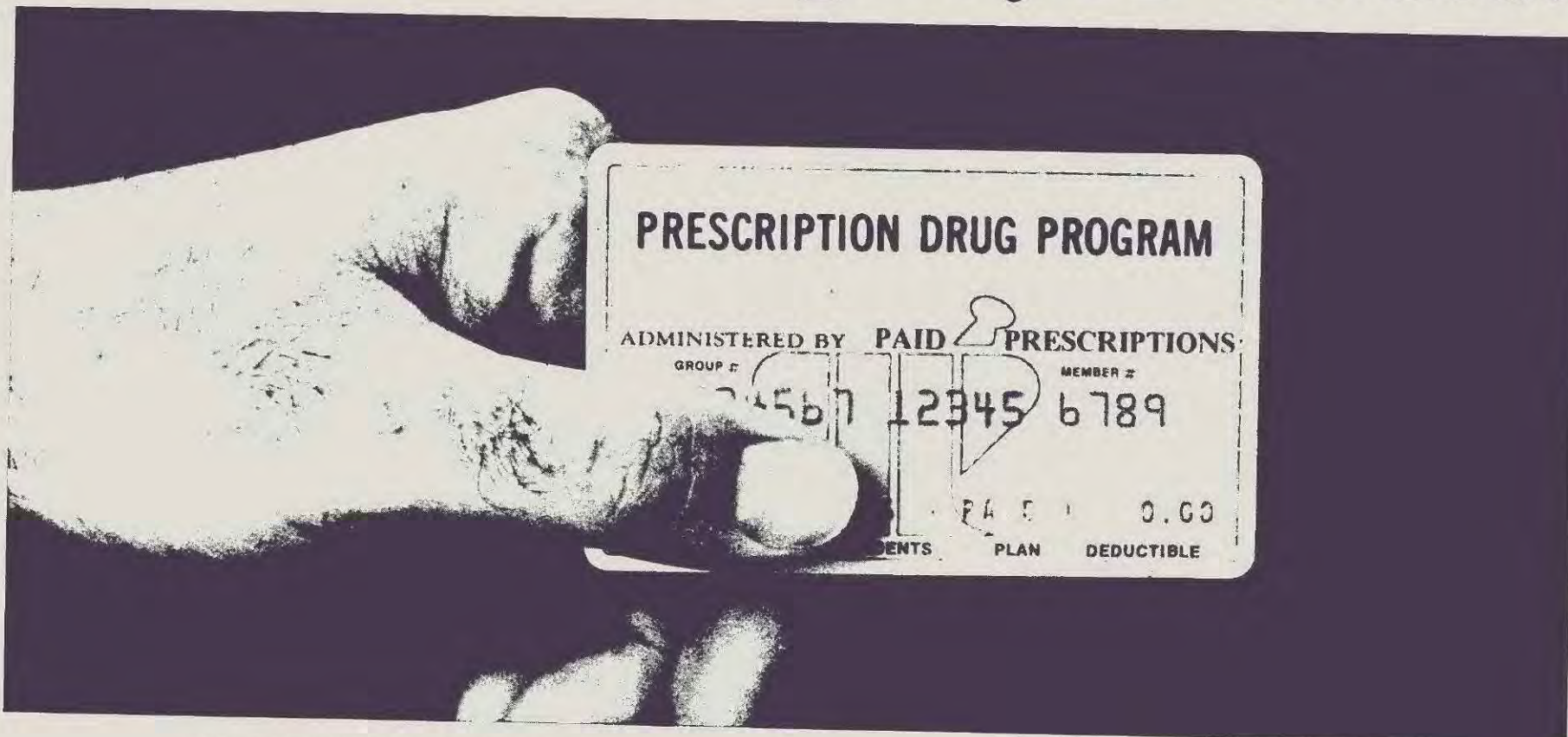
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# National health plan stalls as Carter ponders

WASHINGTON—A shortage of ideas did not impede the drive to establish a national health insurance program this year.

Six key proposals were introduced in Congress with other measures expected to be placed before committees when the second session begins in January.

But there was no follow through on these bills. All failed to even inch their way out of committee. And meaningful progress on the road toward national health insurance is not expected until the Carter administration unveils its own program, said a member of Sen. Edward M. Kennedy's (D-Mass.) health subcommittee.

When Carter's package will come out is anyone's guess. The official position is that the "outlines" of a national health insur-

## Employee Benefits

ance program will be introduced "sometime" next year, said Joe Onek, associate director of the domestic council.

And in testimony before a House subcommittee, Karen Davis, HEW deputy assistant administrator for health planning and evaluation, said it is possible to enact a comprehensive health insurance program over the next four years.

But even within HEW, that prediction is greeted with a considerable skepticism. A senior HEW official working out of undersecretary Hale Champion's office believes a seven-year estimate would be more accurate.

Even if the Carter administration does introduce a complete

Action on national health insurance is unlikely until the Carter administration takes a position, said a staff member of Sen. Edward Kennedy's health committee.



national health insurance program as it has pledged to do, serious consideration of the proposal by Congress is considered unlikely, said a staff member of the Senate Human Resources subcommittee on health.

"With the amount of time Congress is expected to devote to tax reform and energy legislation next year, national health insurance—something many members

of Congress are convinced we don't need—appears to be a pretty low priority item," the staffer said.

One of the forces holding back national health insurance is the failure to get legislation passed that will hold down hospital costs.

In introducing the administration's proposal to impose a 9% ceiling on hospital annual cost in-

creases, HEW Secretary Joseph Califano said a national health insurance program only could be implemented after a leash was put on skyrocketing hospital costs.

Those cost controls measures, however, still are stalled in several congressional committees in the House and Senate. Secretary Califano had expected the legislation to be passed by October.

Without controls firmly in place, a national health insurance program could lead to the runaway costs that have plagued other HEW medical care programs such as Medicare where the costs are roughly double of first estimates.

Furthermore, with a minimum price tag of \$25 billion, a national health program could wreck the administration's pledge to balance the federal budget by 1980, a member of the Senate Finance Committee said.

If and when President Carter does introduce a national health program to the Congress, considerable speculation has developed that the proposal will be similar to one outlined recently by Stanford University professor Alain C. Enthoven. That proposal is being studied by the Office of Management and Budget.

Under the Enthoven proposal, consumers could choose among qualified private health insurance plans or health maintenance organizations. The premium would be paid by a tax credit. A typical tax credit for a middle income family of four would be \$800.

Only plans qualified by the government would be allowed to compete. The credits could only be used to buy coverage, but participation in the plan would not be mandatory.

Tax deductions for employers who contribute to employee health plans would be eliminated and the responsibility for insurance would be left solely with the employee. Similarly, tax deductions by individuals for purchase of health insurance and for health expenses would be ended.

Other health experts believe the administration's first national health insurance plan would provide universal health benefits coverage for mothers and children. Under this proposal, all preventive care for mothers and children would be paid for by the federal government.

That idea already is embodied in legislation introduced by Sen. Jacob Javits (R-N.Y.)

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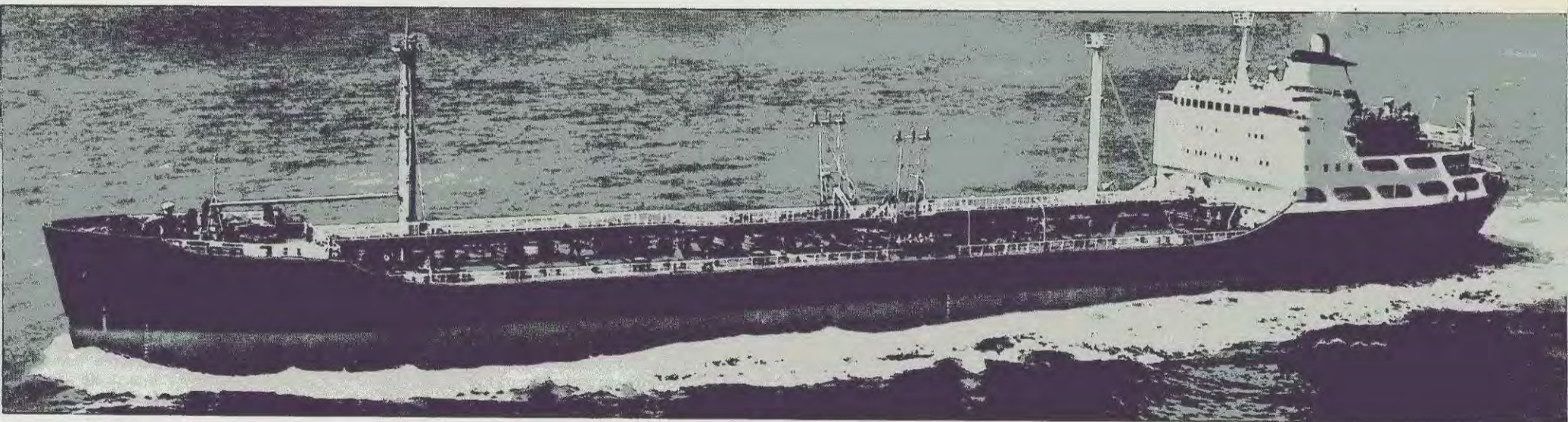
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## Minority reinsurance drive finds slow going

### Employee Benefits Update

CHICAGO—After an impressive beginning, a major effort to increase the group life insurance in force at black-owned life insurance companies encountered slow going.

In last year's employee benefits special issue, *Business Insurance* reported that the U.S. Department of Commerce and the National Insurance Assn. had launched a program to increase by \$5 billion the \$8.5 billion in group life insurance then in force at the 42 black-owned insurers.

The program so far has secured \$1.5 billion, reported executive secretary Charles Davis, with the figure expected to top \$2 billion by the end of 1977.

The grant from the Commerce

Department that is financing the program expires May 31 and Mr. Davis is seeking an extension until the end of 1978. However, J. H. Marks, the Commerce Department official overseeing the program, said he is reluctant to extend the program beyond next summer.

The effort began last fall when then-Commerce Secretary Elliot Richardson wrote the chief executive officers of most of the Fortune 1,000 companies asking them to participate. Representatives of NIA, the trade association of black-owned insurers, followed the letter with personal visits.

Although companies were asked to consider placing part of their group life insurance directly with a minority owned insurer, most of the effort was directed toward asking companies to instruct their primary insurers to reinsure part of the coverage with a black company.

Mr. Marks said there has been "a delay between when a company agrees to designate some of its plan to be reinsured with a black-owned company and when the funds are transferred."

The Commerce Department received several letters from large insurance companies questioning the reinsurance program and suggesting there were better ways to aid minority companies, Mr. Marks continued, but no one suggested an alternative program.

Most of the major insurers contacted by *Business Insurance* last year said they would support the program, but Prudential Insurance Co. questioned whether the black insurers understood the risks involved.

Mr. Davis said many corporations are receptive to the program because it puts the firms in compliance with public policies favoring minority businesses and helps meet internal affirmative action goals.

Mr. Marks said the black-owned insurers had not been aggressive enough in following up Mr. Richardson's letter. These companies had been attempting to get a larger piece of the group life pie for several years without much success, he noted, and the Richardson letter was designed to open doors.

But after about three months the letter lost its impact, he added, "and there's been little action since May."

Another letter, probably signed by Commerce Secretary Juanita Kreps, is expected to be sent to the Fortune 1,000 companies after Christmas, both men said. Ms. Kreps is also expected to make an announcement when the program passes the halfway point next year.

Under the program, reinsurance would first be placed with the six largest black-owned firms, including North Carolina Mutual in Durham and Golden State in Los Angeles. Those companies would then reinsure a portion with the smaller black-owned firms.

That part of the program is working well, Mr. Davis said, although the goal of 50% reinsurance with the smaller firms hasn't yet been reached.

Among the companies designating the largest amounts to be reinsured are General Telephone (\$85 million), Lockheed (\$80 million), Hughes Aircraft (\$62 million) and Bendix (\$50 million), according to Mr. Marks. ■

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## New expertise marks health screening plans

### Employee Benefits Update

CHICAGO—Companies are becoming increasingly sophisticated in health testing, says Willis B. Goldbeck, director of the Washington Business Group on Health.

In last year's employee benefits issue, *Business Insurance* reported that a Washington Business Group on Health survey showed 48 of 101 responding companies maintained multiphasic health testing programs.

Since then, Mr. Goldbeck said, "there's been a decreased romance with annual multiphasic health testing. People don't feel it's worthwhile, though I don't know how you define worthwhile. Plus, there's no real need to test every 28-year-old."

Multiphasic health testing in-

volves the administration of a battery of tests and other preventive medicine examinations.

Mr. Goldbeck observed that companies are developing a "growing appreciation for the need to break down testing needs," for example, into applicable age groups.

**Relating health testing to job function**, particularly in light of Occupational Safety & Health Administration standards, is also emerging, Mr. Goldbeck said. If workplace conditions are believed to have harmed an employee's health, one needs to know what his health was before exposure to determine the damage, he explained. Testing can also measure an employee's susceptibility to conditions, Mr. Goldbeck added.

Though annual testing for everyone seems to be a passing fancy, annual examinations for persons in "high risk groups" is still desired, Mr. Goldbeck said.

Stanley P. deLisser, associate director of Executive Health Examiners in New York City, confirmed Mr. Goldbeck's assertion that the romance with multiphasic health screening has ended. "What counts is evaluation by a physician," Mr. deLisser said, noting multiphasic screening does not necessarily include that.

**Mr. deLisser** advocates a program of primary care services in corporate health programs that includes not only health screening but also counseling and education.

The occupational health services company is now marketing a new program for emotional stress control. After a series of tests, it is possible to develop a profile of an employee showing if there is stress, how much there is and its sources. A stress management plan is developed to help the person understand the stress and to deal with it, Mr. deLisser explained.

A full scale stress management examination runs \$75, he said. So far, 20 companies have contracted for the service in the six months Executive Health Examiners has offered the program.

"In five to 10 years, everyone will be doing it," Mr. deLisser predicted.

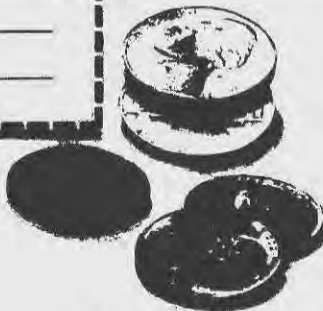
Companies are still primarily interested in cancer and heart disease detection, Mr. deLisser noted. Cardiac stress testing, in which the heart is monitored while at work, with the person running on a treadmill, "is very popular," he said, though expensive, running from \$100 to \$200. ■

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## 1 in 10 face ulcers' torment

WASHINGTON—Ulcers, a by-product of modern living, torment an estimated 1 in 10 Americans sometime during their lives.

Studies reviewed by the Health Insurance Institute show that ulcers are about three times more common among close relatives of afflicted individuals than in the general population. In other words, there appears to be a genetic factor in ulcer proneness.

While ulcers are commonly thought to be caused by emotional conflicts, tensions and stress, no one knows for sure what causes them. ■

# TRESOP binge has only mixed results

NEW YORK—Companies report mixed results from employee stock ownership plans that grew rapidly in the last 18 months after the 1976 tax changes that allowed a tax credit for money put into the plans.

The growing interest in these tax reduction act employee stock ownership plans (TRESOPs) was the subject of a story in last year's *Business Insurance* employee benefits issue.

Most employee benefit managers said company employees liked the stock ownership plans, but noted problems in administration.

Hallmark Cards Inc. encountered so many administrative problems that it discarded its ESOP in favor of profit sharing.

Among its problems, said Al Gurwell, Hallmark's manager of employee benefits, was that it limited the form of payouts to plan participants.

"It was a cumbersome process to make installment payouts for retirements because the trustee had to repurchase stock from employees and then give the employee cash," Mr. Gurwell said.

"We've accomplished the same things with profit sharing that we wanted with the ESOP but now we don't have the technicality with payouts," Mr. Gurwell said.

Most companies, however, reported generally favorable results from the plans, which allow them to claim a tax credit of 1% of their qualified investments when savings are put into the plan.

International Paper Co. solved its administrative difficulties in determining the amount to be distributed by switching the method it used for collecting information on employee earnings.

The New York paper company also encountered problems when the value of its stock dropped precipitously, from \$70 to \$40 a share during 1976, said Kathy McCarthy, coordinator of employee benefits. But the outlook is more "favorable," she said.

Weyerhaeuser Co., a forest products company in Tacoma, Wash., had "no major problems with its ESOP," said Richard B. Spitznass, Weyerhaeuser's manager of employee benefits.

"The biggest single problem" he said, "is finding terminated employees to give them the settlement."

He added that it's extremely

## Employee Benefits Update

well-received by employees and that during its first year in 1975, the company distributed 1.4% of an employee's salary which was increased to 1.9% during the second year of the program.

A decision made last year by Pillsbury Co. not to set up an ESOP hasn't changed, despite the fact that a member of the company's board sponsored ESOP bills in the Minnesota legislature. "Since Pillsbury is not a highly intensive capital company, we didn't find it worth it to get involved in administering the plan," said Michael Holt, Pillsbury's director of compensation and benefits.

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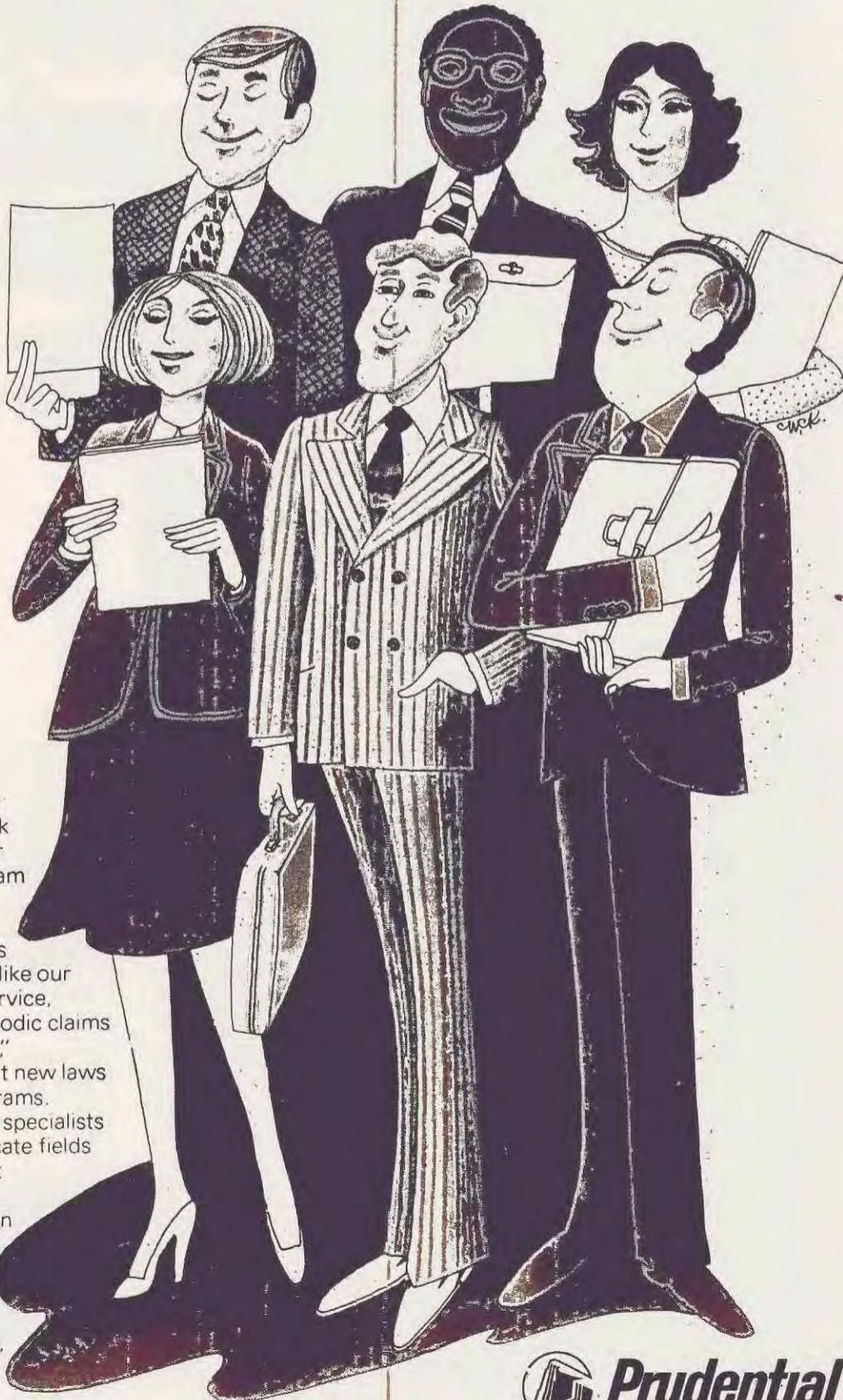
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## Hospital control bills may affect 'discount'

CHICAGO—The hospital cost control bills now before Congress and the state rate review boards that they would encourage offer the best hope for limiting the Blue Cross discount, insurance companies believe.

The discount results in lower hospital charges to patients covered by Blue Cross than to patients with insurance from commercial insurers. A renewed effort to trim the discount was explored in last year's *Business Insurance* employe benefits issue.

Blue Cross reimbursements to hospitals in some areas are governed by contracts based on hospitals' costs. But Blue Cross and government programs refuse to pay their share of a hospital's

### Employe Benefits Update

bad debts and some capital expenditures. Hospitals pay for these costs by increasing charges to patients covered by insurance companies.

New Jersey, Pennsylvania and New York have the largest discounts, said Richard Mellman, a vp at Prudential Insurance Co. and a leading industry spokesman on the discount issue. Some hospitals in New York now charge patients covered by commercial insurance companies \$100 more a day than patients with Blue Cross, he said.

A court suit in New Jersey challenging the discount as unconstitutional failed this year and efforts in that state legislature to control the discount through legislation were also unsuccessful.

But Mr. Mellman also noted that the discount continued to receive widespread attention. A private study by the Government Research Corp. on hospital costs took note of the problem, suggesting that it should be eventually eliminated.

The present system has two major flaws, Mr. Mellman argues. First, "you're not really controlling the rates of hospitals if you are only controlling charges to patients covered by Blue Cross or government programs."

Second, "Why should patients with one type of insurance be charged more than patients covered by another third-party payer?" he asks.

State commissions that can control all hospital charges are the way insurance companies want to attack the discount.

The Carter Administration hospital cost control bill would establish a 9% cap on increases in hospital revenues, Mr. Mellman observed. But those bills would waive the ceiling in states with rate review boards.

Although health insurers will continue to work for state legislation, passage of the Carter administration proposal would be a powerful incentive for such boards.

Mr. Mellman noted that groups such as the Washington Business Group on Health and the U.S. Chamber of Commerce had endorsed the state rate review approach.



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# Executives storm public arena to fight costs

By REBECCA A. FANNIN

NEW YORK—In an effort to help contain hospital costs, several major corporations are encouraging top management to serve on the boards of hospitals, health system agencies and Blue Cross/Blue Shield plans.

While corporate representatives on the boards said they have influence, they denied control of the health groups.

More important than control, they said, is the opportunity their participation allows for long-range planning of hospital facilities, interaction with other concerned community members and participation in making financial decisions about health care.

Corporate representatives denied that they serve for only selfish reasons to help reduce their own employe benefit costs.

The company people just don't make "quick decisions and get quick returns," said Bill Goldbeck, director of the Washington Business Group on Health. "There are several steps between controlling hospital costs and reducing employe benefit costs," he said, adding business has "slight control overall."

But Jacobson Gerold, special projects coordinator for the New York City Health Systems Agency (HSA), disagreed. "They wouldn't serve on the boards if employe benefits weren't costing so much," he said.

Top management, however, has been urged by HSAs to have company officials join their boards,



Ford's Jack Shelton is involved in holding down health care costs as chairman of a Blue Cross/Blue Shield panel.

on HSAs a little bit."

But GM isn't playing a "number's game to gain more representation," Mr. Zink said. "We're not worried about the number who serve because one member who does his homework and is hard working is more effective than a dozen representatives.

"It's just a matter of doing as much as we can. All of us contributed to the situation of high health costs and we're not trying to throw rocks at anyone," he added.

GM now has 150 representatives on health boards, representing an increase from 20 to 25 people last year. Although representatives from four companies, GM, Ford Motor Co., Chrysler Corp. and Goodyear Tire and Rubber Co., said it's difficult to measure their effectiveness, they said they offer financial expertise to their boards.

Ford's Jack Shelton, who chairs the health cost containment committee of Michigan Blue Cross/Blue Shield, said his position as chairman allows him to be a catalyst. "I get the board to produce results, but no one person causes things to happen," said Mr. Shelton, manager of Ford's employe benefits and insurance department.

Perhaps no one is more involved in varied health groups than Martin Otto, manager of personnel, administration and development for the Packard Electric division of GM in Akron. Mr. Otto serves on the boards of the Ohio Medical Indemnity, a local HSA and a local hospital board.

"I think I have a significant impact and that my comments are weighed appropriately," Mr. Otto said.

But the task is difficult. "It's difficult and time-consuming to sit in judgment of requests by hospitals to spend large sums of money," Mr. Otto said.

The financial expertise that corporations offer to the health boards is a "big contribution" in making

tough decisions, said Dick Martin, Goodyear's manager of health services.

Drawing upon his experience as president of an Akron HSA, Mr. Martin noted that his committee has disapproved \$82 million out of a total \$142 million requested for nursing homes and hospitals between August 1974 and February 1977.

Goodyear has representatives on all five Akron hospital boards. Also heavily represented is Chrysler Corp., with approximately 23 members nationally on health groups, some serving for as long as 10 years.

Chrysler's top management makes an "active effort to lobby when health bills are up and to work with hospital boards by mail and phone" even when that board has no Chrysler representation, a spokesman said.

The representatives said they are free to bring individual rather than company opinions to the boards. "We don't tell them how to

vote," said Ford's Mr. Shelton.

But it is sometimes difficult to separate the two views. GM's Mr. Otto said he tries to represent only

his view as a citizen, but that he is naturally influenced by the company and his membership on other boards.

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According to Mr. Goldbeck. Last year, Mr. Goldbeck received only five requests from HSAs for corporate representation. But he's received 125 requests in a six-month period this year.

Corporate representation is becoming more legitimate as those HSAs with company members receive attention from the Department of Health, Education and Welfare and publicity, Mr. Goldbeck said. He noted that HSAs from Akron, Cincinnati, Pittsburgh and Nashville have strong corporate involvement.

Company membership on HSAs, however, is limited. Regulations prescribe 60% representation from consumers and 40% from providers.

Sometimes the companies encounter problems in being labeled a provider rather than a consumer, according to Victor Zink, General Motors' director of employe benefits and services.

If a businessman sits on another health board (such as Blue Cross) beside the HSA he seeks to join, he is labeled a provider instead of a consumer, Mr. Zink said. "This has truncated membership



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## Michigan coalition forms

DETROIT—Private and public groups have formed a coalition in Michigan to deal with common health care problems.

The group, composed of labor, business and government representatives, has drawn up legislation to eliminate excess capacity of hospitals.

The bill has the support of such groups as the state health planning and development agency, the Michigan Department of Public Health, Ford, General Motors, Chrysler, the United Auto Workers, Michigan Blue Cross/Blue Shield and the Michigan Hospital Assn.

The committee is chaired by Jack Shelton, Ford's manager of employe benefits and insurance.

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## Firms report success; 501(c)(9) trusts grow

CHICAGO—Concurrent with continued interest in self-insuring employe benefit programs, 501(c)(9) trusts are becoming more prevalent.

And companies identified in last year's *Business Insurance* employe benefits issue as establishing trusts report their experience has been satisfactory.

A 501(c)(9) trust, (the numbers refer to the section of the Internal Revenue Service code which governs its operation), offers a company a formal funding vehicle for a self-insured program and exempts earnings on money in the trust from taxes.

Robert O'Meara, partner with Hewitt Associates in Deerfield, Ill., said he saw "a lot of activ-

### Employe Benefits Update

ity" in the trust arena this year and expects more in the future.

He cited three basic reasons for establishing a trust: the tax free interest earned on reserves; for plans that entail employe contributions, the accountability afforded by the trust for employe contributions as required by the Employe Retirement Income Security Act, and the withholding tax benefits for the employe.

The contributions made on behalf of employes are not taxable.

Companies maintaining 501(c)(9) trusts say their experience has been only favorable, although more than one noted, wistfully, that the interest earned on reserves could be better.

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"We would always like to see a higher rate of return," said Don Gilmartin, manager of group insurance services at Allied Chemical Corp. in Morristown, N.J. Allied Chemical established a trust in December 1975 to fund its long term disability plan for 10,400 salaried employes.

"So far we're still funding just long term disability through the trust," Mr. Gilmartin said, "but the charter allows the trust to cover all forms of group insurance."

Allied Chemical believes "the trust must be there to accommodate an exposure with a long term payout so that the earnings can accumulate," Mr. Gilmartin explained. "Earnings are the most significant part of a 501(c)(9) trust. The earnings can't be duplicated under a commercial insurance arrangement," he said.

Mercedes-Benz of North America Inc. in Montvale, N.J., though also appreciative of earnings on the money in the trust, cited the security of funding its medical and dental programs for 1,500 employes in a 501(c)(9) trust.

Nita Ballard, manager of employe benefits, said the company realized when it decided to self-insure the benefits in 1976 that "employes would feel more secure knowing it was a funded plan." She also observed, "It's nice to know you are paying so much a month regardless of the claims."

Ms. Ballard, who reports to personnel director Norbert Brandon, noted the company expects to expand the benefit plans funded through the trust.

CPC International Inc. established its 501(c)(9) trust in July 1975 to fund health and long term disability benefits for 5,000 employes. "It was in the best interest of the employes and the company to have a trust because the trust can make money and it is self-sustained," said Carlton Craigwell, senior employe benefits analyst.

But at Xerox, where medical, dental and disability benefits for 50,000 employes are self-funded, a zero balance is maintained in the 501(c)(9) trust. "It's a current investment decision that could change at any time, but the decision was made to keep the money in the business," said employe benefits manager Peter Biggins.

Mr. Biggins observed in a December 1975 *Business Insurance* article that he did not expect a ground swell of interest in 501(c)(9) trusts. "There's been more interest than I thought there'd be," he confessed. ■

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# Benefit placement . . .

Continued from page 13

tion and the director of insurance in New York, who handles financial matters, explained benefit manager Joe Smethen.

However, at companies like Investors Diversified Services of Minneapolis and Foremost-McKesson, a San Francisco-based food processing and pharmaceutical concern, the employe benefit manager handles financing as well as benefit design and administration.

"We do our own costing (of benefits) and then go to the treasury department to see if it's affordable," said William Armstrong, director of compensation, benefits and administration at Foremost-McKesson. Mr. Armstrong reports to the vp-personnel.

While there was a tendency to put benefits into the treasury area because of the insurance negotiations and management of funds, the ERISA requirements for reporting to employes often made the shift to personnel necessary, said management consultant Vernon Keenan of Keenan, Wheeler and Bowman, a Dayton, Ohio, firm.

George H. Foote, a partner in the New York office of McKinsey & Co., added that the importance of integrating benefits with wages has contributed to this movement.

However, because so much of the benefit and compensation function is interdisciplinary and because of the increasing importance of this area, some companies have begun to organize benefits and compensation as a separate division apart from personnel or finance, noted Robert Paul, vice chairman of Martin E. Segal Co.

Typically firms which have "bridged the gap" either designate a senior executive to be in charge of compensation and benefits or appoint a committee to which all persons working in this area report, he explained. So far, about 10 firms have set up separate compensation and benefit departments.

Yet benefit management often remains in the hands of a middle management-level administrator with two or even three people between him and the company's president. In addition his role in decision making on benefits is usually limited to an advisory or participatory one.

A typical chain of command is the one in effect at Ingersoll-Rand, where employe benefit manager Philip Hall reports to the director of compensation, who reports to the vp of personnel, who in turn re-

## Employe Benefits

ports to the president.

At some corporations, such as IDS and G. D. Searle & Co., the Chicago-area pharmaceutical concern, the director of compensation is by-passed. Employe benefits are separate and unique enough to deserve a status higher than a subdivision of compensation, said Bruce A. Peterson, director of employe benefits at IDS.

Regardless of what stature the head of employe benefits is given, "someone has to insure than what's going on in benefits is consistent with cash compensation policy," McKinsey's Mr. Foote said. "If the vp of personnel can do it at his level, there's no need for a director of compensation and benefits."

Mr. Foote added that regardless

of how compensation and benefits relate to each other in the corporate structure, decisions affecting them should be made at a higher level because of their importance to overall corporate performance.

While acknowledging that in some cases benefit managers get involved in policy making, "that's not what it should be," Mr. Foote said. Having the benefit manager involved in decision making lets subjectivity creep into the process.

"The benefit manager should make benefit policy no more than the compensation manager should make compensation policy."

Benefit managers said for the most part that their role in making policy was advisory. "The job is mostly consulting and taking an advisory role on programs," said IDS's Mr. Peterson.

At G. D. Searle & Co., a committee with representatives from the treasury, legal, tax and personnel departments makes benefit deci-

sions. Bruce Mueller, director of employe benefit financing said this team approach provides for a "total view picture" of benefit questions.

Mr. Hall reported that at Ingersoll-Rand most decisions on benefits are made by the vice-chairman of the board, with money management reserved for the president.

Yet, Robert L. Barnes, an actuary with Wyatt & Co. in Chicago, said greater autonomy for benefit managers was needed, particularly in situations where they may be named as fiduciary. "The degree of autonomy reflects the responsibility of the benefit manager," he said. "He must be autonomous where the liability for his actions rests with him."

While it is often limited to purchasing group insurance or deciding on whether to self-insure a benefit, the risk manager still plays a role in the benefit area. Only at IDS was risk management totally divorced from the benefits process.

At Polaroid, Ingersoll-Rand and Eltra, the risk manager's participation went beyond funding.

Ingersoll-Rand's risk manager handles administration of claims and issuance of supplies to branch facilities as well as keeping group policies up to date, Mr. Hall said. "There is a limit to my knowledge of risk management and the risk manager has a limited knowledge of benefits, so two heads are better than one."

And, while Mr. Barnes said that it was possible, in some cases, for the benefit manager to also be the risk manager, he added that he did not think it was necessary for the risk manager to be involved in the funding of group insurance.

In a small company, the risk manager might need to wear several hats, including employe benefits, "but in a large company, the risk manager should be concerned with property and the company's good name," rather than providing benefits, said Mr. Paul.

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SEE OUR AD ON PAGE 3

# Many oppose mixing benefits, risk management

By SUSAN ALT

CHICAGO—One of every three corporate benefit managers opposes mixing the corporate risk management function with employee benefit administration.

The reason: Some benefit managers believe there's no similarity at all between property/casualty insurance management and the tasks involved in planning and funding group benefits, even though group benefit administration often involves purchasing insurance.

This was a key finding of the latest survey of *Business Insurance's* Employee Benefit Board, which drew responses from 70 corporate benefit managers.

Asked what relationship, if any, there should be between the corporate insurance/risk man-

er and the benefit manager, one panelist replied, "Absolutely none. The risk manager should take care of insurance on buildings, etc. The benefit manager should handle all items dealing with employees. The worst benefit managers are those who are (or were) risk managers, because they are too concerned with cost and not concerned enough about the employee relations impact of benefit plans."

Although there's still a large number of benefit managers who would keep benefits and corporate insurance/risk management completely apart, the majority (75%) favor at least some communication and cooperation. They won't always go so far as to say there should be a "close working relationship" or that the two

## Employee Benefits

areas go "hand-in-hand," but most benefit managers do see the need for a consulting relationship between the two departments with a spirit of cooperation and open communication.

For companies under \$1 billion in assets, responsibility for employee benefits, group insurance, risk management and property/liability insurance should reside in the same person, suggested a half-dozen members of the Benefit Board.

Although nearly half of the Benefit Board members believe there should be close communications between benefits and risk management, benefit managers tend to see the benefit function as part of the personnel or indus-

trial relations department in the corporate structure, rather than part of the finance department where risk managers place the risk management operation.

As a consequence, the ideal placement of the benefit department is neither immediately alongside nor under the corporate risk manager, said benefit chiefs. In expressing this general view, they disagree with risk managers.

In Editorial Advisory Panel findings published earlier this year (*BI*, April 4), 59% of the risk managers said they thought responsibility for benefits belonged with the corporate risk manager. But only one-third of the risk manager panelists said they presently had responsibility for benefits and group insurance.

Benefit Board members responding to the sixth benefit sur-

vey of this year revealed they report to a wide variety of corporate officials, including director or vp of personnel (21), director of compensation and benefits (14), vp or director of employee relations (8), vp or director of industrial relations (8), vp or manager of employee benefits (4) and vp of administration (4). The rest report to the chairman, president, vp of finance, treasurer, vp of legal affairs or vp of insurance.

Ideally, benefit managers should report to the vp of personnel (28), director of compensation and benefits (7), director of industrial relations or employee relations (12), chief financial officer (6), vp of human resources (5) and vp of administration (4), said the Benefit Board.

Forty out of the 70 benefit managers responding now report to the corporate officer they think is the ideal person.

To those who would contend that the ideal reporting relationship within the corporate hierarchy is something other than the present one, a frustrated benefit manager for a major service conglomerate responds: "The benefit manager should report to a senior vp or executive vp not identified with a particular function such as personnel or finance. I have reported to the vps of personnel, finance and legal affairs at three Fortune 500-type companies over the last 10 years.

"In personnel, I fought people who wanted to give away the store; in finance, people who wanted to institute controls that would make certain no benefits were ever paid; in the law department, people who wanted virtually every communication with employees reviewed by outside counsel before release."

For those who would isolate benefits from insurance and finance, one panelist offered this arrangement: "The industrial relations department determines the insurance type of benefit plans and level of benefits to be provided. These plans are then arranged and administered by the finance organization."

If it's possible for a corporate benefit manager to come to the job with a specialist's knowledge in a half-dozen different fields, that person would be the ideal candidate for benefit chief.

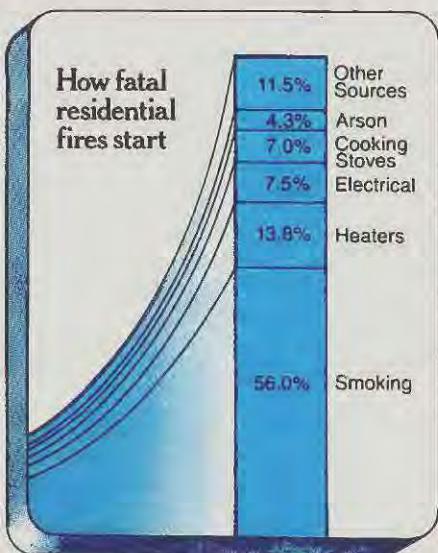
A few managers said it would be impossible to draw the ideal composite, but others had no trouble spewing out education and experience they thought essential for excellence as a benefit manager. Each panelist listed an average of three different areas of expertise.

The leading specialty was finance, listed by 23 benefit chiefs as an important part of the background, followed by on-the-job experience in employee benefit management/administration (17), personnel experience/education (16), insurance background (15), insurance company experience (14), human and/or labor relations experience (14), law (12), employee benefit consulting experience (10).

Aside from the fact that the ideal corporate benefit manager should apparently be something of a dilettante, here's a most interesting description of the supreme candidate for the job: "A language major with an MBA in finance, trained by a large insurance broker, consultant or benefit department of a major corporation."

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## Experts cite government intervention

# Benefit managers need legal minds

NEW YORK—"If I pull files on 10 top benefits people, you can be sure that seven will have legal background," noted Peter Rabinowitz, vp of Bartholdi & Co., a Wellsley Hills, Mass., executive recruitment firm.

Mr. Rabinowitz, who conducted searches to fill top benefit positions at Mobil and W. R. Grace, said that Congress has made benefit regulation so difficult to comprehend that it requires legal exper-

tise.

"If he isn't a lawyer, he should understand law and understand what a pension plan is and how it is structured," Mr. Rabinowitz continued. In addition, the benefit manager should be able to determine what type of plan will be most beneficial for the company and what it will cost, he said.

Herb Cunningham, vp-administration at Transamerica Corp., said a law degree would rank high on

## Employee Benefits

his list of priorities if he were looking for an employee benefits manager. Philip Hall, employee benefits manager at Ingersoll-Rand, said his year of law school is quite helpful in his position.

While Bruce Petersen, director of employee benefits at Investors Diversified Services of Minneapolis, said a law degree "wouldn't

hurt," he did not think it was a necessity.

What one looks for in a benefits manager depends on "whether the client wants a top person or is trying to plug a hole," said Mr. Rabinowitz. "At the \$18,000 to \$25,000 range, you're seeking a different kind of person than if the job was in the \$45,000 to \$50,000 range."

The difference between the two job levels is that one is a benefits

administrator, while the other is a benefits counsel, he explained, but should have in-depth experience in funding requirements and planning.

Dan DeVoto, president of DeVoto, Sullivan & Barry, a Chicago executive recruitment firm, stressed the need for technical expertise. "If he (job applicant) doesn't have it, he's not in the running," Mr. DeVoto said.

In listing what he thought was necessary to be a good benefits manager, Joe Smethen of Eltra Corp., noted being well-versed in benefit terms, being familiar with basic actuarial techniques, costing and underwriting, having a sense of salesmanship, being able to deal with unions and being able to understand contract references.

William Armstrong of Foremost-McKesson stressed having an extroverted personality, good communication skills and being able to associate with peers and find out what's happening in the benefits field. While one did not have to be a financial analyst or a CPA he should know enough about accounting to write a sound financial report, Mr. Armstrong added.

An ability to work with figures and concepts is important in a benefit manager, however technical know-how is not always the most important factor in choosing a benefit manager, explained Ralph Law of Polaroid Corp.

Mr. Law, who was recently promoted from benefits manager to a corporate position in international personnel administration, said that when hiring a replacement for him, Polaroid had to choose between technical know-how and knowledge of the company and chose the latter. ■

## U.K. figures show coal mining peril

LONDON—Official figures released by the U.K. government's health and safety executive show that coal mining is the most dangerous industrial activity as far as accidents are concerned.

Miners face 20,940 accidents for every 100,000 workers, about seven times as high as that for general manufacturing industries.

But the deadliest occupation is quarrying, for it has recorded an average of 30 deaths per 100,000. ■

## New Jersey storm

Insured losses of \$1.5 million are estimated from a storm that swept through New Jersey in mid-November. The storm has been assigned catastrophe number 23.

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SEE OUR AD ON PAGE 3

# Califano finds British health plan advantage

LONDON—U.S. Health, Education and Welfare secretary Joseph Califano said here that Britain had one major advantage when beginning its national health care system.

Mr. Califano, on a fact-finding mission to study Europe's national health care systems, toured British hospitals and health centers.

"The big difference is that at the time Britain started its national health service in 1948 the U.K. government was able to buy into the system as it was, with the voluntary hospitals and the general practitioners and the consultants operating the way they were," he said.

"It's not possible for us to do

that in the U.S. Our hospitals are incredibly obese and profligate and it would be irresponsible to take the system as it is with hospital costs doubling every five years, with tremendous over-investment in technology and with other parts of the delivery system as they are. We have to change the system as we move into national health insurance.

"In the U.S. the hospital associations are very well financed and very active politically and so are the doctors. We have a tremendous insurance industry in our country which is also a political force. None of these things existed in that context at the time Britain moved into national health insurance."

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## Industrial Risk Insurers

# Congress tries, but ERISA's dual split continues

WASHINGTON — Despite intense activity this year, Congress was unable to solve the perplexing problem of having the U.S. Labor Department and the Internal Revenue Service both administer the pension reform law.

But the two agencies and the Pension Benefit Guaranty Corp. were able to solve other problems created by the Employee Retirement Income Security Act (ERISA).

The drive to solve jurisdictional problems by amending ERISA began in March when Rep. John H. Dent (D-Pa.) and Rep. John H.



Sen. Harrison Williams (left) says he will introduce his own bill to revise ERISA next year. Meanwhile, Sen. Jacob Javits (right) has already proposed an SEC-type agency to administer the pension reform law.



Erlenborn (R-Ill.) tossed a bill that would merge the ERISA administrative and enforcement functions

of the Labor Department, IRS and the Pension Benefit Guaranty Corp. (PBGC) into a single "Employee

Benefits Administration" (EBA). The EBA would not be a new independent commission, but would

be put into an existing governmental agency or department. The proposal would establish an ERISA rulemaking body composed of the secretaries of Labor and Treasury with a third person to be appointed by the President.

Before the dust has a chance to settle on that proposal, Sen. Lloyd Bentsen (D-Tex.) introduced a measure in the other chamber which would split overlapping ERISA administration along the informal lines that already have developed.

Under the Bentsen proposal, responsibility for vesting, funding and participation standards would rest exclusively with the IRS while the Labor Department would have sole jurisdiction over the fiduciary responsibility and prohibited transactions provisions.

Of the two proposals, only Sen. Bentsen's bill achieved any measure of progress, clearing the Finance Committee in early August. The

## Employee Benefits

Dent-Erlenborn measure languished in subcommittee, as many argued a new agency might create more problems than it would solve.

Even Sen. Bentsen's bill has a long way to go. It is now being considered by the Human Resources Committee which also has responsibility over ERISA legislation.

Chairman Harrison Williams (D-N.J.) has not come out in favor of the Bentsen bill and has said he will introduce his own reform legislation next year. It is unclear at the moment, though, what approach the Williams legislation will take.

While these proposals were being kicked about, Sen. Jacob Javits (R-N.Y.), the father of ERISA, tossed his hat into the ERISA amending ring in August by calling for the establishment by Jan. 1, 1980, of an "independent SEC-style pension agency" to administer ERISA.

Sen. Javits also recommended other ERISA changes including 100% vesting after five years of service, encouragement of reciprocity arrangements between plans in the same industry or area and expansion of the joint and survivor annuity option so if a worker dies before retiring the spouse still can receive benefits.

The Carter administration is expected to get into the dual admin-

*Continued on page 36*

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# ERISA legislation . . .

## Employee Benefits

Continued from page 34  
istration flap next year by introducing a proposal that reportedly will give the Labor Department sole responsibility for prohibited transactions and leaving minimum standards for vesting, funding and participation with the IRS.

While House and Senate committee staffers believe the final answers to dual jurisdictional problems remain a long way off, other ERISA-related problems were solved this year.

In a move widely applauded by employee benefit plan administrators, the government eliminated for 1977 the dual filing requirements for Form 5500, the basic annual report for employee benefit plans.

Benefit plan administrators and sponsors now will file only one annual report for each benefit plan with the IRS seven months after

the end of the plan year. Previously, employers had to file the annual reports with the IRS and Labor Department on separate dates which caused confusion and excessive costs.

After months of delays, the government issued its final regulations for summary pension plan descriptions (SPDs). Those SPDs were supposed to have been distributed to employees by Nov. 16, although a 60-day extension is available.

The bone of contention which delayed release of the regulations for so long revolved around the wording of the participant's rights statement under ERISA which must be included on the SPD.

The final list of rights which some critics fear might increase litigation include:

- Examine (free) and obtain (at a reasonable cost) all plan documents and forms filed with the government.
- Receive a summary annual financial report.
- Obtain by written request a statement of accrued and vested pension benefits or a statement when benefits become vested. In addition, the SPD itself must provide an easy to understand summary of plan provisions and benefits.

In the exemption area, the government issued in June a long-awaited class exemption under ERISA which allows employee benefit professionals to accept both fees and commissions for services that normally would be prohibited under ERISA as a conflict of interest.

This exemption is of major significance to insurance agents and brokers since they typically provide consulting services in addition to selling a benefit plan an insurance policy.

Another major issue to emerge was the extent to which states may regulate employee benefit programs under their insurance laws. ERISA says that states may not pass legislation to regulate benefit plans but may continue to regulate the business of insurance.

And that's just the distinction drawn by a federal appeals court in Boston, which ruled states may require employers to provide certain benefits through their control of insurance policies. The court also appeared to say, however, the states may not require those benefits in self-funded plans.

ERISA contains few rules for welfare programs compared to its strict rules for pension plans. Many fear a broad preemption would weaken protection for consumers, although companies argue the cost of meeting varying state rules is excessive.

Sen. Daniel Inouye (D-Hawaii) has introduced legislation to exclude state laws regulating health insurance from any preemption. Sen. Carl Curtis (R-Neb.) wants to tackle preemption by restricting ERISA to only pension plans.

Both Sens. Williams and Javits have said the preemption issue will be considered by Congressional committees next year. ■

## Aviation division

Bayly, Martin & Fay International has established a commercial aviation insurance division to handle its growing aviation clientele. Ronald A. Hill has been named senior vp and chief executive officer of the new division. Bayly, Martin & Fay said it expects to expand the division to other U.S. cities.

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## 35% of the compensation pie

## Benefit costs skyrocket to \$300 billion in '77

By JERRY GEISEL

WASHINGTON—Up, up, up and away. In a nutshell that describes the continuing surge in the cost of employee benefits during the last 10 years.

Government statistics and trade association surveys alike reveal that not only are benefit costs increasing at an unabated clip, but that they also are rising about twice as fast as wages.

The Council on Wage and Price Stability, an executive agency that monitors key bargaining agreements, reported earlier this year that employee benefit costs jumped 133.9% between 1966 and 1974 in contracts that it had analyzed. Wages, by contrast, only rose 73.7% during the same period.

Similarly, the U.S. Chamber of Commerce found in a 1975 survey of 761 companies that employee benefit payments ate up about 35% of the compensation pie. A decade earlier, benefits equaled only about 20% of wages and salaries.

This year employee benefits are expected to cost employers a staggering \$300 billion. The biggest chunk of that figure comes from Social Security taxes, which will cost American corporations about \$34 billion, more than any other benefit except compensation covering time not worked such as vacations, holidays and sick leave.

Social Security taxes show no sign of being brought under control. The maximum employer Social Security tax in 1965 was \$174 per employee. Next year, the maximum tax will be \$1,075 and pending legislation in Congress will push that amount far higher in the coming years.

Social Security taxes are only one part of the rising benefit costs story. According to the Bureau of Labor Statistics and the Department of Commerce, employer payments for medical and health insurance increased an incredible 342% between 1966 and 1976. In dollars and cents terms, employer contributions for group health insurance leaped from \$5.9 billion in 1966 to about \$26 billion last year.

Pension costs are another big ticket item. Pension and profit-sharing plans accounted for about 10% of payroll costs last year, up sharply from about 6% in 1966. Pension-related costs are

expected to top the \$30 billion mark this year.

In the steel industry, for example, pensions have emerged as a major factor in the corporate profitability picture. Last year, pension expense was equal to 76% of pretax profit at the nation's five big steel companies, Armco, Bethlehem, National, Republic and U.S. Steel, according to the Council on Wage and Price Stability.

Although dollar figures are not

**Employee Benefits**

available to illustrate what workers compensation, paid sick leave and contributions to stock savings plans cost employers, the cost of providing these fringes has increased by more than 200% in the last 10 years, according to the Chamber of Commerce.

The bad news is yet to come.

Mike Romig, director of the employee benefit section at the Chamber, says the next survey of corporations to be published next year may reveal that fringes will make up 40% of the compensation package.

And a senior staff economist at the Council on Wage and Price Stability believes fringes will continue to grow twice as fast as wages.

Part of the explanation for the explosive growth of fringe costs is sheer demographics. As the population ages and the number of persons entering the age 65 and up category increases faster than the workforce, big hikes in Social Security taxes seem inevitable.

Also of great significance is the increasing role of the federal government in the benefit arena. This year provided one example of that

*Continued on following page*

**Topflight salesman.** Bob Connell spends less time traveling and more nights at home than most traveling salesmen. Yet he holds the company record for annual sales. His company is American Hospital Supply Corporation and Bob has been their No. 1 sales representative for 25 years. □ Bob does most of his traveling by airplane—his own. He has accumulated an Instrument rating, Commercial ticket and 4,300 hours since learning to fly in 1962. About 90% of those hours were on business. 240 of them hard IFR. That Beech Baron is the seventh aircraft he has owned. □ Bob's territory includes the unforgiving topography of western New York and northern Pennsylvania. To him, a good airplane, well equipped, is not enough. □ "Unrelenting attention to details like flight planning, weather briefings, preflights, my own proficiency, close communications with controllers and Flight Service Stations. These," he says, "are open secrets to safe flying." □ Bob Connell is a pro both in selling and in flying. For the past 14 years that same thoughtful care has led him to insure his aircraft with the insurance pros. USAIG. Seems natural, doesn't it?

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Continued from preceding page  
expanding role. After the Supreme Court ruled that companies did not have to include pregnancy as a benefit in sick leave plans, legislation was introduced in Congress that would require employers to include pregnancy in disability and hospitalization plans.

If the measure passes next year as is expected, employers will be paying an additional \$190 million in sick leave costs, the U.S. Department of Labor estimates. Requiring most companies to include pregnancy in hospitalization plans on the same basis as other illnesses is expected to add hundreds of millions of dollars in benefit costs as well.

One company that already includes pregnancy in its sick leave program, Xerox, found that each

pregnancy cost an average of \$2,565 in disability benefits last year.

As a result, out of a workforce of 42,000, the 291 Xerox employees who collected pregnancy benefits garnered \$746,542 or about 9% of Xerox's total disability benefits payments.

A key component of rising benefit costs is the increase in medical care costs which has far outstripped the general rise in prices.

From 1950 to 1976, the overall consumer price index (which measures the cost of all goods and services bought by consumers) rose about 125%. During the same period, medical care costs as a whole rose nearly twice as much, 240%.

But the upsurge in the cost of hospital care was even more striking. Average cost per patient-day was only \$16 in 1950; by 1976, it was about \$175, an increase of more than 1,000%.

In addition, the fires of fringe benefit inflation have been fueled by the shift of labor unions from big wage demands to greater concentration on winning more fringes.

Union members believe their "incomes are at an adequate level so they can buy a lot of things," say Sean Sullivan, a senior staff economist at the Council on Wage and Price Stability. "Now unions are trying to protect members in other potentially costly areas—health and dental insurance and pensions."

Analysis of several key contracts signed in the last year bears that prediction out. The Bakery & Confectionary Workers won a 45% increase in pension benefits in their two-year pact with Nabisco. Monthly pensions for workers with 25 years of service rose to \$400 from \$275 a month.

In the AT&T settlement, the dental plan was broadened to cover workers who retired the day after the agreement was reached. Moreover, the plan was expanded to cover costly orthodontic and periodontal treatment for children.

In the steel contract, a vision care program was established which covers \$20 examinations every 24 months and provides reimbursements of \$10 to \$20 for eyeglass lenses.

The greatest pressures in the fringe benefit field are likely to be felt in job security, as the economy continues to sputter along on a slow-growth pattern, says Mr. Sullivan of the Council.

Those pressures have been particularly strong in the steel industry where rising foreign competition and greater automation has reduced the employment rolls at the nation's five biggest steel companies by about 60,000 workers in the last three years.

To cushion the blow of a lay-off, employees whose age plus years of service equals 65 are now eligible if they are laid off for a \$300 monthly supplement to their regular pension until they qualify for Social Security.

In order to protect earnings and preserve jobs, unions have pressed hard at the negotiating table for more time off. In the pacesetter 1976 auto agreement, autoworkers won an additional 12 extra days of paid leave.

"Viewed together with the Supplemental Unemployment Benefit funds, this reduced work time provision can be seen as a movement toward trying to guarantee workers a certain annual income for fewer hours worked," the Council on Wage and Price Stability said in its analysis of the contract. ■

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# Job security, wages key '78 negotiations

NEW YORK—Demands for extra vacation time, wage increases and job security overshadow modest requests for improved fringe benefits among unions whose contracts are nearing expiration.

Few new employe benefits are being considered. Union leaders are more concerned with keeping traditional benefits in pace with inflation.

While interest in such new programs as prepaid legal and company-provided day care benefits is on the rise, the interest level is still "mild," said William W. Winpisinger, president of the International Association of Machinists whose 900,000-member union is currently involved in negotiations throughout the nation.

The machinists are seeking cost-of-living wage increases amounting to 6.9% the first year and 3% for the second and third year.

High levels of unemployment and the government's lack of initiative to solve the problem have focused union demands on job security rather than wage increases, said John Zalusky of the AFL-CIO's research department.

"We want anything that will create more job openings," Mr. Zalusky said. "Our workers have not forgotten the memory of the 1974 depression when many were laid off and some lost 25 years of seniority."

Other unions, however, are pushing harder for wage increases with improved fringe benefits as a secondary goal.

The United Mine Workers, which is currently negotiating a new contract, is seeking a minimum salary of \$100 day for each worker, up from the current \$67 a day. They also seek a shift differential increase.

New holidays, such as the day after Thanksgiving, and increased vacation time also are among the lengthy list of UMW demands.

Another crucial issue involves a restoration of health care benefits which were cut drastically last summer when wildcat strikes drastically reduced company contributions to the UMW's health and retirement funds.

Increased wages, improved vacations and "modest" improvements in fringe areas are part of the total package the Brotherhood of Railway and Airline Clerks seeks for its 425,000 workers.

## Employe Benefits

According to C. E. Robinson, the union's director of industrial relations, some of the common issues among the 16 or 17 railway unions are wage increases of 15% per year for three years, plus "modest improvements" in dental plans and increased vacation time.

The increasing number of maritime workers who have families has made security for families a "top priority" at the National Maritime Union, said Peter Bocker, vp of the union.

The union seeks improvements in pensions, welfare, hospitalization, dental and vision plans for its 23,000 workers.



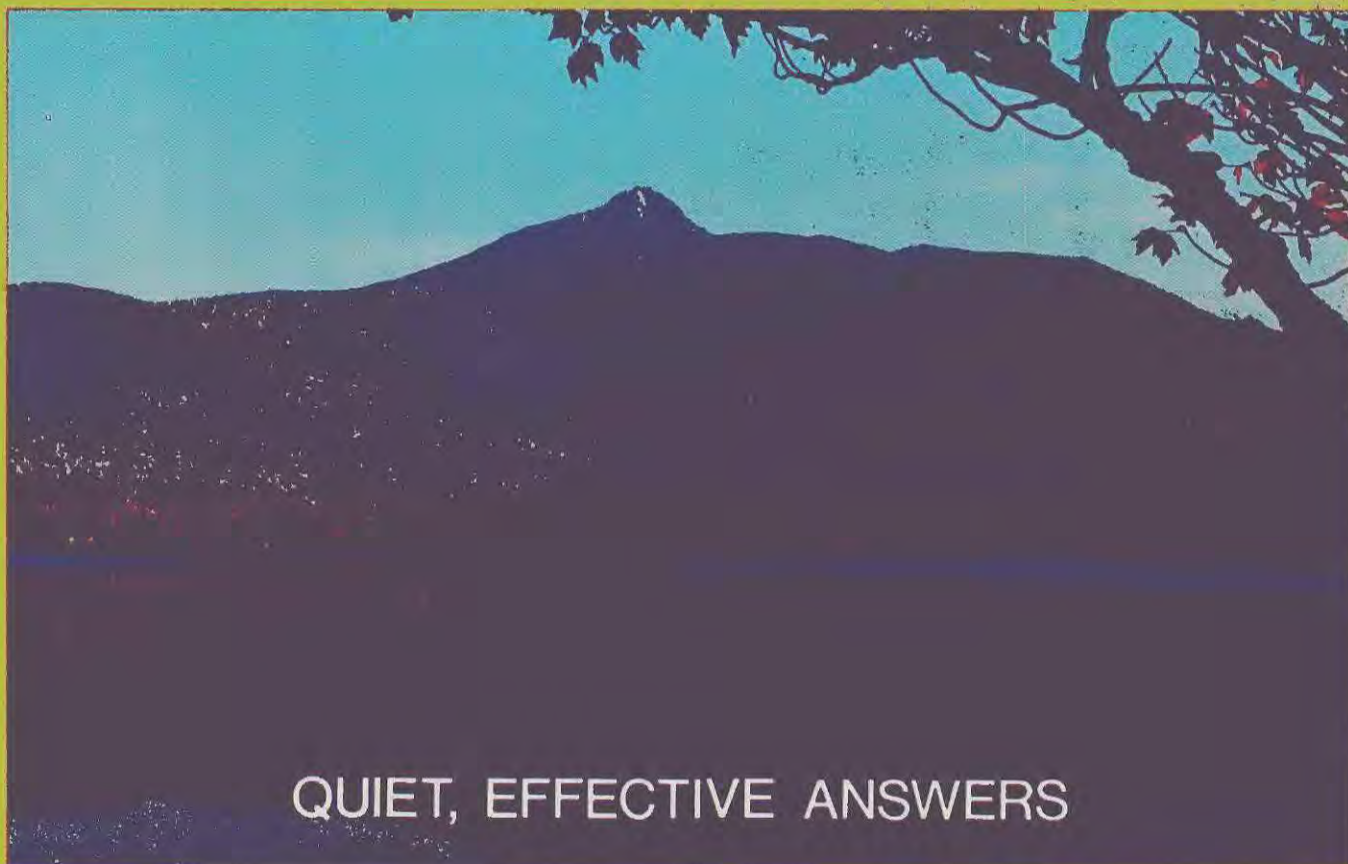
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# Employee

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

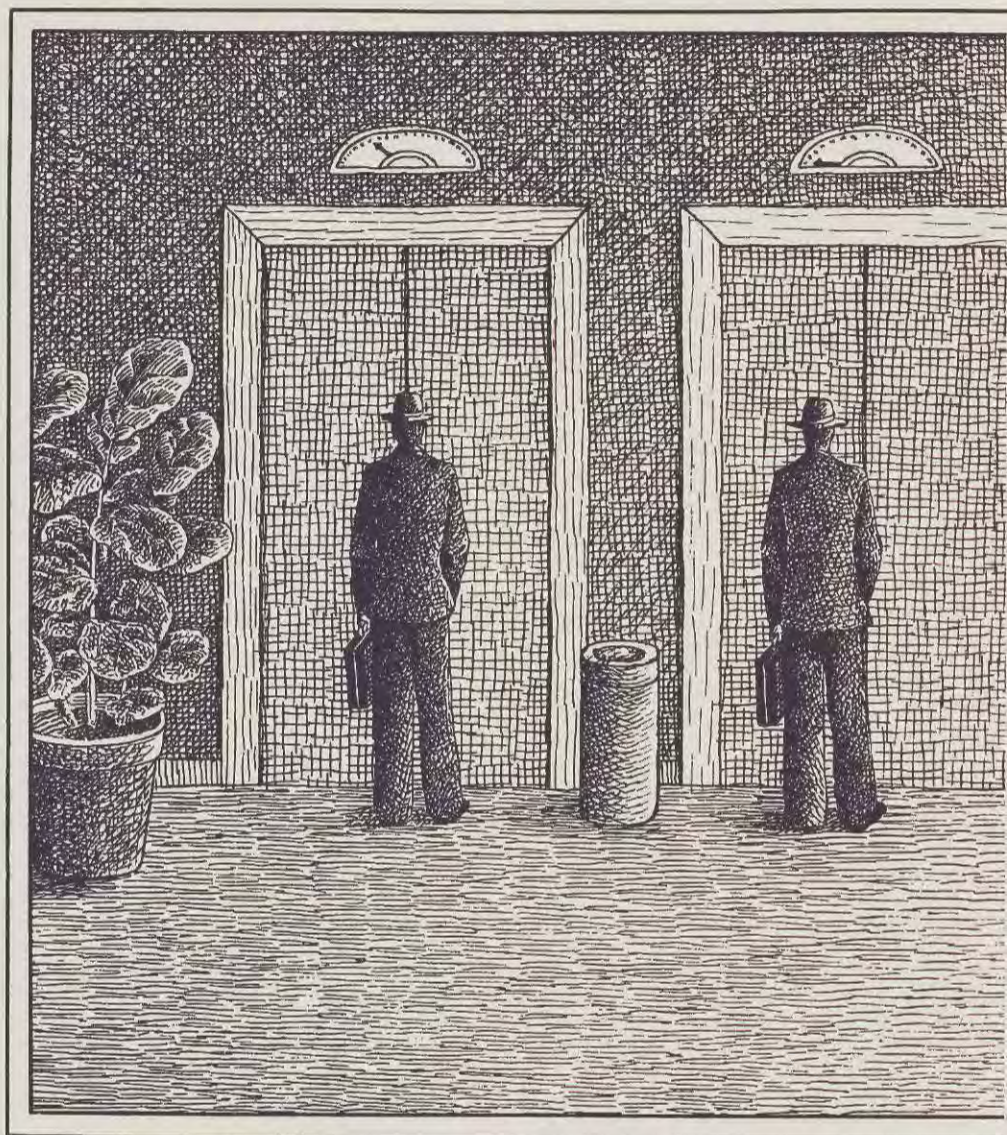
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In 1976, American employers paid out an estimated \$300 billion for employee benefits—equal to almost a third of payroll dollars.

Employee benefit costs—for such benefits as pensions, paid vacations and group medical and life insurance plans—are rising almost twice as fast as wages. In the ten years ending in 1975, benefit costs grew 165% while wages and salaries rose 85%. U.S. employers spent an average of \$76.62 a week for employee benefits in 1975, contrasted with \$28.88 ten years before.

Such expenditures have become accepted as an integral part of the cost of doing business. This is particularly true of premiums for group insurance against illness, accidental injury, disability and death, as well as retirement or pension plans.

But in addition to these basic benefits which meet fundamental needs of employees generally, there are other needs for protection which may be more important to some employees than to others,



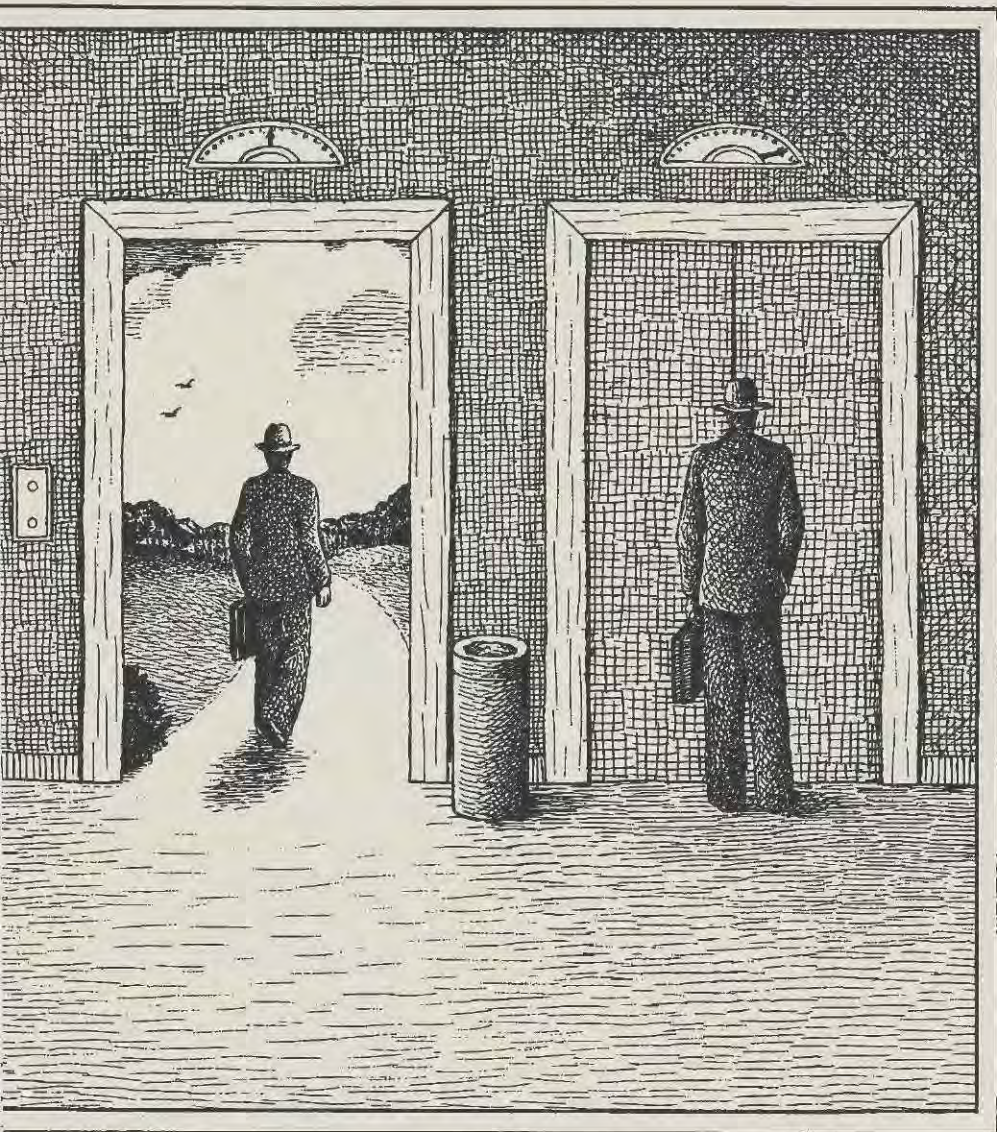
depending on their circumstances. These needs are not as closely tied to jobs and income as are those covered by group insurance. Traditionally, such needs are provided for by the individuals themselves.

An example is life insurance beyond that afforded by a group policy. This need may be felt most strongly by younger married employees with children—people who have not yet been able to set aside large cash reserves. On the other hand, older employees may want to accumulate paid-up insurance or supplemental income for retirement.

## Payroll deduction plans

Insurance meeting such needs can readily be made available for purchase by a firm's employees on a voluntary basis. The entire cost is usually

# Benefits



borne by the employee through payroll deductions, although an employer can contribute to the cost if so desired.

Among the coverages which a company can sponsor are term life, whole life and family life insurance; accidental death and dismemberment; long-term disability; and hospital indemnity.

Although the insurance programs are offered to all of a firm's employees as a group, coverages are individual. Each employee is free to buy or not and, in most cases, to choose the amount of protection and options desired.

## **Saving money on premiums**

Because solicitation, billing and administration are handled on a group basis, with premium pay-

ments collected through automatic deductions from paychecks, important cost savings can be realized. Those savings are passed along to employees. The payroll deduction feature is also a budgeting convenience for the employee.

Moreover, company-sponsored presentations of costs and benefits afford the individual an opportunity to assess insurance needs that might otherwise be neglected. In itself, this can constitute a worthwhile service for employees.

Making voluntary insurance available to employees at reduced cost can contribute to more stable and long-lasting employee relationships. Life insurance agents and brokers can be helpful in implementing voluntary protection programs.

As a fuller discussion of voluntary benefits from an objective standpoint, the life insurance affiliates of INA have prepared a booklet entitled, "Voluntary Employee Benefits: Some Professional Considerations." Copies may be requested by writing INA Corporation, 1600 Arch Street, Philadelphia, Pa. 19101.

\* \* \*

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## Are your benefit communications top-notch? Here's how to find out

NEW YORK—How good is your employe benefit communication program?

One way to find out is to enter your communication program in the sixth annual *Business Insurance* Employe Benefit Communication Contest.

Last year, the judges evaluated 122 separate entries from 99 corporations. Twenty-eight different consultants were involved in the programs judged by a panel of benefit managers and other communication experts.

The competition honors companies that make their communication programs accessible and relevant to their employes and lead the way in improving the field of benefit communication.

### Employe Benefits

The deadline for entries is Feb. 20. Winners will be announced at the annual Risk & Insurance Management Society conference in New Orleans in April and profiled in a spring issue of *Business Insurance*.

There are four categories: total communication effort, booklets, personalized correspondence and audio-visual.

A \$60 entry fee is required for the total communication category, \$45 is needed for an audio-visual presentation and the fee is \$35 for booklets and personalized correspondence.

Two copies of booklet and per-

sonalized correspondence efforts must be submitted with the entry application. Audio-visual presentations are returned to the companies after the awards are presented in April.

Mead Corp. of Dayton, Ohio, walked off with top honors last year for the total communication effort for a program that involved the use of booklets and an audio-visual presentation. Runners up in this category were Borden Inc. of Columbus, Ohio, and Crocker National Bank of San Francisco.

The top audio-visual award went to Bristol-Myers Co. followed by Unijack of Jacksonville, Fla., and Foremost-McKesson of San Francisco.

The judges said Bendix Corp. of Detroit had the best booklet while Medtronic Inc. of Minneapolis prepared the past personalized correspondence.

Among the consultants that worked on winning entries were Hewitt Associates, Franklin Creation Group, Kwasha Lipton, Benefit Consultants Inc., International Communications Corp., A.S. Hansen and Benefacts Inc.

Entry forms may be obtained by clipping the coupon on this page. Questions and more information on contest rules should be directed to Ronnie Drachman, Awards Coordinator, *Business Insurance*, 708 Third Ave., New York, N.Y. 10017. Ms. Drachman may be reached by telephone at 212-986-5050. ■

# Here's a pain killer that really works



If you haven't been to a dentist in a while, you may be in for a few surprises. More and more dental procedures are virtually painless. In fact, the only thing that still seems to hurt—especially when there's extensive work to be done—is paying the bill.

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## Third World risks called 'unbalanced'

MANILA—Examples of unbalanced risks in some African countries were given by Cyril Hodge, U.K. insurance consultant, to the Third World Insurance Conference in the Philippines.

He said underwriters needed better insurance management as their portfolios of property fire risks were becoming out of step in relation to overall premium income.

Ghana has a total annual premium income of \$27 million, less than \$4 million of which is for fire insurance. Yet one petrol refinery alone at Tema is insured for \$45 million.

Nigeria has less than \$40 million set aside for fire risks despite its premium income of \$180 million. But a tire plant and a textile mill between them are covered for \$90 million.

Kenya has premium income of \$45 million, of which \$10 million is for the fire risks. But an oil refinery in Kenya will cost insurers more than \$70 million if it is destroyed.

Mr. Hodge warned, "There is a serious shortage of risk management consultants in many African and Middle East countries and training programs ought to be stepped up in many of them." ■

## Fire losses down

Fire losses in the U.S. in September totaled \$285 million, a 9.8% drop from the same month in 1976. The estimated loss from fires for the first nine months of the year is \$2.8 billion, up slightly from the \$2.75 billion figure for 1976.

# Small firms lead, but prepaid legal grows slowly

By ELLIS SIMON

NEW YORK—Interest in prepaid legal services as an employee benefit is growing, but so far unions and small firms appear most receptive to the new benefit.

Large corporations have taken a wait-and-see attitude.

Last year's *Business Insurance* employe benefits issue reported predictions that prepaid legal services would "take off" following passage of legislation that gave prepaid legal the same income tax exemption extended to medical insurance.

However, employers have been unable to add the benefit because of the priorities and the need to meet rising health care and pension costs, said Joe Bitterman, vp-employe benefits in the Chicago office of Corroon & Black.

A *Business Insurance* Employe Benefits Board survey this spring found that none of the 85 large corporations responding offered the benefit and only four were giving it serious consideration.

Mr. Bitterman had tried to market to employers an open panel prepaid legal plan sponsored by the Chicago Bar Assn. While many employers expressed interest, none chose to participate this year.

Open panel plans, by which plan participants can choose their attorney and have him bill the insurer or plan sponsor, have had little acceptance. Several insurance companies, including Employers of Wausau and Stone-wall Insurance Co. of Birmingham, Ala., which offered or considered offering open panel plans, have stopped marketing the product.

However, bar associations in New Mexico and Oregon offering open panel coverage have achieved moderate success with small firms, noted Sandy BeMent, executive director of the National Resource Center for Consumer Legal Services.

While there are fewer insurance companies offering prepaid legal services now than a year ago, interest in the benefit is on the rise and most of that interest is a result of the tax break, she argued.

The closed panel, in which a law firm or group of attorneys is retained to provide legal services, remains the most popular type of prepaid legal plan. Typically, the union or plan sponsor

has gone directly to a law firm, rather than working through an insurance carrier, Ms. BeMent explained.

In this way, prepaid legal coverage differs from the normal pattern of benefit development in which the insurance companies have played a major role, she noted. With prepaid legal, the insurance industry has maintained a low profile.

William B. Pugh Jr., associate general counsel with INA Corp., said that while the signs point to prepaid legal insurance becoming a success story, "like any other new thing, it will be accepted by the majority of people when their next door neighbor gets it."

Norman Koch, director of product development at Employers Insurance of Wausau, predicted it would be another five to 10 years

## Employee Benefits Update

before prepaid legal comes into its own. There is presently far greater interest in dental care and other benefits, he noted.

One insurance carrier which has achieved success with prepaid legal is Midwest Mutual Insurance Co. of Des Moines. Wes Graham, vp and general counsel, said current enrollment is 20,000 with 70 participating groups, triple the 1976 figure.

Unlike other carriers, which marketed open panel plans, Midwest Mutual uses a modified closed panel in which any attorney can participate provided he agrees to accept the carrier's predetermined fee schedule, Mr. Graham said.

Part of the carriers' problem has

been state laws, particularly in large industrial states, which prohibit them from selling prepaid legal coverage as a form of insurance. However, the National Assn. of Insurance Commissioners hopes to get model legislation passed by these states which would recognize prepaid legal as a separate class of insurance, Mr. Pugh said.

Ms. BeMent sees active participation by insurance carriers as vital to the long run growth of prepaid legal since only the insurers have the facilities to successfully deliver services in many states.

Insurance would have greater feasibility than a maintenance program where the beneficiaries were dispersed, noted Mr. Pugh.

However, a prepaid legal plan set up by the United Auto Workers for 150,000 members and their

families at Chrysler Corp. will provide information on the feasibility of a closed panel in a large-scale operation, according to Ms. BeMent.

"Chrysler will produce numbers that no one else has and it will be good actuarial information," she said.

The Chrysler plan was not won through collective bargaining, but is being set up as the result of a surplus in the union's supplemental unemployment benefits fund. However, it has set a precedent which could lead to inclusion in demands at the next contract talks involving the UAW.

While few companies offer it on their own as yet, "no one said it's a poor benefit," Mr. Bitterman noted, adding that, like a pension plan, it might take a few years to sell a package. ■

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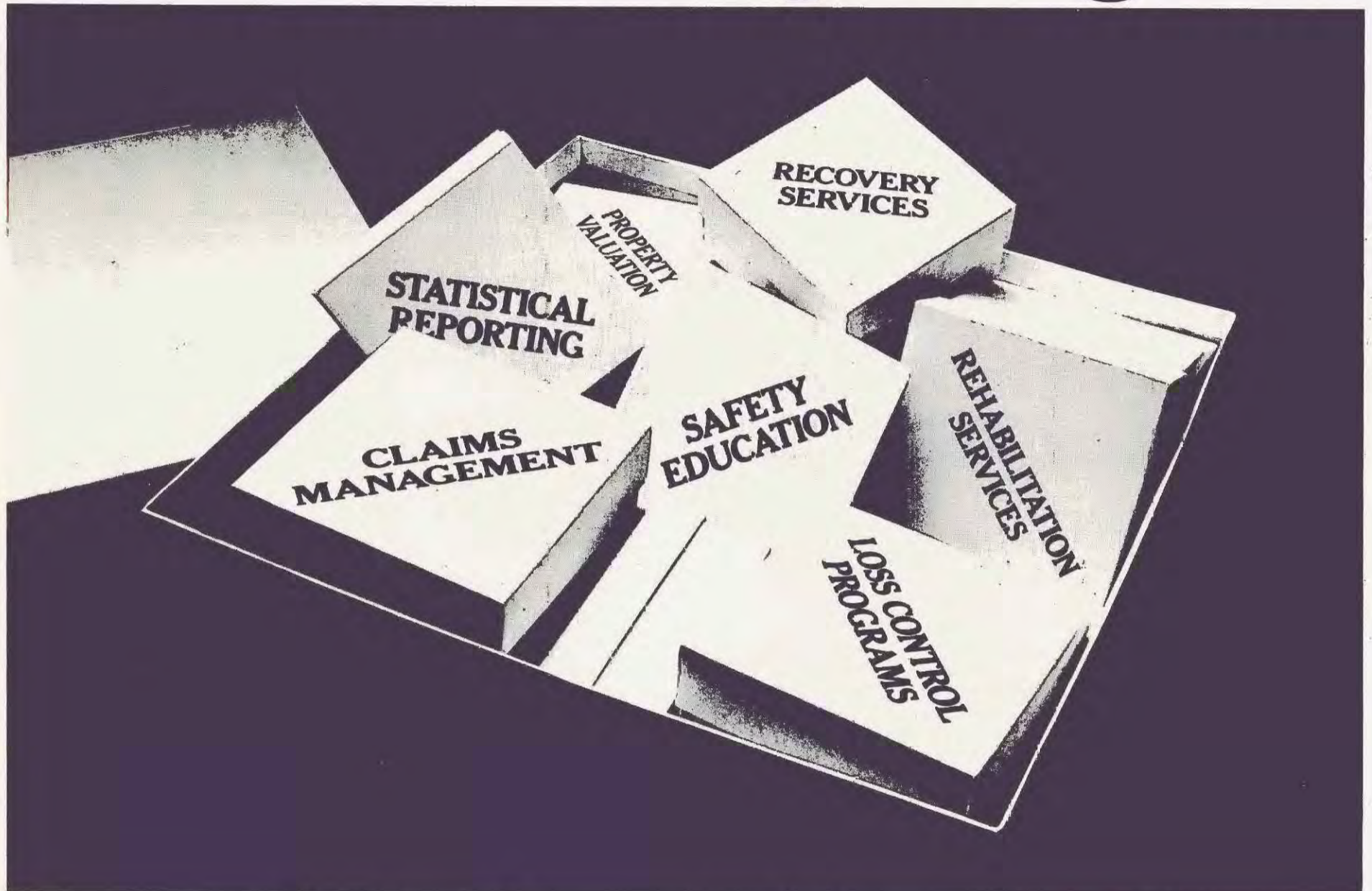
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# PERSPECTIVE

## Employees shouldn't get a free ride as the cost of their benefits go up

By Gene McGarrh

Corporate benefits manager  
Texas Instruments Inc.  
Dallas, Tex

**H**OW WOULD a typical employe answer these questions:

- Would you like to have a salary increase?
- Would you like to have more employee benefits?
- Would you like for someone else to pay all of your health care costs?

The logical answers would be: "Yes." "Yes." "Yes." However, if the "yes" answers prevailed—that is, if all employers readily agreed with their employes on the "yes" answers—then there would probably be an even faster acceleration toward the welfare state, an acceleration that in the eyes of many in the U.S. is already far too fast.

One can look around the world and see how the "yes" answers have influenced business, industry, government decisions and action and broadened the base of the welfare state in many countries.

Generally, when someone else is actually paying the employe's bill for a product or service—whether it be a government agency, an employer, or an insurance company—then the employe pays relatively little attention to the rising cost of the product or service. The usual employe reaction is, "Why should I be concerned? I'm not paying the bill."

The escalation of health care costs in recent years, especially since 1973, certainly suggests that the "I'm not paying the bill" attitude exists in the health care area.

A basic and universal guideline for health care should be that the recipient

of health care services never gets anything free. The users should always see and feel the impact on their own pocket-books of the cost of health care services. The employe should share in these costs all along the line, except perhaps when the costs reach a catastrophic level. This approach would introduce an element of consumerism into the health care field.

There are some group health plans where the employer pays the total cost for both the employe and all dependents and the employe has no out-of-pocket expense other than a token annual deductible of \$25 or \$50 a year. In this situation, the employe views health care as "free."

Nothing is free in today's society. When the employer has to pay out more money each year for health care, then less money is available for wage and salary increases and employe benefit improvements.

**This cost-sharing** between employe and employer on health care should begin at the front end. The employe should share in the premium cost of the group health care insurance plan. When the bills come in, the employe should pay some type of deductible plus coinsurance. In addition, the covered expenses should always be subject to a "reasonable & customary" schedule.

In other words, the employe should share the costs with the employer all along the line; he should never get a free ride.

From the employe relations point of view, this approach is not the most palatable one. When an employe of Company A has a friend or neighbor who works for Company X where all health care costs for both employes and dependents are fully paid by the company, the employe of Company A tends to feel he is missing out on something.

At least one large insurance company



Pinpointing where health care costs are increasing is crucial to a cost-sharing system.

has been espousing broader cost-sharing in its national advertisements. More carriers, in fact all carriers along with insurance brokers, consultants and employers, should adopt this concept. Just imagine the strides that could be made in health care cost control if the entire insurance community were to act in unison.

Adoption of this concept and its successful and timely implementation and administration would require very sophisticated and up-to-date data systems—data collection, analysis and reporting.

For many years, Texas Instruments has embraced this cost-sharing concept. Current emphasis is now on data systems that will minimize the cycle time from cost incurrence to data analysis feedback and management decision regarding future cost sharing.

The objective should be to have very prompt, almost instantaneous response through computers, indicating precisely where the costs are being incurred. With this knowledge, the employer and the in-

surance carrier can identify the real reasons for cost increases and those cost points that need critical review and adjustment.

The cost-shared elements that should be reviewed and adjusted periodically are:

- Premiums
- Deductibles
- Coinsurance level
- "Reasonable & customary" schedules

Initially, the employer needs to establish his company philosophy regarding premium cost-sharing between the company and the employe. For instance, the employer could pay 90% of the premium cost of the employe's health care coverage and 50% of the premium cost of dependent coverage. Once the philosophy is established, then it would be very simple to pass along to the employe, on a regular basis, his share of any premium cost increases.

Deductibles and coinsurance levels need to be established and then increased to track the appropriate Consumer Price In-

*Continued on following page*

## Here's what ERISA really cost one typical firm

By Grant Morris

Consultant,  
Morris Associates  
New York

**E**RISA HAS BEEN law now for slightly more than three years and perhaps it is not too early to begin assessing what it has actually cost employers to comply. Actually, as opposed to the various prognostications (usually gloomy) to which we have been treated over the past three years, prognostications which have usually been based on worst-case generalizations from a very limited base of facts. Actually, as opposed to extrapolations (again, usually gloomy) from limited PBGC or IRS statistics, extrapolations which tend to forecast a very poor future for the private pension system in this country.

This article is primarily a plea for obtaining a broader and more accurate base of facts from which to generalize. It is rooted in the assumption that after three years there are sufficient facts available from which to construct such a base.

No one would suggest that the only way we can determine how much ERISA compliance has cost to date is to add up all the additional costs attributable to ERISA for every employe benefit plan in the country, even if that were possible. A limited number of case histories, properly weighted and spread so as to take into account employers of various sizes in dif-

ferent industry groupings, with a consistent definition of what constitutes extra expenses due to ERISA, should be sufficient to make statistically valid comparisons and conclusions.

Then the prognostications and extrapolations, even if still gloomy, would be based on something more solid than what we have today.

**The prospects for putting together** such case histories are dim. It would be an enormous effort. The difficulty of arriving at a consistent definition of ERISA-added costs and then applying it in a consistent manner would be nearly insuperable. Perhaps worst of all, most companies are loath to expose their internal costs to outside view.

### Benefit Costs—Jones Widget Co.

	Before ERISA	After ERISA	Dollar Increase	% Increase
Benefit Dept.	\$ 50,000	\$ 200,000	\$ 150,000	300%
Actuary Charges	180,000	280,000	100,000	56
Accountant Charges	-0-	40,000	40,000	
Plan Funding	5,004,099	6,145,912	1,141,813	23
PBGC Premiums	-0-	10,000	10,000	

Nonetheless, curiosity alone (how are we doing, compared to the other guys?) makes it worthwhile to have such facts available. The following case history from my consulting practice contains very close approximations to the actual numbers one firm recorded in 1975, their last pre-ERISA plan year, and in 1976, their first post-ERISA year. The focus is on four key areas where costs could be expected to rise because of the new law: plan funding, actuary charges, outside accountant charges and cost of operating the employe benefit function.

The Jones Widget Co. is a long-established, successful, Fortune 500 company with well over 10,000 employes. About one-third of them are salaried, two-thirds are hourly and very few unionized. As

can be seen from the chart, benefit costs did rise substantially in the four key areas. But when we try to figure out how much of each increase is actually attributable to ERISA and how much is due to other factors, we begin to see the difficulties. Getting an accurate fix on how much ERISA itself added in each area is not easy.

For example, it is tempting to think that the 300% increase in costs of running the employe benefit department can all be laid at ERISA's door. However, the fact is that the company ran this function understaffed for many years, with heavy reliance on its actuary to perform many routine clerical and administrative tasks. As a result, its pension recordkeeping was approaching a shambles, with or without

*Continued on following page*

# PERSPECTIVE

## Sharing health costs . . .

*Continued from preceding page*

dex, just as Social Security and Medicare benefits track the CPI.

The periodic adjustments on premiums, deductibles and coinsurance levels should probably be changed no more frequently than once each year. Once this type of program was started, the employee would learn to expect his share of health care cost increases annually, just as he expects increases in fuel costs, groceries and clothing. Why should the employer continue to absorb the bulk of the cost increases for health care?

The fourth cost-shared element on the list is the "reasonable & customary" schedule. This schedule should probably not be changed too often, like every month, but perhaps at quarterly or six-month intervals. The ability to change a "reasonable & customary" schedule frequently is dependent on the timely feedback of incurred expense statistics through the data system.

If a particular increase appears to be justified, then the employer would simply accept it and instruct the carrier to increase the amount on the schedule of reasonable and customary charges to be covered. If, in the opinion of the employer and carrier, a particular increase does not appear to be justified, then the employer would instruct the carrier to make no change in the schedule for that particular item.

To be effective, such "reasonable & customary" schedule reviews and changes, where justified, need to be timely in order to have the desired impact on the provider as well as the recipient of the health care services. The recipient of the health care services will feel the cost increase impact in those instances where there has been no "reasonable & customary" schedule increase, even though the provider has increased the cost.

This approach should create some consumer awareness on the part of both the provider and the recipient of health care services of the increasing costs and hopefully result in some greater cost control/cost containment awareness to hold down cost increases. Hopefully, the recipient would apply pressure to keep his out-of-pocket expense at a minimum and the provider would become more concerned about his community responsibilities to avoid unnecessary expenses and expense increases.

To my knowledge, no employers except for the federal government are using this system of adjusting benefit levels and cost-shared elements for changes in the CPI. Texas Instruments, as well as a number of other corporations, does periodically revise its schedules of "reasonable and custom-

ary" charges, usually adjusting the allowable charges once or twice a year. But no one is going far enough, linking all four of the important cost-sharing features of benefit plans to the economy.

Philosophically, this system could work. There are some areas of the economy where consumerism has slowed down or held off cost increases. Why not in health care?

Two key support mechanisms must exist to make this health care cost-sharing system work. First, the overall system should have broad support from business and industry and from the insurance community. Second, the system must be supported by a very comprehensive data collection and feedback system.

Data must be collected and analyzed promptly after the cost is actually incurred and then fed back to the employer for review and decision making. Many systems for data collection, analysis and

feedback are slow processes, entirely too slow to support timely decision making that could really impact the near-term cost of health care and, ultimately, the employer's cost of maintaining a group medical insurance program.

Today's computer systems are certainly capable of digesting, analyzing and reporting information at a very rapid pace. The initial problem is that of getting the right data collected in a usable, understandable format, and then getting it into a computerized data base from which it is retrievable and meaningful. Many companies, especially new technology companies, have to a large extent been successful because of their very innovative use of computers in new product development, manufacturing and process control, product marketing and short-term and long-term financial planning and control.

Why can't these same computers be used as innovatively in the health care cost control area as they have been used in major electronics and new technology companies?

A segment of the insurance community—carriers, brokers and consultants—has been content with the status quo, continuing into the future with things as they have been in the past. This attitude of

contentment needs to be changed.

The insurance community is one of the most successful, powerful and profitable segments of American business. Here is an opportunity for the insurance community to establish even closer ties with other business and industry and make a gigantic public service type of contribution to our society rather than perpetuate their business ways of the past.

*As corporate benefits manager at Texas Instruments Inc. since 1973, Mr. McGarran has responsibility for the planning and administration of employee benefit programs in the U.S. plus 25 foreign countries. His experience with TI includes operations and management assignments, both in the United States and abroad. Before he joined TI in 1959, Mr. McGarran was on the faculty in the School of Engineering at Texas A&M University. He is a graduate of the United States Naval Academy and holds a Master of Science degree in Mathematics and Statistics from Texas A&M. Mr. McGarran joined TI as a statistical analyst and within 1½ years moved into international operations.*

## 10 criteria to evaluate communication

Herbert Zeltner, a marketing and communications consultant, has established 10 criteria for assessing the effectiveness and content of employee benefit communications.

Mr. Zeltner moderated three sessions at the two-day *Business Insurance Employee Benefit Communications Conference* here in October. He led an audience of 188 conference registrants through the exercise of judging and assigning scores for the eight audio-visual benefit presentations screened at the conference.

Mr. Zeltner provided a commentary and invited audience response and participation in the three sessions entitled "You Be the Judge." Plenty of controversy resulted and the only conclusion that could be drawn from the three working sessions was that there was little agreement about scores assigned for each of the 10 criteria to each audio-visual presentation.

The 10 guidelines used by Mr. Zeltner to judge the benefit presentations included:



Herbert Zeltner talks communications with Bill Badgett of Motorola.

- Objectives: Are they clear cut, sensible, actionable? Is the presentation "on target?"

- Persuasion: Does the effort have good "sales value?" Are the elements presented as favorably and strongly as possible?

- Organization: Are the elements arranged for easy comprehension? Is the sequence logical? Is the emphasis and the recap appropriate?

- Communication: Is the content sufficiently developed? Are the ele-

ments explained correctly? Is the language used understandable to the group?

- Content: Are the facts, figures, relationships, projections shown interestingly, meaningfully and clearly? Are the building blocks and interrelationships handled well?

- Tone: Is the approach used persuasive, believable, acceptable? Is it empathetic?

- Packaging: Are graphics or other production values appropriate or not? Are they a help or a hindrance?

- Motivation: Does the presentation involve the audience? Does it call for a particular action or change in attitude? Does it clearly tell the audience what to do next?

- Adaptability: Does the effort have staying power? Can it be readily adapted to different employee group or circumstances? If appropriate, could it be updated over time?

- "Over-Purpose:" Does the presentation help to "sell" the company to the employees? Does it create a positive identification?

## What ERISA costs . . .

*Continued from preceding page*  
ERISA.

The decision to upgrade and properly staff the department was taken about the time pension reform became law, but some portion of the increased costs would have been incurred in any case. I have noted a similar pattern in many other companies encountered in my practice.

The outside accountant's charges apparently show an infinite increase, purely due to ERISA's requirements. However, the fact is that the accountant did routinely check pension records as part of his annual auditing procedure before the new law, but without breaking out the charges separately. Doubtless, his auditing procedure for pension records is both more extensive and more intensive than in the past, but this apparent increase cannot all be attributed to ERISA either. This pattern also can be observed in other companies.

The fourth item on the chart, PBGC premiums, is clearly totally attributable to ERISA. What's more, these charges stand to rise next year by more than 100%. However, as can be seen in comparison with the other costs, PBGC premiums them-

selves have not added a great deal to company benefit costs. In fact, they represent at present only about one-tenth of 1% of total benefit costs and after the increases they will still represent only about two-tenths of 1%.

Actuary's charges have presumably gone up for every company since the advent of ERISA, but in this case there are a number of other factors which have affected the cost picture. As with the decision to upgrade the employee benefit function, promoted by but not wholly attributable to ERISA, Jones Widget decided to change actuaries at the time pension reform came along. For the past two or three years, they have incurred additional costs which are a natural concomitant of such a changeover.

In addition, and perhaps not surprisingly, the new actuary has changed the valuation method in conjunction with the other plan changes required to conform to the new law. But even before ERISA, new actuaries have frequently changed the valuation method and the assumptions used by their predecessors, so the extra fees paid for this work probably should not be charged to the pension reform law.

Included in the fees for 1976 is a charge of \$200,000 for ERISA compliance, all of which was clearly generated by the law and another \$25,000 for summary plan description booklets, most of which resulted from ERISA. It is expected that similar fees will be charged during the 1977 plan year, but after that, these items will lessen considerably.

The actuary has also been involved in a joint project with company benefit people to produce a set of administration manuals for all plans in the company. The charge for this will be about \$50,000, spread over 1976-78, but this project appears to be another item which can't be charged totally to ERISA, since such manuals should have been in existence (they weren't) regardless of any pension regulations.

As might be expected, the plan funding figure shows the greatest dollar increase. For various reasons, I have integrated the contribution figures for all of the company's pension plans. In this area, there are a bewildering variety of factors to be considered before attempting to estimate the effects of ERISA. If everything had remained equal and we had the same body of employees after ERISA as before, it would be possible to see how much it had cost this employer to liberalize eligi-

bility, vesting and accrual, add the joint and survivor benefit, etc.

Everything, of course, did not remain equal. The actuary changed the interest, mortality, turnover and salary scale assumptions. And the valuation method. Some divisions had layoffs and others hired a substantial number of new employees. The largest pension plan sponsored by Jones Widget was a good deal more generous than ERISA requires and was downgraded, partially offsetting increased costs of earlier eligibility and vesting. One of the plans turned out to be overfunded by the new standard and a few were markedly underfunded.

What conclusions can we draw from the experience of Jones Widget? That ERISA compliance has driven up their benefits costs, yes, but by how much is not easy to determine with any degree of accuracy. Defining "how much" carries us into areas of judgment, where opinions will certainly vary.

My personal opinion, which has been reinforced in going over this material, is that much of what is loosely characterized as the "cost of ERISA" turns out on closer examination to be the cost of running benefits operations the way they should have been run all along, something for which ERISA has been the catalyst, not the sole cause.



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# Employers' view of national health plans

By Willis B. Goldbeck

Washington Business Group on Health  
Washington, D.C.

Mr. Goldbeck delivered the following statement on national health insurance during hearings held by Health, Education & Welfare secretary Joseph Califano in October.

WE ARE A MEMBERSHIP organization of 150 very large employers who are greatly concerned about our nation's health policy, the cost of medical services and the quality of care.

To give you an idea of the magnitude of our members, as well as the degree to which this relatively small number of corporations serves as a major health services payer, provider and consumer, note that over 30 million employees, dependents and retirees receive their health benefits from these employers.

Recognizing the need to reorient our health system toward prevention and health maintenance and the need to close the gaps in coverage which now plagues portions of our population, we approach national health insurance (NHI) positively.

Our feeling has been, and remains, that we should be working for the improvement of our existing reimbursement and delivery systems without waiting for any professed NHI cures.

What we are really talking about is rationing of care—or at least rationing of the resources through which care is purchased. Rationing already exists as resource allocation decisions are made by individuals; as employers and unions choose from a broad array of potential benefits and as the government assigns larger budgets to cancer research than it does to heart disease research, despite evidence that the reverse holds the greater potential for improving our population's health status.

As the cost of care goes up and medical technology provides us with the capability to repair and replace more parts of our bodies, our financial capacity to cover the costs of such procedures will become increasingly strained. A decision to make all care available to all people at no direct patient cost would bankrupt this country.

Therefore, we are compelled to talk of incentives: incentives to conserve, to question the philosophy that "more equals better," to waste less and in so doing, expand the service capacity of our existing system. Like over-nutrition, over-utilization can also be bad for your health.

## How much to spend?

We are convinced that no one knows the appropriate proportion of the Gross National Product to spend on health care. The problem is less one of how much than one of how good and how necessary. There is a perception, which industry shares, that we are simply not getting a very good return on a gigantic investment—an investment that limits our capacity to meet other public policy objectives.

Industry and labor must recognize that employment-based insurance plans, with their first dollar coverage and undue emphasis upon hospitalization, have been part of the stimulus for the rate of cost escalation. We also believe that many of the critical elements of a national health insurance program have already been legislated.

Our recent efforts have been devoted to compatible themes:

- What industry can do through its own reimbursement policies to shift the system's economic incentives.

- Health care delivery systems and external programs which industry can support.

Among the industry reimbursement and incentive changes to be considered are: second surgical opinion experiments; pre-

admission testing; concurrent utilization review; incentive programs for employees to make more informed utilization decisions; employee financial participation in the payment of all new benefits, and health education programs.

Behavioral change programs in the areas of smoking, alcoholism and drug abuse, hypertension control and off-job safety deserve study.

In the area of reimbursement for alternatives to in-patient care, emphasis can be shifted to ambulatory care, home health care, surgi-centers and mental health residency programs. Benefit programs can provide reimbursement for care rendered by various categories of non-physician providers.

Industry can support efforts to restrict reimbursement to those facilities and equipment which have been approved by the local health systems agency. Expanding the corporate medical facility to a full service system for employees and dependents might also shift the nation's economic incentives.

## The problem areas

External programs industry supports include the following programs:

- **Health planning**, including strengthening the HSAs by recertification authority, decertification authority (with a buy-back mechanism), including all government facilities under this authority with due consideration for the national scope of their patient load, increasing the consumer majority and including all major equipment purchases, regardless of where the equipment is to be located.

- **Health maintenance** organizations, IPAs and other forms of prepaid practices that place the provider at risk.

- **Extending PSROs** to all classes of patients while developing instruments and collecting data for monitoring and evaluating standards and enforcing and influencing provider behavior as to quality and appropriateness of care.

- **State rate** regulatory commissions, on a case-by-case basis.

- **Capital controls** on the growth of medical facilities as proposed in Title II of your own hospital cost containment act.

The critical point is that all of these programs, incentives, and innovations will be essential whether or not we have any national health insurance program.

Contrary to popular rhetoric, the United States does not have a health care crisis. If anything, we have a crisis of affluence, of successfully developing a super medical system that is doing exactly what we pay it to do. As a population, we have never been healthier. Our technology and professional skills are a magnet for the great brains and most seriously ill people from around the world.

## External programs

Unfortunately, we are also doing some things very wrong. Your NHI Advisory Committee heard and saw more than enough examples in Watts and East Los Angeles, in the chaos of Los Angeles County Hospital, in the 49-year life expectancy of the Southwest Texas migrants, in the waiting lists for the adult mentally retarded residency in Wisconsin. The list is too long.

Fortunately, few Americans fall into the gap areas I just mentioned. For most, the delivery system, while too expensive, works quite well.

Therefore, the first task facing both public and private sectors should be eradicating those serious problems while retaining the good qualities of our existing system. There is no single, uniform, national solution.

For those who would call for a single federal program, I respectfully suggest they listen to the voices calling from the neighborhoods for more autonomy, for more



First collar coverage in employment-based plans has contributed to pushing up health care costs, says Mr. Goldbeck.

uniquely designed programs which reflect their particular cultures, priorities and circumstances.

Yes, access to affordable care is long overdue and we support its advent fully cognizant that we will have to make some sacrifices. But, no, we neither support nor hear any public voice suggesting that the best or only way to achieve access for those now left out is to reduce the access for those who are not. Mediocrity benefits no one.

This statement would be less than complete if it did not frankly address a major problem in obtaining industry support for NHI. To the extent that NHI is to be a government program, we are very concerned that the record of existing government programs bodes ill for much expansion. Already, much attention has been given to the Medicare and Medicaid fraud issue: an ugly but relatively small matter.

America's industrial giants will not close because of our health system, no matter what shape it takes. Unfortunately, that fact has been misconstrued by some to mean that industry does not care about medical service costs or quality. Nothing could be further from the truth.

## Limited industry money

A related and equally incorrect assumption is that NHI will have industry money. This is not true for several reasons:

- The more extensive corporate programs already provide greater benefits than any national program will ever be able to afford. Any benefits above the national program will have to be continued by the company.

- Corporate income taxes will be increased proportionally to the increased cost to general revenues for the public sector share of NHI.

- A growing number of the largest industries have contracts which require them, in the event of NHI, to transfer any savings to another category of compensation.

There are several principles which the Washington Business Group on Health feels are essential for any national health insurance program to be successful.

Coverage should be universal to assure access for all to needed care and protection against financial catastrophe from medical expenses. So-called "catastrophic" insurance should not be initiated apart from the comprehensive program.

We support equity of access to needed

care but do not extend this support to mean all care must be equally apportioned among all people regardless of need or ability to pay.

Employment-based plans should be financed through shared premiums. Payroll taxes should not be used. It is a very regressive system. And, by both public and private sector estimates, refunding the Social Security System will, by itself, stretch the payroll tax to—many feel past—its limit. Coverage for the poor, near-poor and otherwise medically indigent, should come from general revenues. As a cost control device, providers should be held at risk for some portion of their services' reimbursement.

## How to administer NHI

The program should be conducted under federal guidelines administered by HEW with maximum flexibility for state level and private sector programs which exceed the guidelines to function independently. Full utilization should be made of the expertise and competition inherent in the commercial and not-for-profit private insurance systems.

There is no such thing as free medical care. Any national program will have to have cost controls despite the fact that such controls, by definition, limit utilization.

Among those that we support are:

- FSRO for all classes of patients, including those receiving outpatient care.
- Prospective budgeting.
- Limited coinsurance and deductibles.
- A strengthened health planning system.
- A major investment in health education.

Industry spent \$29.9 billion last year on group health insurance. Billions more were spent for corporate medical programs and other health and safety efforts. In an era when we rather glibly speak of rights, industry clearly has earned the right to a full measure of participation in health policy development.

With this right comes the responsibility to make a major, ongoing commitment to the improvement of our health care system. There is no single, simple answer, no quick fix that can succeed either through legislation or volunteerism. The future will depend on the degree to which the public and private sectors can work together.

## PBGC says single plan hike to stand

WASHINGTON — The Pension Benefit Guaranty Corp.'s request for an increase in the premium for termination insurance for single employer plans should be sufficient to meet the claims the agency will have to pay in the next several years.

At the moment, employers pay \$1 per participant for termination insurance. PBGC would like to see that premium hiked to \$2.60 per participant to cover an expected \$60 million deficit in the single employer plan fund.

The \$2.60 premium "reflects a level which we think will cover administrative expenses and the net claims which we anticipate over the next five years," PBGC executive director Matthew M. Lind said in an interview.

Although the premium hike currently is being held up by a jurisdictional dispute in the House, Mr. Lind and congressional committee

### Employe Benefits

staffers are optimistic that the dispute will be settled soon and the hike will go into effect Jan. 1.

But while the premium hike may be of immediate concern to administrators who manage the nation's estimated 450,000 single employer plans, a problem with far greater significance is the health and stability of multiemployer pension plans.

Multiemployer plans involve industries in which all employers are covered by one labor contract and pay into a common pension plan. Many of those multiemployer plans, which cover about 7.5 million workers, are floundering.

One problem involves multiemployer plans in declining industries such as the hat, dairy and anthracite coal industries. Under multiemployer termination insurance arrangement, when one company folds, surviving companies are forced to pay the pension obligations.

To pay for those obligations, termination insurance premiums would have to shoot up dramatically, perhaps to as much as \$40 per participant. This big increase could in turn cause the shaky surviving plans to go under because they couldn't afford to pay the higher rate.

One possible solution to the problem of sick plans taking healthier but still shaky plans down with them is the establishment of a sliding rate scale.

Under such a system, those plans which stand the greatest likelihood of collapse would pay a significantly higher premium than plans with less risk of collapse.

A different problem was created by a provision in ERISA which makes corporations responsible for any unfunded benefits up to 30% of its net worth.

Under that ERISA provision, a company with massive unfunded liabilities would be able to terminate its plan and eliminate its financial obligation to pension plan beneficiaries by paying PBGC 30% of its net worth.

Mr. Lind concedes that when the liability of an employer is 30% of its net worth, termination "may be an attractive way for the employer to reduce his burden. . . . Thirty percent could be a real bargain."

One way to hit at this problem would be for PBGC to wipe out that 30% ceiling and only limit an employer's liability when the company goes bankrupt. ■

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# Employee Benefits

## Granddad Kaiser enters third stage as firms join up

By MARGARET LeROUX

OAKLAND, CALIF.—When Kaiser-Permanente Medical Health Care Program, the granddaddy of all health maintenance organizations in the U.S., was finally certified this fall by the U.S. Department of Health, Education & Welfare, Secretary Joseph Califano noted that "corporate America is beginning to understand the significance" of Edgar Kaiser's vision of prepaid health plans.

More than 35 years after prepaid health plans were introduced to workers at Kaiser shipyards in California during World War II, the Kaiser-Permanente program is in the midst of a third stage of growth, gaining high credibility with corporate purchasers of health plans.

"We've been satisfied with the performance of the Kaiser plan," said Ian Thomson, benefit manager for Pacific Telephone. Employee subscribers at the company total 10,000 and their dependents increase the group to 25,000.

Although monthly charges for the Kaiser prepaid health plan have increased over the five-year period Pacific Telephone employees have been members, "the increases have been at a lower

rate than other health plans," Mr.

Thomson said, "and nowhere near the increases in premiums paid to Blue Cross," the basic health benefit plan offered employees.

Pacific Telephone, as well as every other group subscriber to the Kaiser Plan, offers it as one of several choices of benefit plans to employees.

"We believe strongly in presenting Kaiser Plan as an alternative to traditional health benefit plans," said Alan Abel, director of enrollment for Northern California Kaiser Foundation Health Plan Inc.

Since the program's first decade as a community plan, it had the rule of not enrolling groups unless the members were offered a choice of plans, including at least one fee-for-service plan such as Blue Cross or Blue Shield.

Even among Kaiser Health Plan employees there is a choice, although only 6% of the northern California Plan's non-medical employees opted for the alternative, a New York Life Insurance Co. health insurance plan.

Employees in any group subscribing to a Kaiser Health Plan are given the option of changing to another program, usually at 12-month intervals.



A young Kaiser Health Plan member is fully covered for his blood test and unlimited outpatient treatment from doctors and "physician extenders" such as nurse practitioners and physician assistants.

"During open enrollment periods, we've found that for every member who opts out, five or 10 join the plan," Mr. Abel said.

Another reason Kaiser is gaining corporate subscribers is its record of cost containment. There are 150 groups, each with 1,000 or more members in the Northern California Plan.

"For 80% of them, Kaiser is cheaper than the alternative health plans offered and in most cases our benefits are broader than those offered by other health plans," the enrollment director said. "In some cases the rate discrepancies are tremendous."

Monthly charges to Kaiser Plan members in Northern California increased 6.9% in 1977 and will increase another 3.3% in 1978, Mr. Abel said. "In comparison, other benefit plans have increased premiums by at least 18% both those years."

The Kaiser official stressed the use of the words "charges" or "dues." "Don't say premiums. We're not an insurance company," he said. "We deliver service, not dollars."

S.S. Philbrick, manager of group insurance for Crown-Zellerbach Corp., which has participated in the Kaiser Plan since the early 1960s, praised the plan "for doing a great job at keeping the lid on costs."

"Our renewals on alternative plans are running 20% to 25% higher, while Kaiser plan cost increases are 6% to 7%," Mr. Philbrick said.

"We can control costs because we know who we serve, where

they live, what types of physicians and medical facilities are required for each of our six regional plans," Mr. Abel said. "The Blues and other insurance company health plans don't have this sort of data compiled."

In Northern California membership data is computerized. If a member requires treatment at any of the 16 offices or medical centers, his or her medical records can be called up for inspection or computer terminals.

"Our early strength was with unions," Mr. Abel said. The United Steelworkers of America AFL-CIO local union 1440 has offered the Kaiser Plan to members at the Pittsburgh, Calif., plant of U.S. Steel since 1953.

"We're well satisfied with the Kaiser plan," said William Milano, union representative. Offered both Kaiser and Blue Cross, at least 80% of our employees chose the Kaiser plan, he said.

As a result of collective bargaining with the union US Steel has purchased additional services for members of the Kaiser plan.

The Kaiser plan's second stage of major growth came in the late 1960s when federal, state, county and local government employees joined. More than 120,000 employees of the state of California are members of the Kaiser plan; 65,000 of them are with the University of California system.

"The Kaiser plan seems to be most attractive to young family groups, Kathleen Baldinelli, benefit administrator at the University of California at Berkeley. The university contributes \$66

per employe per month for health benefits.

It offers a range of benefit plans including Blue Cross and Equitable Life Insurance.

The average monthly premium for an employe and two dependents with the Blue Cross plan is \$127.58, Mrs. Baldinelli said, while the Kaiser plan charges \$81.70 for a family group of three.

The plan has come a long way since the days when the per employe monthly charge was \$1.50. That was in 1933 when Dr. Sidney Garfield pioneered the prepayment for health services principle for employes working on the aqueduct project in California.

His plan worked so well that in 1938 Edgar Kaiser asked Dr. Garfield to organize hospital and medical care services at the site of the Grand Coulee Dam project. In the 1940s prepaid medical care plans were introduced at Kaiser facilities in Northern and Southern California and Vancouver, Wash. After World War II, membership in the Kaiser program was opened to the public.

Today the Kaiser program operates in six geographic regions including Hawaii, the greater Denver area and the greater Cleveland area. The Kaiser program is the largest non-government provider of medical services in the U.S., with more than 3.3 million members as of Oct. 1.

The six Kaiser plans own and operate 26 general hospitals with 5,711 beds and 86 outpatient centers, representing a capital investment of more than \$616 million.

## Cost isn't tops at Reynolds

While Kaiser-Permanente proudly points out its charges for HMO membership are often less than other health plans, R. J. Reynolds Industries Inc. plays down economics when discussing its in-house HMO.

The company, in fact, prefers to call its HMO a "health plan" because it serves only its own employes and does not meet the definition of an HMO under the HMO Act of 1973.

Vp Rodney Austin said the Winston-Salem Health Care Plan was created to provide accessible, personalized, quality health care that focuses on prevention to promote better health among R. J. Reynolds employes in Winston-Salem, N.C.

Controlling health care costs was "not one of the primary factors" in spending nearly \$3 million to establish the health plan, Mr. Austin said. But if the company finds the health plan can provide better service at the same cost, or at a lower cost, than its indemnity plan, "we will be well ahead," he observed.

There are no cost comparisons available yet, Mr. Austin said, but "we see some potential from the preventive elements of the program." Enrollment in the plan is now 18,000 and it's expected to be 30,000 within the next year.

He explained that most public and private studies show a 20% savings when using an HMO compared to traditional health care delivery systems. That translates into a \$70-a-year savings for each member.

So, it will take 1.1 million member days in HMOs for the savings to equal the investment. "We're already half-way there," he noted.

Of the 49 qualified HMOs, 33 received federal support. It's projected that development of 83 HMOs will be supported by federal grants under the current program.

In all, 168 organizations have received federal grants to work on development of an HMO. The bulk of the \$58 million already awarded (71%) went for initial development efforts. Planning efforts ate up 19% of the grant money to date and feasibility studies were supported by the other 10%.

As would be expected, the most dead-ends were met at the most preliminary stage: feasibility studies. With grants up to \$50,000, about 48% of the recipients did not go beyond the feasibility study. Planning grants, available up to \$200,000, had a better record, with only 9% dropping out

after that stage.

The best record of all was for initial development grants with a failure rate of just 6%.

There has not been one default of a federally qualified plan, Mr. Masso noted.

Though there is criticism—especially from the American Medical Assn.—of the government for subsidizing one health care delivery system, Mr. Masso contends that continued federal initiative is needed in the face of continued health care inflation.

"The HMO is the only proven mechanism for cost containment that still provides quality ser-

vice," he said. "And HMOs discourage over-utilization without imposing excessive regulations."

The Group Health Assn. of America, the HMO industry group, has criticized the federal government for not providing enough development money. Mr. Masso said Congress authorized spending \$250 million on the program, "but Congress was more liberal with its authorization than with appropriation."

On the qualification side, 34 more applications are pending. Based on the grant program, the office of HMO qualification expects another 56 applications by Sept. 30, 1978.

## Federal support to top \$80 million by 1978

WASHINGTON—The federal government has handed out \$58 million in grants and guaranteed \$68 million in loans for the development of health maintenance organizations under the HMO Act of 1973.

It's projected that grants will total \$80 million by the end of fiscal 1978, the last year money will flow under the current legislation.

Return on investment should equal outlays by the end of 1979, said Anthony R. Masso, chief of monitoring and reporting in the HMO division of the Department of Health, Education and Welfare.

## Prepaid health arrangements

# Independent or group—which will triumph?

CHICAGO—As the HMO movement surges forward again, there's debate over what model will or should step out in front: group practice plans or individual practice associations.

Health Care Systems, a division of Employers Insurance of Wausau involved in HMO development in Wisconsin, considers IPAs the better the model. "There's free choice of physician (within the IPA), no new facilities are needed and there's no specific location" since doctors practice in their own offices, explained assistant vp Jacob Spies.

When an IPA is established, often by the local medical society, there's strong doctor participation so patients can stay with their own doctors and will join the prepaid medical plan. The patient's perception of his care is the same unlike in a group model with a staff of doctors.

Because no new facilities are needed, IPAs cost less in time and money to develop. That's an attractive feature to employers considering development of an HMO, Mr. Spies observed. "It can be done in less than a year and for not a lot of money—a couple hundred thousand dollars to develop."

Doctors providing prepaid medical care out of their offices bring the alternative delivery system to more people than one central HMO facility, IPA advocates note.

Though doctors are paid on a fee-for-service basis in the IPAs established by Employers of Wausau, they share in the risk of over-utilization because they must continue to provide services when the common fund paying their fees runs dry. If there's surplus at the end of the year, the doctors receive it.

Criticism of the IPA model is generally aimed at its dimin-

ished management control of doctors compared with the group practice setting. "Theoretically," said Hewitt consultant William Hembree, "there is not as strong a peer review system in an IPA model."

Since IPA practice is just a minority of the doctor's work, his commitment to the plan and to the concept of preventive medicine is often challenged. "I say to IPAs, 'You can't count on a great deal of allegiance from a doctor with 5% of his practice through the IPA,'" said John vanSteenwyk, vp in the health services division of the Martin Segal Co.

Though member doctors work-

## Employe Benefits

ing out of their own offices may bring the prepaid system to more people, the cost containment feature of sharing common facilities is lost, Mr. vanSteenwyk noted.

Mr. Spies of Health Care Systems argues that IPAs can operate under a strong peer review system that holds the plan together. Health Care Systems operates a statistical program for comparative review that took five years to develop.

He also answers the question of the doctor's commitment to the program: "IPA practice affects a doctor's entire practice." Not

only does the educational peer review process expose him to other doctors' methods, but he is influenced in the rest of his practice by the IPA's treatment standards, Mr. Spies said.

IPAs have proven they reduce hospital utilization, but the July HMO census by the Department of Health, Education and Welfare showed that IPAs had the highest number of hospital days per thousand members (605) of any type of HMO. Group plans averaged 500 hospital days per thousand members and network plans averaged 462.

While saying they recognize that IPAs may not be as cost effective as group plans, there are

those who predict the IPA is the model HMO of the future. Willis B. Goldbeck, director of the Washington Business Group on Health, said, "Because there is a degree of control, because they are quick to set up and are palatable to physicians, IPAs will be the way in the next few years though they may not be as effective as a facility-based HMO."

Victor Zink, director of employee benefits and services at General Motors, asks pointedly, "What's the good of getting people to join it if it doesn't mean anything? There's got to be discipline in an HMO and the opportunity for discipline is much greater in a group practice." ■

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## Index adjustments

Every time the Consumer Price Index goes up one percentage point, it triggers the outlay of another \$666 million annually in payments to Social Security beneficiaries under the automatic adjustment mechanism of the Social Security system, according to the American Council of Life Insurance.



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SEE OUR AD ON PAGE 3

# ERISA and HMOs: A brewing tempest

CHICAGO—There may be a conflict between ERISA and the HMO Act, and there could be burdensome reporting responsibilities for employers offering HMOs.

The Employee Retirement Income Security Act requires that you act as a prudent man as the fiduciary of an employee benefit plan. The HMO Act requires that you offer a federally qualified HMO as an option to your employees if you are properly approached.

What if a federally qualified health maintenance organization waves the mandatory dual choice provision of the HMO Act in your face, but you think the HMO is shaky financially? Do you violate the HMO Act and refuse to offer the HMO as an option to your employees, or, assuming you are the HMO plan fiduciary, do

you violate your fiduciary responsibility under ERISA to satisfy the HMO Act?

Who is the plan fiduciary of a health maintenance organization? Asked those questions, the director of HEW's HMO office of qualification and compliance, William J. McLeod, answered, "The HEW position is that ERISA should not pose an impediment to implementation of the HMO Act."

He then referred the query to the Labor Department for any additional comment. "We're trying to work with HEW on this," said a Labor Department official, reading a section of ERISA which says the law should not be interpreted to supercede any other laws of the United States.

"We're trying to decide if there is any recourse against the employer. There is no decision yet,"

## Employee Benefits

the Labor official said.

Employers questioned about possible liability for unpaid medical care should an HMO they have offered go bankrupt generally believe their employees would be picked up under their indemnity or service plans.

Those who've experienced an HMO collapse said they had no problem bringing employees back under their conventional plan. They conceded, however, that they represented large accounts and that a smaller employer might experience more difficulty.

Hewitt Associates consultant William Hembree suggests that employers offering the HMO option negotiate with their insurer so if something happens to the

HMO, those covered by it will be picked up.

Who is responsible under ERISA for reporting on HMOs? A high ranking Labor Department official would not answer, responding through a subordinate that "the whole area is under consideration by HEW and DOL."

A later call for clarification was routed to an information officer who said ERISA clearly requires summary plan descriptions and annual reports on HMOs from employers, though the HMO may write the reports.

But employers don't always agree and some say they are not preparing SPDs on health maintenance organizations. Among them are Dayton Hudson Corp., General Motors Corp., Sears, Roebuck & Co., Eastman Kodak Co. and Control Data Corp.

Dayton Hudson's employee benefits manager Fred Hamacher explained, "I'd feel very uncomfortable doing an SPD on a plan I have no control over." GM's benefits and policy director Victor Zink said, "We assume it's their (the HMO's) responsibility. We're not doing SPDs but we do describe the basic program to our employees."

Joe Reddington, director of policy and benefits at Sears, said, "The responsibility for reporting or summary plan descriptions is not defined. We'd all like to see a clarification of what the responsibilities are. To require separate SPDs for each HMO offered is not realistic. It's easier for the HMO to define its plan."

Martin Beal, director of corporate employee benefits at Kodak, said, "We take the position that the SPD is provided by the HMO to the employee."

One of the companies that is preparing SPDs on the HMOs it offers is General Mills Inc. Benefits manager David F. McIntire said, "I know there's been a difference of opinion on reporting and disclosure on HMOs, but we filed form 5500 under ERISA and we're working on the SPDs."

Ruth Stack, executive director of NAEHMO, a national organization of employers concerned with offering the HMO option, has looked into these two areas also. Her understanding is that HEW said an employer is not saddled with fiduciary responsibility when offering a federally qualified HMO.

But, "there's been no clarification of the reporting requirement," she observed.

The Labor Department, according to its information officer, would find an employer "not in compliance" with ERISA if he fails to distribute and file SPDs on the health maintenance organizations offered his employees. "If we found out an employer was not in compliance, we would make every effort to get the company into compliance. We would send out a compliance officer to discuss the matter," he said.

Asked why the Labor department doesn't clarify an obviously muddled issue, the information officer replied that the regulations are clear and he doesn't think the department has an obligation to do anything more. ■

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## A definition

What's a health maintenance organization?

Prepaid health care delivery systems that have been qualified under the HMO Act of 1973 say they are the only organizations entitled to be identified as an HMO.

But Dr. Paul Ellwood Jr., president of Interstudy in Minneapolis and originator of the term HMO, said, "When devising the strategy to promote them, we had to come up with some name that would embrace a variety of prepaid health care systems."

NAEHMO, the national organization of employers concerned with HMOs, uses the term HMO generally to identify an organized system of health care that is comprehensive, continuous and coordinated, with emphasis on preventive health care, and delivered under a prepayment plan.

# HMO bandwagon . . .

Continued from page 13

on Health, is among those working with HEW on plans for the meeting. He said it will be a working session, addressing the pros and cons of HMOs, administrative difficulties and ways to cope with them.

But GM's Mr. Zink fears a "promotional" event. And he expects Secretary Califano to "try and get private industry to finance some of these."

There's movement in that direction now. Ford Motor Co. has engaged Kaiser-Permanente Advisory Services in a feasibility study on development of a new community-based HMO in Detroit. Though entirely Ford's effort at the moment, the company is hoping for support from other Detroit corporations if the study indicates an HMO is desirable.

The decision is expected next spring, said Ford employee benefits manager Jack K. Shelton. Obviously enthusiastic about the prospects, Mr. Shelton said, "I would hope more companies would do this. If employers establish programs, they would be properly structured and there would be community interest."

**Kaiser-Permanente Advisory Services**, a new non-profit company funded by the Henry Kaiser Foundation, is working on two other HMO feasibility studies. One is a joint study with Prudential in the Dallas/Fort Worth area.

"I can tick off eight or 10 major companies we've talked to directly or indirectly about setting up HMOs," said executive vp John J. Boardman at Kaiser-Permanente Advisory Services. Of course, he wouldn't do it for the record.

Health Care Systems, a division of Employers Insurance of Wausau involved in HMO development, is "in active discussion with five very large employers on developing HMOs," said assistant vp Jacob Spies. Three of the employers are located in the East, one is in Chicago and the other is in Denver.

Corporations can bring to HMO development "know-how, prestige and community impact that is tremendous," observed Interstudy's Dr. Ellwood. If just two or three major industrial corporations were to successfully form HMOs, "we expect many, many more would follow suit," he said. Corporate development of

HMOs will affect not only the immediate community, "but it will also catalyze the insurance industry," Kaiser's Mr. Boardman predicted.

"As the indemnity industry looks down the road and sees major corporations, like R.J. Reynolds, establishing HMOs and it realizes this is business it will never write again . . . the indemnity carrier may say, 'We should get into developing HMOs.'"

That too is already underway. Jeffery Cohelan, executive director of the Group Health Assn. of America, a trade group representing HMOs, said the insurance industry has invested \$80 million in HMO development. That is equal to the total federal outlay expected through 1978.

Corporate interest isn't limited

to developing new HMOs. Voluntary offerings of HMOs to employees increased in the last 18 months while other employers have been induced by the 1973 HMO Act to offer the option.

Basically, an employer must offer a federally qualified group practice HMO and a federally qualified independent practice association (IPA) if 25 employees reside in the HMO's service area and the HMO properly approaches the employer.

**Growth of HMOs**, however, has been slower than hoped and several reasons are cited.

For one, the wage and price controls of 1972 to 1975 held health care inflation under 10%, so there was limited interest in a system that promised to control health care costs, observed Mr. Boardman.

Even when prices were unleashed in 1975, other factors stymied HMO acceptance. Chief

'If employers would establish (HMO) programs, they would be properly structured and there would be community interest.'

—Jack Shelton, Ford Motor

among these was the 1973 HMO legislation, which was called the "anti-HMO act" for its severe regulation of HMOs. (The more objectionable provisions have been amended.)

By mandating that employers must offer employees the option of health care from an HMO when properly approached by a federally qualified HMO, the government put business on the defensive. Then the regulations implementing the dual choice mandate weren't released until late 1975.

Many employers delayed of-

fering an HMO until they knew the rules. Dayton Hudson Corp. in Minneapolis awaited the regulations for a 18 months, said benefits manager Fred Hamacher, then finally went ahead with the HMO option without them.

When the regulations finally emerged, some companies decided to only do what they had to in offering only qualified HMOs. That approach is less prevalent now, observes Ruth Stack, executive director of NAEHMO, the national group of employers concerned with HMOs, but it still

Continued on following page

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# HMO bandwagon . . .

Continued from preceding page exists.

The Employee Retirement Income Security Act (ERISA) was also monopolizing the employee benefit managers' time—time that might have been used to

investigate HMOs if it hadn't been for trying to digest that massive piece of legislation.

But with more qualified HMOs knocking on employers' doors, forcing them to investigate HMOs, and with the continued

cost spiral in indemnity and service plans, more corporations are offering the HMO option with enthusiasm and hope.

"I see a more positive attitude among employers," said Ms. Stack, who has worked in the HMO area since 1972. "Many employers are responding positively because they see the cost effectiveness of HMOs," she observed.

Indeed, HMOs are proving their worth. Of the 60 health plans available to federal employees, 30 of the 46 HMOs now cost less than the high option Blue Cross/Blue Shield family plan priced at \$99.91 a month.

And hospital use by federal employees enrolled in an HMO is less than hospital use by their co-workers served by Blue Cross. In one study, federal employees in HMOs used 383 hospital days a year per 1,000 members, while federal Blue Cross subscribers used 724 hospital days per 1,000 members.

Corporations too are finding the cost of their indemnity and service plans have increased so much that some HMO charges are equal to or less than the traditionally cheaper conventional plans. Consultants Hay-Huggins said HMO prices have risen only half as much as the cost of group insurance plans.

Eastman Kodak Co.'s experience with HMOs bears that out. In the period from mid-1973 through 1977, the basic Blue Cross/Blue Shield health plan premium rose 81%, to \$62.64 from \$34.56. But the two Rochester HMOs increased their rates only 48% during the same period.

Still, the Rochester Blue Cross/Blue Shield family plan at \$62.64 remains less expensive

than the HMO rates at \$73.46 and \$83.95—a condition some say results from HMO competition.

At Illinois Bell Telephone Co., however, employees with family membership in the Chicago area HMO, Northcare, find the bill is company-paid. Last year they had to pay an additional \$15 a month for Northcare membership, but the cost to the company of indemnity coverage caught up with the HMO.

If that trend continues, companies will be faced with "the difficult decision of whether they should require employees to pay the difference in cost for indemnity cover compared to the cost of an HMO," says Interstudy's Dr. Ellwood.

Dr. Ellwood expects more HMOs to charge less than conventional plans. The most inflationary component of health care is hospital care, he explained. Because HMOs reduce hospital utilization, they aren't as affected by hospital cost increases.

This competitive edge isn't always translated by the HMO into its rates, charges GM's Mr. Zink. "Some plans follow the regular coverage and raise rates when they do," he said.

Lower prices also shouldn't be expected from new HMOs, notes Hewitt Associates consultant William Hembree.

Even in the glow of a resurgence in HMO activity, the limitations of prepaid medical plans are recognized.

"They're not the solution to all our problems," cautions GM's Mr. Zink, a sentiment echoed by other benefit managers, consultants and HMO representatives.

"It's a very difficult concept to sell to employees," observes

Mr. Zink, because an HMO limits their options "and they don't want their options limited." A prepaid health plan is a hard concept to explain and it's "even harder to demonstrate why an employee should give up freedoms when he has such broad service coverage anyway." HMO patients give up their own doctors, receiving treatment only from physicians practicing in the HMO.

HMOs are also limited by their own handicaps at the moment, not the least of which is a lack of capable management. "To run an HMO takes a lot of skill," said Mr. Zink. "If there were all those people available, why would those capable people keep moving around?" he asks.

The GM benefits manager also questions whether the success of the Kaiser plans can be duplicated elsewhere, as proponents of HMOs claim. The ingredients of the Kaiser plan—good management, good financing, backing by a respected man with charisma—won't be easily copied, Mr. Zink says.

In addition to a shortage of good management for HMOs, Mr. Zink doesn't think past problems of financing and of convincing enough quality providers to work in the HMO setting have been solved.

It's generally agreed among the experts that HMOs will continue to grow but will not monopolize health care delivery.

"A great many people with a lot of money, who want free choice, will go where ever they want, to whom ever they want," said Sylvia Coppersmith, an official with Intergroup, a Chicago area HMO.

Though employer attitude toward HMOs has been improving, past president of NAEHMO David F. McIntire believes "there's a lot more to occur."

Ford's Mr. Shelton, though supportive of the HMO concept, is concerned with "the real risk of overselling HMOs. We cautioned Secretary Califano against overselling. . . . There's an acceptance problem and not all HMOs are financially competitive."

But Dr. Ellwood of Interstudy suggests that if prepaid medical plans are to provide the competition in the marketplace necessary to hold down rising costs and preempt more government regulation, then more than half the population will have to be in an HMO or some variation of it. ■

## Shirt-Sleeve Forum

### Do You Need to Update Your Employee Benefit Program?

By Dinner Levison

(Asked in the financial district)

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# HMO response . . .

Continued from page 13

Cost hasn't influenced employee choice at Ford. In the last five years, HMO rates have been 10% less than Ford's umbrella rate for the local Blue Cross/Blue Shield program.

Fred Hamacher at Dayton Hudson Corp. in Minneapolis is offering seven HMOs around the country. "Administration isn't burdensome. It's quite the contrary with no claims," he said.

"We've always had reasonably good participation," he said, pointing to a 32% average participation rate in Minneapolis and Houston.

Mr. Hamacher has detected trends in HMO use among predominately female retail employees: a lot of young females and young families opt for the HMOs but older employees, who have lived in one area for a number of years and apparently have established relationships with their doctors, elect HMOs less often.

Among executives transferred from out-of-town, he's found 90% take the HMO option.

Costs vary across the board, with HMOs still more expensive in some areas and undercutting the indemnity plan in others. Where the HMO is less expensive, Mr. Hamacher has seen an increase in HMO participation, "but no jump."

Mr. Hamacher, who offered HMOs before the dual choice regulations were released, has never been pushed into a corner by an HMO wielding the mandatory dual choice option. He said he once advised an HMO interested in enrolling employees in one area that it wouldn't be successful because the indemnity rates were so low the HMO just couldn't compete. The advice was taken.

David F. McIntire at General Mills says his company voluntary moved to offer HMOs in the spring of 1973. Participation in the Minneapolis area is more than 55% of eligible employees. But outside Minneapolis—a hotbed of HMO activity—participation runs in the 3% to 6% range.

Since 1973, Mr. McIntire has seen the price gap between HMOs and his indemnity plan close and in Minneapolis the HMO is now less expensive than the indemnity coverage.

Though employee meetings to compare HMO benefits with those under indemnity coverage, payroll deductions and additional administration eat up time, Mr. McIntire said, "The HMO is one of the easiest benefit additions we've had in Minneapolis."

Xerox Corp. set up a computer program to handle administration of 200 to 300 HMOs. Though the company is offering only 10 this year and possibly 20 next year, benefit manager Peter Biggins anticipates HMO activity will eventually get to the projected mark.

Since Xerox self-insures its medical plan, it must determine the value of its plan in areas where it offers the HMO option. It's about a 50-50 split on which is more expensive.

Mr. Biggins believes cost does influence employee reaction to an HMO. In Westchester, N.Y., where employees did not have to pay anything for HMO enrollment, participation was 10%. But when there's an additional charge for HMO membership, a 2% to 3% participation is more normal, Mr. Biggins observed. Six hundred and fifty Xerox employees belong to HMOs.

Control Data Corp. offered 10

## Employee Benefits

HMOs around the country to its employees last September and found participation rates ranging from a high of 21% in the Minneapolis area to a low of 3% in Houston. The average was 18%. All the HMOs offered were more expensive than the company's indemnity plan, with HMOs running about \$12 more a month.

Dick Petrowski, manager of health benefits and group insurance, said there was an administrative burden to the program on the accounting side, with a multitude of rates, records and enrollment forms to contend with. And there was a good deal of time devoted to preparing explanatory material on HMOs and conducting employee meetings.

Joe Reddington, director of policy and benefits at Sears, Roebuck & Co., said the worst part of offering 30 HMOs this year "was getting prepared initially." The company developed a slide show and pamphlets to explain the HMO option.

Next year Sears will offer 75 different HMOs, mostly the result of federally qualified HMOs exercising the mandatory dual choice regulation. Participation rates have ranged from 2% to 5% in HMO plans that cost 20% to 30% more than Sears' own plan which Sears partially self-insures and places the balance of coverage with its Allstate subsidiary.

Mr. Reddington said an additional charge to employees for HMO coverage does affect employee enrollment, "but what's of major importance is location and reputation of the HMO. And if it's not close, reputation doesn't matter," he observed.

Employers interviewed differed in their approach to offering qualified and non-qualified HMOs.

Xerox works with only qualified HMOs, though in some instances the qualification is by a state and not by HEW. "It's a standard for determining their quality," said Mr. Biggins.

Illinois Bell Telephone Co. made an exception to its rule of working only with qualified plans. Benefits director Floyd Brown explained that in Springfield, Ill., 95% of the doctors have joined a medical foundation and the company wanted to take advantage of the prepaid alternative.

Of the benefit managers interviewed, more will also offer plans that have not been qualified by HEW or a state. Eastman Kodak, for instance, offered Kaiser plans before they were qualified. "We look the plan over and employee demand," explained benefits manager Martin Bael.

Mr. Petrowski at Control Data maintains "qualification doesn't denote quality. Our thrust is to look at their track record." Plans that weren't HEW qualified, but well established, were offered along with ones that were qualified to provide employees with options.

Benefit managers also disagree on whether or not HMO representatives should be allowed to make their pitch at employee meetings when the HMO option is explained.

Mr. Petrowski hands the HMO representative an outline of what he wants explained.

Mr. Hamacher at Dayton Hudson says flatly, "I don't want them there selling." He does want HMOs to sponsor open-houses so employees can review the facili-

ties and to establish hot lines for answering questions.

Other benefit managers say they have no problem with allowing the HMO representatives to talk to employees at the company, though some set aside company time for the visit and others do not.

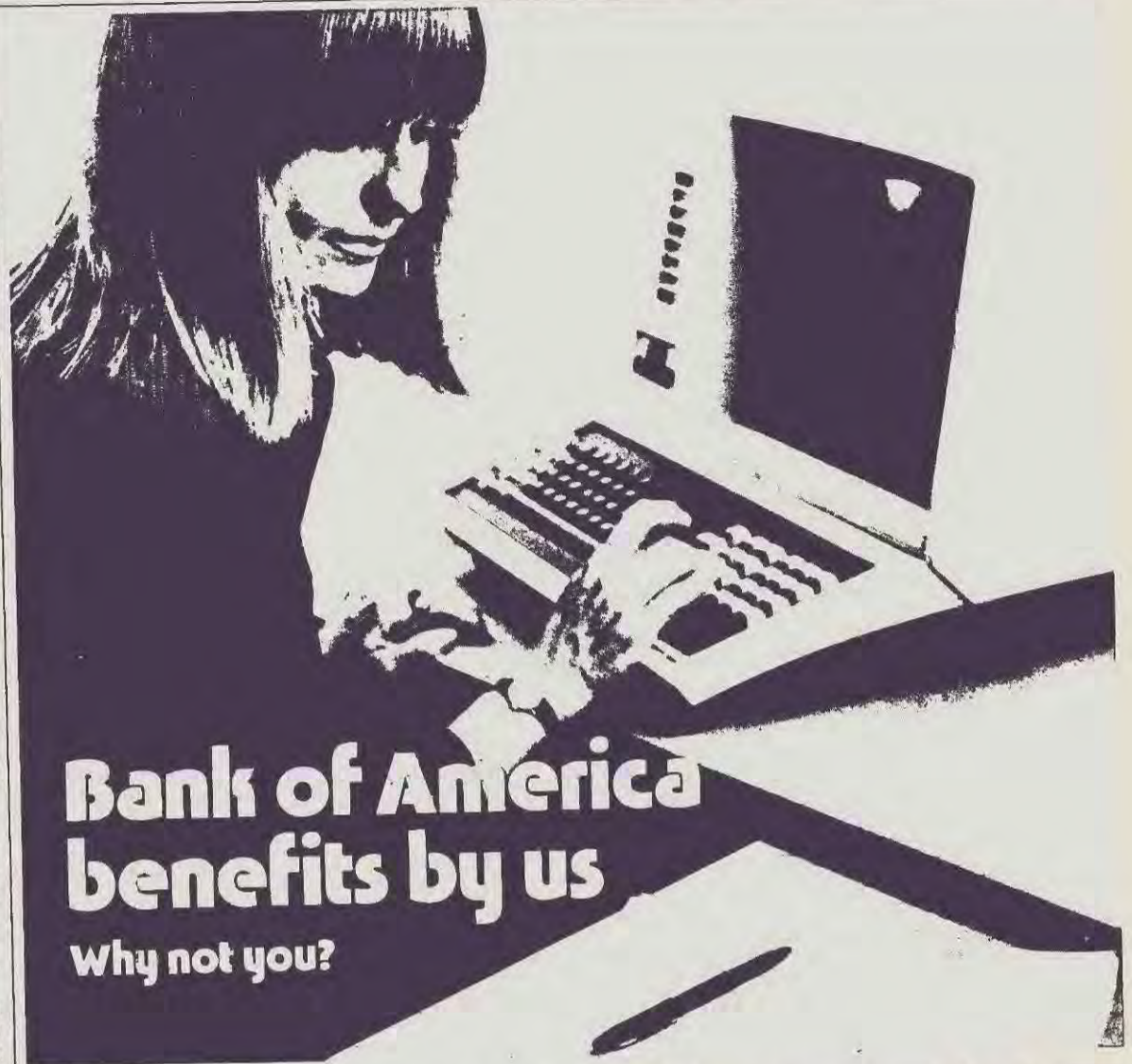
The benefit managers interviewed generally expressed per-

sonal support for the HMO movement and hope for future cost containment through the prepaid plans. But they said they are also careful not to influence an employee's choice.

"We don't advocate, but we do go out of our way to develop our own communication package," said Xerox's Mr. Biggins.

Despite an objective stance, employee benefit managers find

that employees interpret the offering of the HMO option as a company endorsement of the plan. With that understanding, employees contact the benefit manager when they have a complaint about the HMO. The employees are easily hooked into the HMO's grievance procedure, the benefit managers say, and the problems are generally resolved amicably.



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# HEW can't find an HMO office director

WASHINGTON—Know anyone with good HMO operation and management skills, policy intuition, and who wants to go to work for the federal government?

Tell him or her to contact Health, Education and Welfare Department Secretary Joseph Califano.

He's looking for someone to take on a new position as director of HMOs, overseeing both the development and qualification work. The two functions have been separated and the secretary wants them coordinated under one boss.

The new HMO office will be organized in the Assistant Secretary for Health Office, a promotion in the bureaucracy for the HMO development office that has been in the Bureau for Medical Services. "It will give the program visibility," observed a development office staffer, "and it will operate more efficiently."

But no one offered the job as director of the new office has accepted.

"It's a tough job," said Bruce Wolff, special assistant to the secretary of HEW, with a hint of understatement in his voice.

Not only does the secretary want someone who will "consolidate and manage the program as a coherent whole," but he also wants someone willing to identify policy issues that must be resolved and someone who will focus attention on "new directions," said Mr. Wolff.

Some of the policy issues identified for resolution are a way for national employers to deal with a multitude of HMOs in some cohesive way so they aren't faced with 32 different plans with different procedures and different anniversary dates and the proper role for private insurers and Blue Cross/Blue Shield to play in the development of HMOs.

Interested?



Joseph Califano

# Rural HMO finds task too costly

BLOOMFIELD, Iowa—Operating a health maintenance organization (HMO) in a rural area requires a different set of rules than are applied in urban settings.

So says Blue Cross/Blue Shield of Iowa. After two years of experience, Blue Cross is pulling out of a pilot HMO program it established here with the county's doctors.

When Rural Health Services closes its books Dec. 31, Iowa will be without an operating HMO.

To the participants—16 doctors, an osteopath, a hospital and nearly 4,000 members—the program was a glowing success, said a Blues spokesman. But for the Iowa Blues, it was a real money loser: \$890,000 for two years of operation.

The Blues say Rural Health Services failed financially because the population base it served was too small with too many bad risks. Among the 8,000 residents of Davis County in rural, southeastern Iowa, a large number are over 65 and a "meaningful percent of the population never had health insurance," explained the Blues spokesman.

Rural Health Services' open enrollment with no restrictions on pre-existing conditions attracted members in need of medical care.

## Employe Benefits

"Doctors treated people they had never seen before," the Blues spokesman noted.

"We knew there'd be losses the first year, but we thought that was the price to pay for bringing these people up to good health," the Blues spokesman continued.

The first year the family plan charge was \$69.10 for a benefit package that included annual physicals, immunization, diagnostic x-rays, prescription drugs, therapeutic radiology, other preventive and restorative services and Blue Cross/Blue Shield benefits.

The family rate was raised to \$94.85 in January 1977, but even that didn't cover costs. The actuaries determined that the rates needed to support the program would be beyond the reach of people in that area.

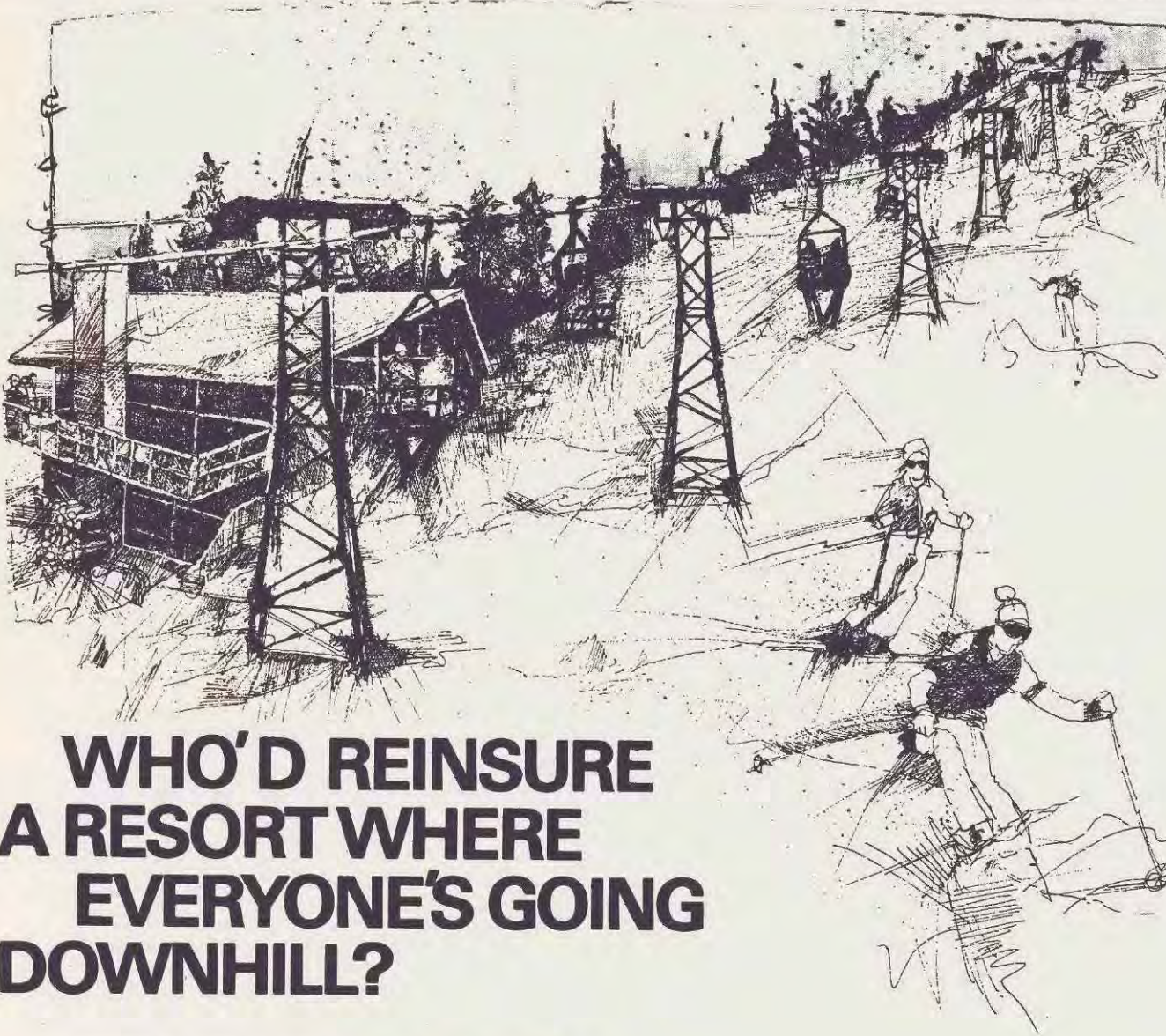
The Blues have concluded that to succeed an HMO needs a larger community, with an improved mix of ages. It also needs a population base that can provide a better mix of direct pay and employe group members. In a rural area, the largest employer is generally the school district, the Blues spokesman noted.

"The experience proves we need an underwriting program," the Blues spokesman observed.

When the Blues introduced Rural Health Services it cautioned prospective members that the program was a pilot project, the spokesman said, and promised that should it be terminated the members could secure Blue Cross/Blue Shield coverage. A service center has been established in Bloomfield to assist HMO members signing up with a Blues plan.

Rural Health Services had not been qualified by HEW under the HMO Act of 1973.

The Iowa Blues are chalking the expensive project up to experience, though they aren't planning at this point to back any other HMOs in the state.



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# Broker paves way in mental health prevention

By SUSAN ALT

LOS ANGELES — The talk about preventive mental health care is finally turning into reality for West Coast organizations that are implementing a program that encourages employes to use psychologists or psychiatrists.

The benefit costs only \$4 a month per family unit for generous coverage including 100% payment for the first five visits.

The program is meant to lower health insurance costs by reducing the physical illness caused by depression or other emotional disorders, correct the growing problem of alcoholism in the workplace and eliminate accidents traceable to mental illness.

It's also hoped the program will help slash the \$17 billion a year in lost productivity the National Assn. of Mental Health believes is attributable to employes' emotional problems.

If this sound like a lofty goal, no one would agree more than John Armer, the Los Angeles broker responsible for putting the program together. Mr. Armer, head of the firm that bears his name, has believed for years that mental illness is at the root of many corporate problems and most visits to a doctor.

With health costs skyrocketing, Mr. Armer looked for "something inherently wrong with the system."

What was wrong, Mr. Armer decided, was that employers discouraged workers from seeking help for emotional problems. They were doing this by typically limiting benefits for outpatient mental health care to 50% of the cost of the visit, subject to a maximum fixed dollar payment which was usually quite small, such as \$10 or \$20.

That doesn't even begin to cover the \$45 to \$75 an hour charge for treatment.

To counteract this disincentive, John Armer established a non-profit corporation in California funded initially by 250 psychiatrists and psychologists who believe that good health care means looking after the total person, including his mental condition.

Besides the high cost of treatment discouraging employes from seeking treatment, Mr. Armer saw another problem—that of confidentiality—to be overcome in his program.

"The biggest deductible of all

is that of crossing the threshold of the employment or personnel office to get the claim form for this care," he says. So Mr. Armer did away with a claim form, providing for treatment charges to be billed directly by the participating doctor or psychologist to the California Psychological Health Plan (CPHP) claims office.

So far, Mr. Armer has signed up two insurance companies—Mass Mutual Life Insurance Co. and Crown Life Insurance Co.—which offer reduced rates to group clients that offer CPHP as a benefit to employes. He currently has about 40 to 50 employer groups (about 4,000 employes) covered under the plan, which is in effect a closed-panel prepaid health plan to provide

## Employee Benefits

mental health care.

On the panel are 250 psychiatrists and psychologists, receiving a fixed rate of \$50 per hour no matter where they're located in California. Monitoring these 250 providers are 12 committees, known as Professional Standards and Management Committees. Each of the 250 participants in the program must submit to close scrutiny of treatment methods by the committees, each having three paid members from the consumer-users of the plan and the treatment group.

The CPHP has elements to prevent employes from taking advantage of the program. Although the first five visits to a participating doctor or clinical

psychologist are completely free to the employe, visits six through 10 require the employe to pay 15% of the cost. After the 10th visit, the employe pays 30% of the cost of treatment and after the 15th visit the employe pays 50% of the cost.

At that point, the benefit level is reduced to about where it would be under a conventional health benefit plan, although CPHP provides that under certain conditions a patient can seek treatment up to 500 times.

There are also disincentives for the psychiatrists and psychologists to abuse the program. After five visits by an employe, the doctor must go before the standards committee. The provider shares with the committee the prognosis, diagnosis and the proposed plan of treatment, either

Most firms don't encourage preventive mental treatment, but Massachusetts Mutual hopes to use the CPHP program as a tool to attract corporations. Page 62.

er receiving approval for another 15 visits by the employe or being turned down for more treatment.

"There is fiscal responsibility as well as treatment responsibility in these committees," says John Armer.

The average number of visits per patient is running much higher than Mr. Armer anticipated—about 11 visits—although Mr. Armer thinks eventually the figure will drop. Studies have shown that crisis intervention

Continued on following page

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## Mental health . . .

Continued from preceding page  
treatment in the mental health area generally requires about 4.5 visits, he said.

The utilization rate, however, is running lower than expected.

Only about 4% of the employe population covered by the benefit is presently using the program, although Mr. Armer expects this to rise as more people realize treatment is available.

The low \$4 per month per family unit premium probably also will rise with this increased utilization. But if Mr. Armer's hypothesis proves true—that over the long run, health care benefit costs and health insurance rates will decline as mental health improves—the cost of this benefit could be more than offset by reductions in other insurance expenditures.

Mr. Armer's marketing plan for

CPHP is basically one of brokering this program to agents and brokers, earning an override of 1% to 3% of premiums.

Pacific Service Industry Trust is the largest group in CPHP, with about 2,000 employes insured. Pacific Service, a multiple employer trust representing the non-union workers in California's restaurant and hotel industry, has offered the CPHP benefit since November 1975, first under a health insurance plan with Crown Life Insurance Co. and now through a plan underwritten by Prudential.

Neither the employes nor the trust pays anything for the added benefit, as Prudential absorbs the cost, offsetting it by reducing outpatient psychiatric treatment benefits formerly provided under the insured plan.

The city of Inglewood joined CPHP in August, bringing about 500 full time employes into the fold. Shirley Williams, assistant personnel director, said the move was prompted by the city's union, which included demands for a good mental health benefit in negotiation documents.

"Their biggest concern was confidentiality. The employes didn't want the city to know anything about who was using the benefit," she said. The city is insured for its group indemnity plan with Mass Mutual, which agreed to absorb the CPHP \$4 premium per month per family unit.

"It's too early to tell what the results will be, but we've talked with management supervisors who had previously witnessed the poor performance of troubled employes, and they say the program has the potential to help employes cope a bit better with their stress," says Ms. Williams.

Another recent convert is Dean

'The (mental health prevention) program has the potential to help employes cope a bit better with their stress.'

—Shirley Williams,  
Inglewood, Calif.

Palius, personnel director and risk manager for the city of Santa Barbara, who's been wrestling for over two years with the dilemma of a growing employe alcoholism problem.

As risk manager, benefit manager, chief negotiator for the city and also chief safety officer, he found himself confronted with an increasing number of people sent by their superiors for disciplinary actions. "But I didn't feel this was the best way to handle the problem," he said.

The city ultimately asked Pacific Mutual Insurance Co., its health insurer, to lift the policy exclusion which prevented coverage for alcoholism treatment. "We were paying for the treatment anyway, but doctors would call it by a different name. We thought it would be a lot better to call alcoholism by its real name."

At the same time, the city instituted a training program for all supervisors, enabling them to identify personnel alcoholism problems and make the appropriate referrals through the personnel department.

"That's what turned me on to the idea of looking at the whole person. I also was thinking in terms of finding a benefit that would be used by employes, but that would return something to the employer for the dollars paid out," said Mr. Palius.

"I've currently got three cumulative trauma cases pending that are psychiatric, which could run us a total of \$100,000 in work comp benefits."

The City of Santa Barbara instituted CPHP for only about 60 of its management employes, but intends to add the benefit for the rest of its 750 employes over the next couple of years. The city picks up the full tab of \$4 per month per family and views the benefit as a bargain.

For police officers, the city already was providing psychological services, using a consulting psychologist to refer officers to doctors when necessary, with coverage under the insurance plan of \$25 per visit for up to 52 visits per year.

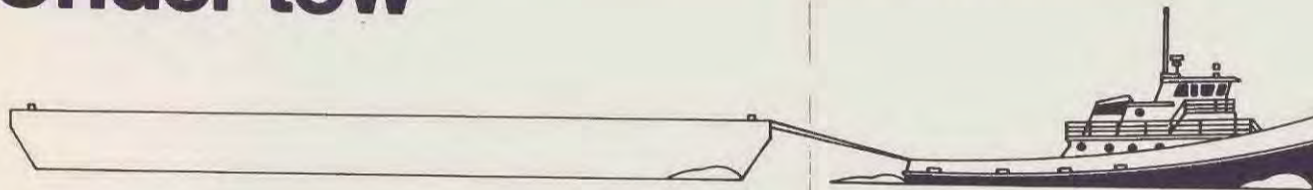
"But CPHP is aimed at crisis intervention, not long term psychotherapy," reasons Mr. Palius. "It gets at the people who can't cope day to day."

Because the city eliminated its mental health benefit under the Pacific Mutual insured program when it signed up with CPHP, Pacific Mutual rebates to the city about \$1.30 per month per employe as the savings on that narrower coverage, so CPHP has a net cost to the city of about \$2.70 per month per employe. ■

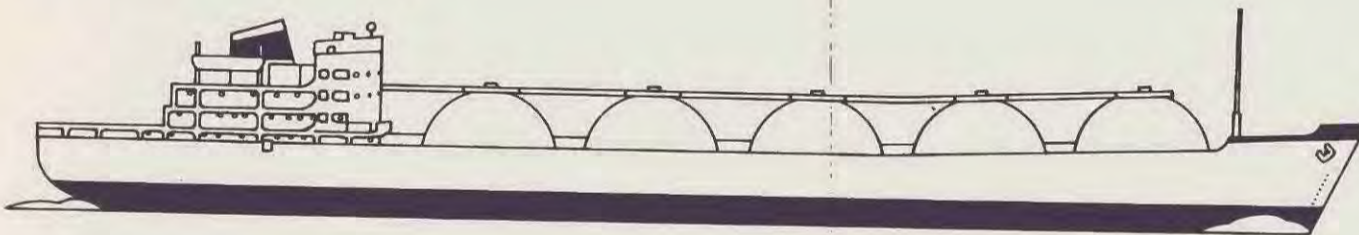
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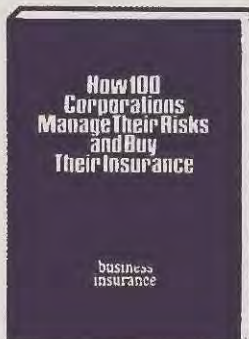


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# Most firms don't encourage prevention

WASHINGTON—Although most corporations currently offer mental health benefits to employees, most don't do anything to encourage early detection or treatment of mental illness.

Most employers ask employees to pay anywhere from 20% to 50% of the cost of visits to a psychiatrist or psychologist and many benefit plans also involve deductibles for these benefits.

These are a few of the findings of a limited study of mental health benefits conducted by The Washington Business Group on Health during 1977.

The Washington Business Group surveyed 79 large employers and found all 79 provide at least some mental health benefits for employees. Generally, mental health benefits were found to be equally available to all personnel. Schizophrenia, depressive disorders, alcohol and drug abuse coverages were the most common afforded.

A high portion of the firms also provide the benefits to dependents, while a slightly smaller percentage offer the benefits to retirees.

Family, marital and sexual problems were only beginning to be included as covered problems, with less than one-fourth the firms offering these benefits, the group said.

There was an almost even split between those firms which pay 100% of the premium for the mental health benefit (52%) and those sharing the cost with the employees (48%). For those that share, the employee portion is most commonly limited to 20% or less.

Close to half the group agreed that mental health benefits helped the company by improving employee morale, lowering absenteeism, reducing instances of severe mental illness, improving hospital utilization. Only a small number (16%) said it helped lower total insurance premiums.

Three-quarters of the companies admitted that they don't provide any incentives to encourage early detection or treatment of mental problems.

Almost half the companies provide coverage for charges involving treatment in an in-patient facility other than a hospital.

# Insurer uses mental plan as lead-in

SPRINGFIELD, MASS.—Massachusetts Mutual Life Insurance Co. is aggressively marketing the California Psychological Health Plan established by John Armer. It hopes to use the program as a competitive tool to attract new corporate policyholders.

The insurer already has about 30 to 40 clients using CPHP, said vp Kenneth C. Krueger, noting that this includes about 1,000 employees in groups ranging in size from 10 or more to several hundred workers.

Moreover, Mass Mutual recently added the benefit to its own package covering 300 California full time agents. "Our reasoning in providing this benefit and in selling this program as part of our coverage is to really run a pilot program to see what's going on, to see if this has any effect

## Employee Benefits

on physical care. We feel the idea is worth exploring, if CPHP ends up reducing the physical manifestations of mental illness," said Mr. Krueger.

When Mass Mutual instituted CPHP for its own agents several months ago, the company was hoping that eventually the plan would lower 5% to 10% the cost of total health and medical expenses for these agents over a couple of years.

"Our contract with agents previously contained out-of-hospital psychiatric benefits, so we eliminated that and replaced it with CPHP. It was hard to figure out what mental health treatment under that program was costing us in the past, but we feel it was probably between \$2 and \$6 a month per employee," said Mr. Krueger.

Mass Mutual wrote its first contract including this CPHP coverage in January of this year, but activity wasn't much to sneeze at initially. Since June, however, "there's been a lot more done with it and now we're really promoting it. We have agreed to reduce our premium by the amount of the CPHP premium, reducing as well outpatient psychiatric benefits." ■

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# Dental insurance tide slows as clouds appear

By GREG DAVID

CHICAGO—When David G. McLinden joined Delta Dental Plans three years ago the goal was "80 by '80"—80 million persons covered by dental insurance by 1980.

The national coordinator for the Delta Dental Plans Assn. smiles when he recalls that and other predictions that dental insurance would soon become as common as medical coverage.

Today, only two years from that target, 35 million persons are enrolled in prepaid dental programs which pay for \$1 billion of the \$8.5 billion spent each year on dental care. F. Gene Dixon, president of the Delta system that insures 14 million persons, says the day is still far off when even 70 million Americans will be covered by dental insurance.

After several years of rapid growth, dental insurance is being added to employe benefit plans at a much slower pace. And dental insurers worry that the trend to reduce coinsurance payments by employes in dental coverage will destroy cost control efforts and bring the unchecked inflation of the medical field to dental care.

Half the population in the West now has dental coverage, said Mr. Dixon, as well as most large labor unions and employes of many of the nation's largest corporations. But, he added, it seems unlikely that the major groups now without coverage—local, state and federal government employes—will win the benefit in the near future.

Future growth in dental insurance will be slow since most large unions have already negotiated the benefit, agreed Dr. William G. Downes, director of group claims for Aetna Life & Casualty. Aetna covers 5.3 million persons for dental.

The Prudential Insurance Co. is now working with a diverse group of union and non-union companies on dental insurance compared with the unionized companies that first instituted dental coverage, said vp Richard Souders.

Prudential's dental business has been concentrated on the West Coast and the East Coast but now appears to be spreading geographically, Mr. Souders added. Both Prudential and Delta Dental executives agreed the South lags with most Southern employers who provide dental insurance including the coverage in their major medical plans.

Unlike Aetna and Delta Dental, Prudential expects "fairly rapid expansion in dental insurance," said Mr. Souders.

A typical dental program set up by Delta Dental Plans provides full coverage for preventive care, 80% coverage for basic services such as fillings and 50% reimbursement for prosthetics. Many companies are opting for \$1,000 maximums, up from the \$500 figure often elected by companies in the early 1970s.

Orthodontic coverage is selected by about 15% of the companies and unions insuring with Delta Dental Plans. The dental plan for the International Machinists union, similar to the typical plan, costs about \$16 a month per employe (including dependent coverage).

Aetna Life & Casualty recommends a program providing 100% payment for preventive care and 80% coverage for basic services.

The cost varies between \$10 and \$20 a month per employe, depending on deductibles. Less than half of Aetna's plans include orthodontic coverage, but those plans that offer orthodontic coverage involve most of the employes Aetna insures.

About half of Aetna's dental clients also use the company for medical insurance; the large majority of Prudential's dental clients also use the company for medical coverage.

But all three insurers are concerned by the trend, especially in union plans, to reduce the coinsurance payment by the employe.

"When the patient doesn't have to pay anything," said Delta's Gene Dixon, "there is an incentive to say, 'Do it all!'"

Dr. Downes at Aetna pointed to the International Harvester

## Employe Benefits

contract with the UAW to illustrate the trend to reduce coinsurance payments. Coverage for basic services began at 75% when the first dental provision was negotiated but has been increased to 100%.

Dr. Downes argued that employes do not benefit when coinsurance is reduced if maximums are not increased. "All you do is give the dentist an incentive to do the work with dentistry that takes the shortest amount of time," he said.

For example, an employe whose dental program covered 75% of a \$185 crown with a \$750 maximum in 1971 merely receives fewer crowns in 1977 under a program paying 100% of a

\$285 crown if the maximum has not increased.

Inflation in dental care has been held to the level of increase in the cost of living, around 7%. But eliminating coinsurance could bring the 15% annual inflation rate of medical care to the dental field, the insurers agreed.

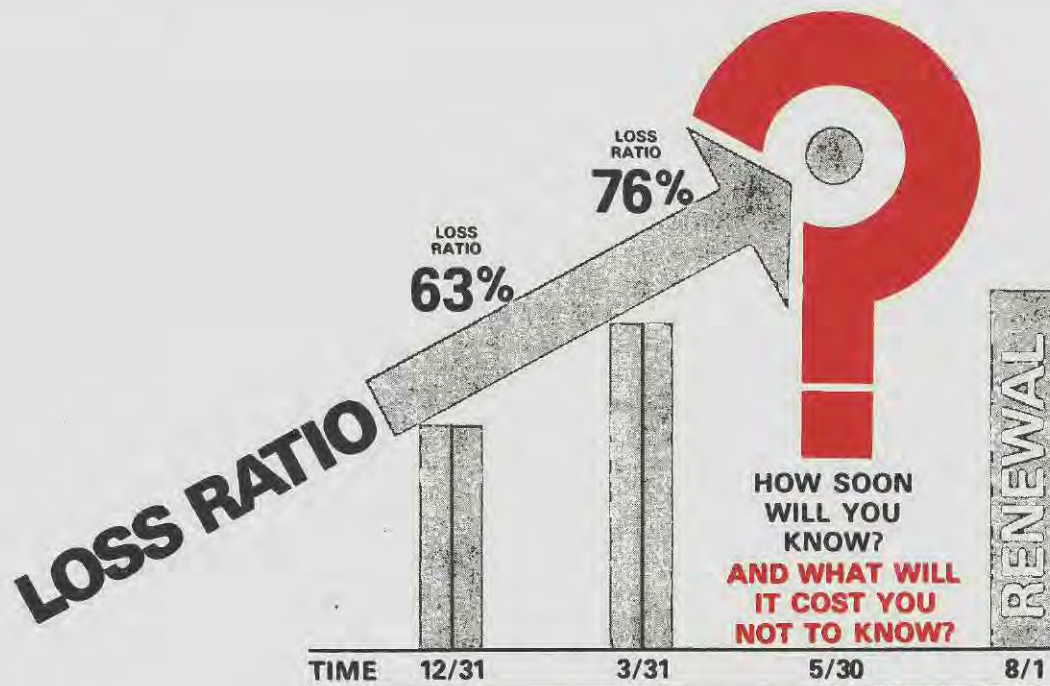
Despite the mild inflation, there has been an increase in dental costs as more and more employes use the benefit. Delta Dental plans has not seen the decrease in use expected after the first year of a program. Aetna is now seeing many plans with as many as three claims per year for each covered employe, up from 1.5 claims in the early 1970s.

"As a result, employers are

beginning to have difficulty paying for dental insurance," said Dr. Downes.

To cope with rising costs, emphasis will have to be placed on preventing disease, the original objective of dental insurance, Dr. Downes said. Insurers will begin paying for work by dental assistants, for example, to encourage frequent check-ups and cleanings.

In addition to cost control, Delta Dental expects to explore ways to cut administrative costs and speed claims work. Under a pilot program, computer terminals have been installed in dentists' offices to eliminate claim forms for routine work. The system could be expanded to a prior-approval system for more complicated procedures, Mr. Dixon said.



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# Tanker losses up for 9 months; 6 nations top Liberian figures

NEW YORK—Tanker casualties, both partial and total losses, during the first nine months of 1977 were higher than for the same period of 1976, but below figures for the corresponding period of 1975, according to the Tanker Advisory Center.

Partial and total losses affected 681 vessels out of the world fleet of 4,229 ships. To date, 17 ships have been reported as total losses. This compares with combined losses of 603 in 1976 and 718 in 1975; total losses for those years were 13 and 18 respectively.

Deaths resulting from the tanker incidents reported to date numbered 107, considerably higher than the 80 reported in 1976 and the 85 in 1975.

Oil spills have resulted in the loss of 175,583 tons so far this year, compared with a loss of 164,277 tons in 1976 and 184,991

tons in 1975.

Contact with stationary objects or while anchored caused the greatest number of incidents—220. Damage to machinery and propellers affected 144 tankers, weather damage 60 ships, strandings 53, fires and explosions 45 and collisions at sea 25.

In additions, 134 ships suffered casualties due to miscellaneous causes.

Eight tankers became total losses due to fires and explosions. Other total losses were due to weather damage, four; strandings, two; collisions, one, and miscellaneous causes, two.

The overall casualty rate for the world fleet of 4,229 vessels was 16.1%. Tankers weighing between 20,000 and 100,000 tons suffered a greater incidence of casualties than smaller or larger

ships. Vessels built between 1956 and 1970 had a higher incident rate than ships built prior to or after those dates.

The Australian fleet had the poorest casualty record for the period with eight of 15 vessels affected, or 53.3%. Other nations whose fleet suffered a greater than average number of incidents were Algeria, three of nine ships, 33.3%; Cyprus, eight of 22 ships, 36.4%; Greece, 102 of 326 ships, 31.3%; Liberia, 242 of 1,028 ships or 23.5%; Panama, 29 of 178 ships, 16.3%; the Philippines, three of eight ships, 37.5%; Saudi Arabia, three of 14 ships, 21.4%; United Kingdom, 96 of 354 ships, 27.1%; United States, 58 of 294 ships, 19.7%, and Venezuela, three of 13 ships, 23.1%.

Arthur McKenzie, director of the center, noted that while the Liberians have had the reputation of maintaining the world's most unsafe tanker fleet, six nations including the United Kingdom have had poorer records to date.

Among the fleets reporting the fewest incidents were the Soviet Union, four of 226 ships, 1.8%; Japar, nine of 288 ships, 3.1%, and Singapore, five of 78 ships, 6.3%

## A&A buys Columbus firm

NEW YORK—Alexander & Alexander Inc., the nation's third largest insurance broker, is merging with Turner and Shepard Inc., a leading insurance agency in Columbus, Ohio.

The Columbus agency will continue to operate as Turner &

Shepard. Arthur E. Shepard and Jack Hesler will continue as president and chief executive officer of the agency.

Turner & Shepard employs 100 persons and has branch offices in Cleveland, Cincinnati and Toledo. ■

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## riskWatch

By GREG DAVID

### Boating group rejects treading to part product liability waves

About three years ago the executives at the Boating Industry Assn. began hearing cries of pain from their members, the kind of moans that all trade association officers have heard in the past few years.

"We thought we had an insurance problem" remembered president Matt J. Kaufman in his Chicago office overlooking Lake Michigan. "But it turned out we had a product liability problem."

The boating association appointed a committee to look into the problem. But their efforts didn't end with that committee and the product liability program they have developed could be a model for other trade associations.

Association counsel Jeff W. Napier recalls the specifics, so much like the stories that have been so frequent in the past few years. An accessory company involved mostly in electronics reported that its premiums increased to \$100,000 a year from \$6,000. An Indiana boat manufacturer reported its renewal quote was \$30 per \$1,000 of sales, 10 times the \$3 per \$1,000 it had been paying.

The association took the routine survey of its members. A typical company with \$10 million in annual sales had only about \$8,000 in pending claims, most of them involving warranties, said Mr. Napier.

"But the insurance companies told us the rates were not based on claims experience, but on a prediction of future claims," the attorney continued. "It seems to us that past claim records should count."

At first the association attempted a group insurance program, using the combined negotiating power of its membership. Mr. Kaufman said their broker approached 19 companies, most of them in the U.S., but only one insurer was interested. Even that company eventually pulled out.

The whole experience has left a sour taste in the executives' mouths. Every time insurance companies come up in a conversation their smiles disappear and their comments become impatient.

The failure of the group insurance program didn't stop the association. It created a manufacturers' assistance program, a consumer education effort, stepped up legislative lobbying and began exploring a captive insurance company.

The manufacturers assistance program is based on the group's long-established boat certification program. A person buying a certified boat can expect a certain level of quality control in the manufacture, said Mr. Kaufman.

The association also put together an "Executive's Guide to Product Liability" illustrating how product liability cases involving boat manufacturers developed. The group made its staff available as expert witnesses and prepared a list of attorneys competent to handle product liability cases.

The consumer education effort involves a booklet published last month to be included in each boat, explaining what should and, more importantly, what should NOT be done with a boat. Warnings are presented on a blue background highlighted by bold face introductions—"CAUTION:"

Plaintiff attorneys often try to cite a manufacturer's failure to warn in product liability suits as a negligent act when there is no negligence in design or manufacture, notes Mr. Napier. The booklet is a type of "inexpensive insurance," he adds. It also allows the companies to meet their duty to warn users about the dangers inherent in a product without seeming to disparage it.

The Boating Industry Assn. is also heavily committed to lobbying for tort reform and tax changes to solve the product liability problem. The association has clout, representing companies that employ 350,000 persons and have \$8 billion a year in sales.

In approaching a congressman, the group always tells the legislator how many companies and jobs are involved in boating in his district. Mr. Napier said a large number of the sponsors of a bill to allow tax deductions for self-insured reserves signed on after lobbying by the boating group.

Finally, the boating association is negotiating to make a captive insurance company available for its members. Mr. Kaufman and Mr. Napier were reluctant to discuss the details just now, but the idea involves "renting" a captive established by a private investor. That way the association doesn't have to come up with a substantial amount of capital.

There is one final benefit to the product liability program: It adds members and credibility to the group. "This is one hell of an 'association' program," says Matt Kaufman.



David

## London line

# Lloyd's adds 3,800 new members; \$1 billion more capacity possible

By JOHN H. MILLER

LONDON—Lloyd's reports that it will have 3,800 new members effective Jan. 1. This is less than the 5,000 new names that were forecast at one time, but it will still provide a total increase of 30% in membership.

The figures just released mean Lloyd's market will have a record membership of 14,300, compared with its total of 8,500 two years ago.

One reason why the expected growth in membership for next year is less than anticipated is that traditionally Lloyd's keeps strict watch on the suitability of applicants because of their potential unlimited liability.

There may well be many other applicants in the pipeline who will be able to take up membership toward the end of next year. For the time being the figures are regarded as very hopeful toward meeting capacity needs.

It seems possible, of course, that the predicted increase of \$1 billion in capacity envisaged in some U.S. quarters will be reached. Premium income for the current year is already likely to be well over \$2.5 billion and may reach nearly \$3 billion when final returns are available, so that a 30% increase is not out of the question.

Traditionally many people favor the marine market, but there are hopes the new members will extend their interests across all markets.

The problem of U.S. coverage still looms large at Lloyd's, however. Sir Havelock Hudson, its chairman, has pointed to renewed anxiety over the proposed convention for reciprocal enforcement of court awards between the U.S. and the U.K.

"No final decision has yet been taken at government level for its adoption, but the proposal comes at a time when the very high level of U.S. damage awards and the tendency of U.S. courts to extend their jurisdiction more and more widely are causing problems to underwriters," he said.

### Legionnaires disease

LONDON—Public health authorities in the U.K. are probing a mystery illness related to "legionnaires disease" which killed more than 20 persons in the U.S. after an American Legion convention last year.

Five people have contracted symptoms similar to the U.S. disease in the city of Nottingham and one man has died. Their blood samples have been checked by U.S. health authorities and produced results which were sim-

ilar to those found in the convention members who fell ill last year.

Food samples are likely to be checked in case they can give a clue to the illness, which leads to severe chest infection, followed in some cases by fatal pneumonia.

### Ulster coverage

BELFAST—U.K. insurers are pulling out of their long-standing agreement to provide complete fire and business interruption coverage in Northern Ireland

during the continuance of civil troubles there.

In April next year insurers will hand over responsibility for terrorist acts on industrial premises, estimated to have cost commercial insurers close to \$250 million in fire and related losses in the past six years, to the British government.

They will continue to provide ordinary insurance for fire risks in business premises and private homeowners will still be fully protected.

Although many of the insurance companies' pay-outs for bomb claims have been recouped from U.K. government funds, insurers have found that the task of operating this system in the hope of supporting corporate clients is too formidable.

Both Lloyd's underwriters and the British Insurance Assn. have now announced that "in many cases where payments under insurance policies have been made,

the insurers have eventually succeeded in recovering a proportion of their outlay when the policyholder has received compensation under the government scheme.

"But this can be a long and complex procedure and insurers have found that by accepting primary liability and relying on eventual recovery, they have faced duplication of work and a heavy financial burden.

"Under the new scheme effective April 1, 1978, owners of property can get compensation from the government if it is proved to be a terrorist act, but will still be entitled to lodge their claims under ordinary fire policies if it is not so."

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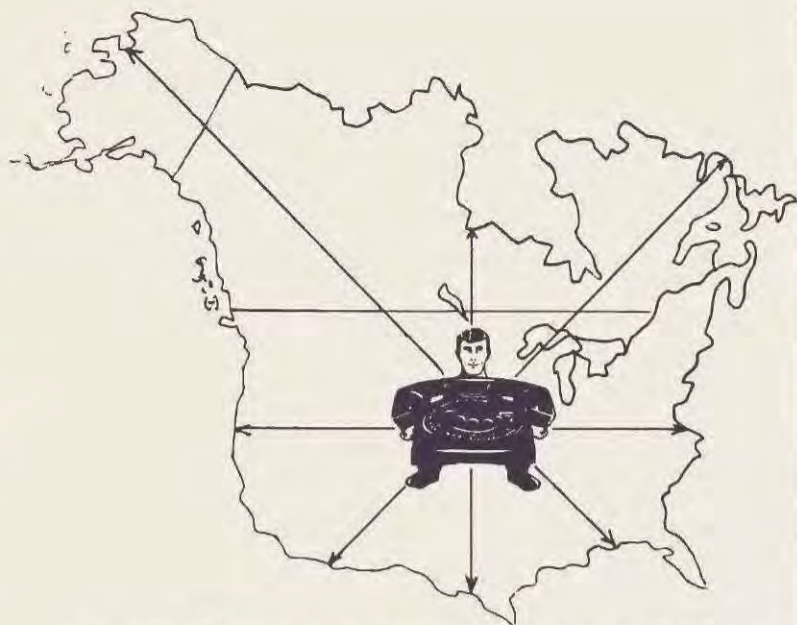
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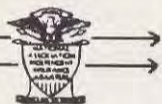
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## benefit tax slants

# New exec options replace stock plans

By JOSEPH S. ROBINSON  
Attorney-at-Law

TAX REFORM and stock market declines have shattered the results of qualified stock options. So non-qualified options, appreciation rights and phantom stock have become more widely used by companies as compensation add-ons for career executives. Trouble is, these plans also have tax limitations and depend in large measure upon stock market success. But the stock market is not always a dependable foundation for personal financial growth. Consequently, more and more companies are installing incentive stock plans that are not related to the stock market; rather they are geared to other factors that measure success.

The following is a sampling of such plans now in operation:

**Performance share plans:** Here a deferred stock award is tied to the attainment of stated performance goals. For example, if company earnings reach the goal, the executive will receive the promised number of shares. This is a form of bonus paid in stock, but qualifying for the award does not depend on the stock market.

**Performance unit plans:** Here the reward is in dollars, but the measure is stock value when the plan starts. An amount equal to X number of shares is promised if the goal is reached. The company's cost is not at the mercy of a rising market, but the value of the executive's reward depends on stock value when he gets it.

**Book unit plans:** Units are issued to the executive equivalent

to shares of stock at book value. At the end of the stated period, such as five years, the appreciation in book value is paid to him. The plan could provide that dividend equivalents would accrue for him over the period.

**Book purchase plans:** Stock priced at book value is sold to the executive. He can resell to the company at the end of the period, or on leaving, at the then book value. Or he might exchange for market value stock. He may be given voting and dividend rights in the meantime.

### Pension problems?

It's no secret that many pension and profit-sharing plans have been scrubbed because of mounting red tape and bureaucratic snags. The IRS being aware of this and in an effort to stave off further plan terminations has set up a "Hot Line" to help iron out problems and explain the available alternatives. Here's the number to call: 202-566-4300.

### Handling yearend bonus

If a top flight executive or even a middle management employe has say as to when he or she can pick up extra loot by way of a yearend bonus, he or she faces a dilemma as to whether payment should be made this year or next. The planning goal is to adjust total compensation—salary plus bonus—so that the combination produces the lowest total tax for the two years. The decision is more difficult to calculate at

this time in view of a promise of further tax cuts for 1978. Trouble is, there may be a tax rate increase for higher brackets.

This much should be pointed out, however. This year's bonus can be postponed until next year—or even to a later date—through an arrangement with the employer that acknowledges the obligation but puts off the actual payout to a later date. Except in the case of a close corporation, the employe will not be taxed until the income is received.

The courts and the IRS both hold that for a cash-basis taxpayer, the employer's promise to pay is not current taxable income. So if there is an understanding before the bonus is finalized the employe has no tax liability until he actually receives the cash.

### Taxing discrimination

Companies, charged with discrimination against job applicants, sometimes enter into settlement agreements that call for payments to the individuals seeking redress. Query: Can the employer take a deduction for such payments? Should the payment be treated as wages subject to withholding and Social Security taxes?

In response to these questions, IRS approved a write-off since such payments do not fall within the definition of nondeductible bribes, kickbacks or other illegal payments, or fines or penalties paid to a government for violating the law. The IRS also ruled that these payments are wages for withholding purposes. (*Letter Ruling 7742028*)

### The Supreme Court

We can expect decisions by the U.S. Supreme Court affecting tax angles of certain fringe benefits. Some of the tax issues involve:

- Whether employes under a company pension plan can be compelled to take early retirement.
- Whether women employes can be required to kick in larger pension contributions than men simply because they statistically live longer.
- Whether meal allowances for employes are taxed as additional income and whether companies must withhold tax on meal money.
- Whether a new owner of a business can be held responsible for old payroll taxes that had not been paid.

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# Rubber firms ponder restricting women's jobs

Crain News Service

AKRON—The major rubber companies are looking into policies to restrict women of child-bearing age from jobs where they might be exposed to vinyl chloride, a chemical of potential harm to the fetus.

These restrictions promise to pit management against labor; labor against labor, and at least one federal agency against another federal agency.

The arguments at hand include the complex issues of a company's "right" (as opposed to responsibility) to protect its workers and a woman's right to equal opportunity.

The debate in the rubber industry started last year when Robin Schorn, a female Firestone employee, applied for a job opening in Pottstown, Pa., where vinyl chloride was being processed.

Firestone, which had adopted a policy in 1974 to keep women of "child bearing potential" away from vinyl chloride areas, turned down Ms. Schorn and the battle began.

Her United Rubber Workers (URW) union local filed a complaint alleging sex discrimination with the Equal Employment Opportunity (EEO) office and then took up the battle directly with Firestone management.

The case went into arbitration in mid-1976, and by the summer of 1977 the arbitrator ruled that Firestone's policy, which restricts women from jobs where more than one-half the allowable limit for vinyl chloride emissions (now 1 part per million) is present in the workplace, was non-discriminatory and "reasonable."

"The arbitrator essentially said this was not sex discrimination per se because Firestone wasn't discriminating against all women, but only those of child-bearing potential," explained Jim Peake, URW director of fair practices.

"The arbitrator also ruled that a company has the right to make reasonable rules, and he considered

this a reasonable rule," Peake added.

The case is still pending before the EEO and Ms. Schorn has taken a technical position in another section of the Pottstown plant where there is no vinyl chloride exposure.

Firestone, the only major rubber company to restrict women from vinyl chloride exposure, took the action because "there was medical evidence that said exposure might cause damage to a fetus, so we established the policy to eliminate that risk," according to a company spokesman.

Louis Beliczky, head of industrial hygiene for the URW, said Firestone's policy can be viewed as an "overt attempt by industry to limit women in the workplace."

At the same time, he said, the

union and all organized labor, "is really caught in a bind" on the issue and still hasn't decided "which way to go."

"We can't be against motherhood as such . . . we must see that women are protected," Mr. Beliczky said.

B.F. Goodrich, another major producer of vinyl chloride, does not restrict women from exposure to the controversial chemical.

Instead, according to a company spokesman, the woman is informed of the risk she is taking and the decision is left to her.

"While it has not been proved, medically or scientifically, that vinyl chloride emissions or exposure will affect the fetus, we discuss the matter with all women who may be working in or apply to work in any area where there is a possibility of VC exposure.

We tell them that reports have been issued to the effect that there is a possibility of birth defects resulting from such exposure," the BFG spokesman said.

He said he wasn't aware of any women who left their jobs or dropped their bids for jobs after this "discussion" took place.

"We're giving them the choice. In other words, no surprises," the spokesman said.

Both Goodyear and Uniroyal said they have no policies at present and issue no warnings to women working around the chemical.

Nevertheless, both companies said they are currently looking into the matter.

Industry sources said the controversy would eventually boil down to a court battle between the

Occupational Safety and Health Administration (OSHA) and the EEO.

"They're definitely at cross purposes and there has to be a show-down eventually," said one source.

The URW sees "great potential" for this issue to "snowball" as benzene and other chemicals used in the rubber industry come under medical scrutiny. The threatening scenario in the mind of organized labor is that women would eventually be eliminated from the industry.

One solution to the equal opportunity-motherhood debate, according to the URW, "is to make the workplace safe for everybody."

"Labor has to feel that levels of emission will be equally safe, which naturally means lowering emissions," said URW's Beliczky.

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## Insurers act to remain in flood plan

WASHINGTON—A suit has been filed in U.S. District Court here to prevent the Department of Housing and Urban Development (HUD) from terminating its relationship with the insurance industry in the operation of the national flood insurance program.

The suit, which was filed by the National Flood Insurers Assn., a consortium of 132 insurance companies that has operated the program and put up \$48 million in risk capital, contends HUD cannot remove NFIA unless the program is a "failure" or if the two sides cannot agree on the terms of continuing the joint venture.

So far HUD has not proved that the eight-year-old program has failed or that a joint operating agreement cannot be reached, the suit said.

HUD officials, said, however, that ending NFIA's role in the program will save millions of dollars. HUD already has awarded an \$1.1 million contract to EDS Federal Corp., a Texas firm, to run the program. EDS will act only as a fiscal agent and not put up any risk capital. EDS's \$11 million bid was \$15 million less than NFIA's offer. ■

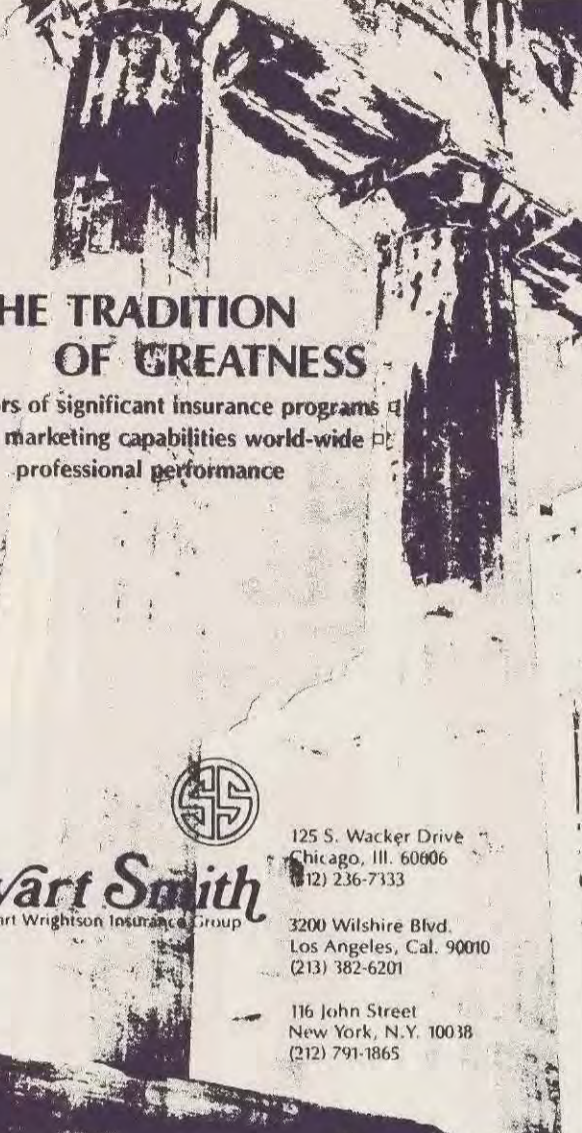
## The first pension plan

WASHINGTON—The first pension plan for workers in the U.S. was introduced in 1859 when New York City established a fund for retired policemen, but the idea was slow in being adopted nationwide.

In fact, by 1930 only 15% of all privately employed, nonfarm


workers in America enjoyed the benefits of pension programs, the American Council of Life Insurance says.

But by 1976, over 50% of the nation's entire work force was covered by some kind of private pension. ■



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■ **Vocational and Educational Opportunities for the Disabled** is a 34-page booklet for disabled workers published by the INA MEND Institute, a rehabilitation facility of the Human Resources Center in Albertson, N.Y., and Insurance Company of North America. The booklet, the fourth in a series of publications for the disabled, answers questions frequently asked by the disabled concerning vocational services, eligibility, continuing education and future employment. Single copies are \$1.25, 100 for \$75 and 1,000 for \$600. Write INA MEND Institute, Human Resources Center, Dept. 33, I.U. Willets Road, Albertson, N.Y. 11507.

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● **The 1976-77 Source Book of Health Insurance Data** is available from the Health Insurance Institute. The 80-page booklet is a handy reference guide on private health insurance coverage, benefits and premiums. The introductory chapters describe continuing efforts to

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● **An Analysis of Automobile No-Fault Statutes** is a 32-page booklet produced by GAB Business Services. It analyzes 16 laws described as pure no-fault, where restrictions or limits have been placed on the right to recover for pain and suffering. For a free copy write J. W. Weatherstone, Marketing and Products Division, GAB Business Services Inc., 123 William St., New York, N.Y. 10038.

● **Bibliography of Cost Indexes** is intended to give financial executives a summary of cost index sources applicable to construction, building, machinery and equipment valuations. The American Appraisal Co., which prepared the 31-page booklet, suggests technicians may want more detailed treatment of their specific interests. For a free copy write E. J. Francione, The American Appraisal Co., 525 E. Michigan St., PO Box 664, Milwaukee, Wis. 53201.

● **SEC Liability Insurance** for Private Placements, a promotional brochure from National Union Fire Insurance Co., discusses the company's expanded SEC insurance program which now includes protection for liabilities arising out of private placements. For a free copy write: Product Information, Corporate Communications, American International Group, 102 Maiden Lane, New York, N.Y. 10005.

● A new brochure, **Industrial & Commercial Fire Detection Devices**, from Fenwell Inc. describes a complete line of smoke, flame and thermal fire detection devices. The brochure outlines the basic features of ionization and photoelectric smoke detectors, thermal detection devices, ultraviolet response detectors and continuous fire detectors. For a free copy write Fenwell Inc., 400 Main St., Ashland, Mass. 01721.

● The American Appraisal Co. has prepared a four-page brochure on the new **Income Tax Credit and Component Depreciation**. It discusses how to identify qualifying property, costs and application. Tables compare potential tax credits by facility and depreciation methods. For a free copy write E. J. Francione, The American Appraisal Co., 525 E. Michigan St., PO Box 664, Milwaukee, Wis. 53201.

● **The Essential Role of Marine Cargo Insurance in Foreign Trade** is a publication of the International Union of Marine Insurance. Copies, which cost 25 cents each, are available by writing Robert A. Herbst, American Institute of Marine Underwriters, 14 Wall St., New York, N.Y. 10005.

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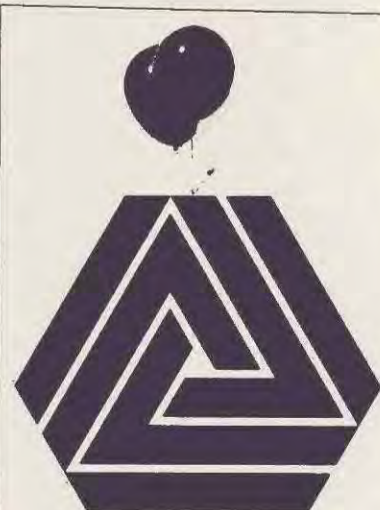
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# Work comp . . .

Continued from page 1.

loss of a hand was lengthened to 190 weeks from 175 weeks. In addition, the waiting period to qualify for total disability benefits was reduced from seven to three days.

In Maryland, the maximum compensation allowed for permanent partial disability was changed to 500 weeks of compensation from the old statutory limit of \$17,500.

Illinois' maximum weekly benefit is now \$304, the second highest in the nation; following a major liberalization in benefits in 1975. An effort by employers to limit further increases in state work comp costs was the most controversial issue in this year's legislative session, but the effort failed.

In Louisiana, a spinal fusion or the surgical removal of an intervertebral disc was added to the list of conditions which constitute permanent partial disability. In addition, an employer may be slapped with a \$250 fine, plus attorney fees, if he fails to furnish an employe with results of a medical exam.

## Administration

While the expansion of workers compensation benefits in these and other states is a major factor in rising costs, experts in the field also blame sloppy administration in state compensation or industrial boards for compounding the problem.

"If the cost of workers compensation is ever to level off, it will have to come through improved administration," said Andre Maisonnier, a vp with the Alliance of American Insurers.

"During the last six or seven years, the emphasis has been on the upgrading of benefits, because people felt benefits were inadequate. As a result, there has been little, if any, attention paid to the administration of those benefits," Mr. Maisonnier said.

"The administration of workers comp traditionally has been very political," said one insurance company executive. "Administrative jobs often were political plums, doled out for past political services rendered, rather than awarded on the basis of ability. That has to stop."

## OSHA's impact

Ironically, government safety standards have been blamed for workplace accidents which in turn cause rates to shoot up. Some businesses have falsely assumed that compliance with "ridiculous" Occupational Safety and Health Administration (OSHA) standards was the best way to stop losses, said Mr. Maisonnier of the Alliance.

## More planning their retirement

WASHINGTON—More and more American workers are giving thought to their future retirement; a survey by the American Council of Life Insurance reveals.

Some 65% of those interviewed indicated that they had given at least some thought to their retirement finances, while 34% said they had given very little thought to their future needs, the Council said.

In a similar survey in 1969, the Council noted, 59% said they had given at least some thought to their future retirement financial needs, while 40% of those surveyed had given it very little thought.

"There has been too much emphasis on attempting to comply and not enough emphasis to prevent accidents," he said. "OSHA standards have handicapped us in the education of the business community of what safety is all about."

One response to rising workers compensation costs has been the growth of self-insurance. General Tire and Rubber Co., for example, will expand its self-insurance program to eight more states in the next two years "because there is substantial savings," said Carl Vogt, manager of workers compensation.

In Arkansas, the number of employers who self-insure their workers compensation increased 17% in the last year, according to the state workers compensation commission.

In Indiana, the number of companies that self-insure for workers comp has increased "fairly substantially in the last two years," said a spokeswoman for the Industrial Board of Indiana. And in Ohio, 33.82% of employes work for companies that have self-insured programs, according to William Johnston, chairman of the Industrial Commission of Ohio.

In order to make self-insurance programs work, tough measures have to be implemented to hold down losses: At General Motors, for example, where workers compensation costs have jumped 381% in the last 10 years, the corporate workers compensation staff has been beefed up by 50%.

## Self-insurance

All workers compensation administrators have attended a week-long seminar at the Flint Institute, GM's engineering school,

to learn the techniques involved in administration of workers compensation, Ralph Adams, director of unemployment and workers compensation, said recently before the annual meeting of the Council of Self-Insurance.

Companies that want to self-insure, however, face stiff licensing requirements. In Ohio, a \$100,000 surety bond or negotiable governmental securities is required. In Arkansas, a \$100,000 surety bond also is required, that's up from a \$30,000 minimum in 1975.

Companies that can't meet these requirements face sharply higher premiums in the conventional market. In Ohio, premiums have risen by an average of 57% during the last two years. In Illinois, workers compensation premiums jumped 88% in the last two years.

At the same time, inadequate rates have resulted in an expan-

sion of assigned risk pools around the country. In Indiana, the number of companies in assigned risk pools increased from 1,630 in 1975 to 2,960. In neighboring Illinois, the increase was even greater from 14,000 in 1976 to an estimated 25,000 in 1977.

Insurance executives are not very optimistic when looking at the future of workers compensation. "The old demarcation line on what is an on-the-job injury is getting extremely fuzzy," said Mr. Maisonnier of the Alliance.

Major problems loom in deciding cases like emphysema where it is difficult to determine where a disability occurred.

In addition, a very "sophisticated" plaintiffs' bar has been significantly broadening the definition of workers comp. In one case in Michigan, an employe claimed he was entitled to benefits because the repetitive nature of his job drove him out of his mind.

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of the writers and their staff—who are risk management consultants—with both large and small companies and institutions in the U.S. and abroad.

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# Riddell victory . . .

Continued from page 1

product liability lawsuits in which the plaintiffs cite strict liability. A \$5.3 million judgment against Riddell in Miami in 1975 focused nationwide attention on the problem of defending product liability lawsuits, especially those brought by young and severely injured plaintiffs.

Riddell could have won the Miami case, Mr. Black conjectured, if medical information presented at the Phoenix trial had been available. In the Miami suit, it was charged that the young plaintiff was paralyzed when a blow caused the back of the helmet to sever his spinal cord. It is now known that is not possible from a bio-mechanical standpoint, Mr. Black said.

Riddell had appealed the Miami decision, but it's insurers settled

the case earlier this year. The settlement was sealed by the court and participants in the case would not discuss the payment.

American Home Assurance Co. was the excess carrier for the liability, providing a \$10 million policy over a \$250,000 primary policy with a \$10,000 deductible underwritten by the Insurance Co. of North America.

American Home was also the excess insurer on the Phoenix case over a primary policy underwritten by Employers Fire Insurance Co., now Commercial Union.

For everyone, it was a long drive to Riddell's Phoenix victory.

The plaintiff, Kevin Byrns, suffered a head injury in a 1970 high school football game that caused paralysis of his left side, a severe mental deficiency and a

severe personality change.

A 1972 trial was concluded by the judge when he granted a motion for a directed verdict for Riddell after the plaintiff's case was presented. The decision was appealed and in 1975 the Arizona supreme court ordered a new trial.

## Defense costs

Mr. Black took on the case in February and since then built a defense costing \$150,000, paid for by insurance.

Riddell's chairman of the board, E. L. Gordon, attended the trial, as did a representative of American Home. "A motel room gets awfully lonely in six weeks," observed Mr. Gordon, who lives in the Chicago area.

But Mr. Black said Mr. Gordon's appearance at the trial gave the jury a "live defendant" to consider instead of a cold corporation. Mr. Gordon's expertise on

the industry was also invaluable during the trial, Mr. Black said.

"We're not usually lucky enough to have the chairman of the board sit with us," the attorney added.

The suit, based on strict liability, charged that Riddell's TK-2 helmet was defectively designed so as to make it unreasonably dangerous, Mr. Black explained.

His game plan was to prove the helmet was not defectively designed. He had the helmet tested by Dynamic Science Inc. in Phoenix and showed the jury a film of the tests. The test results showed the helmet held up under blows far more powerful than would be received in a football game.

The director of environmental medicine for the U.S. Armed Forces inspected the helmet and his determination that it is "the best helmet on the market from the standpoint of heat dissipation" was presented to the jury.

Arizona State University coach Frank Cush, who has used the helmet for 15 years, testified to that also, indicating that the helmet's track record was as good as the scientific tests suggested.

But the defense didn't stop at proving the quality of the helmet.

Watching a film of the game in which young Byrns was injured, Mr. Black discovered the boy was injured in a play much later in the game than had been thought originally. The film showed the injury occurred not from a blow to the helmet but from an upper cut—something the helmet could not be expected to protect him from.

Mr. Black was using a projector from Harvard University when he discovered the new evidence, the projector used to analyze the film of the assassination of President Kennedy. Computer analysis of the film confirmed that it was young Byrns playing later in the game.

The jury agreed with Mr. Black on when young Byrns was injured and that the helmet was not at fault.

## 'Good jury'

But most heartening to Riddell's Mr. Gordon is what the jury said after the verdict was announced. "We polled the jurors and they said they had concluded after hearing the testimony and seeing the films that Riddell had a damn good helmet," he said.

Mr. Gordon gave high marks to the jury. "I'm not saying that just because we won. We had three engineers on the jury and we directed our evidence at them. We don't know if they persuaded the others or not."

Mr. Gordon has already received calls from other manufacturers who wanted to confirm that Riddell had won a case and to find out how.

Mr. Black hopes that information presented during the trial will help "coaches, insurance companies, helmet manufacturers and the public become aware of the injuries that a football helmet can protect against and those it cannot."

## Other suits

Wynn's International is "very encouraged by the verdict in Phoenix," said assistant general counsel Thomas M. Jones, "though we don't know if it will affect new filings." Suits involving Riddell helmets, Wynn's biggest product exposure, have so far been fewer this year.

American Home, however, dropped Riddell last year. Insurance is now provided by several underwriters over a deductible in excess of \$100,000.

Riddell's Mr. Gordon observed that the recent victory "isn't going to help the insurance market, though one lost case can destroy it. . . . If we win two or three cases, then we'll see," he mused.

Two of the pending cases are in the discovery stage in Illinois. Riddell is named in a \$6 million suit filed on behalf of William Galindo Jr., paralyzed from the neck down as the result of injuries suffered in a 1974 varsity football game.

A suit for unnamed damages has also been filed against Riddell charging James Turner died as a result of injuries suffered in a 1976 football game.

American Home is the excess insurer for \$10 million in both the cases. INA is the primary insurer to \$250,000 with a \$10,000 deductible in the Galindo case and Columbia Casualty is the primary underwriter in the Turner case to \$300,000 with a \$5,000 deductible.



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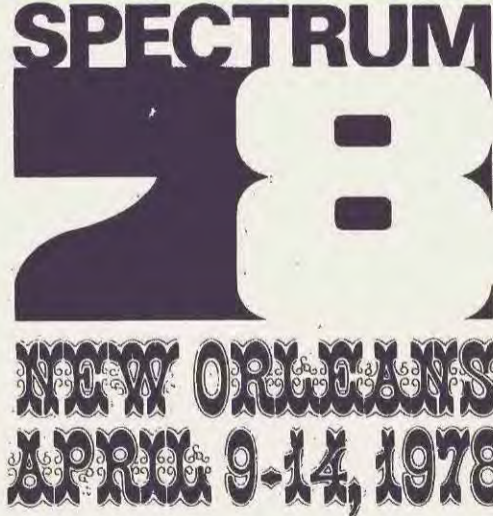
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BI 12/77

# Growing U.S. legal impact worries U.K. insurers

By JOHN H. MILLER

LONDON—A Lebanese citizen hurt in a terrorist bomb explosion in a London hotel is bringing a \$50 million suit in Florida against the U.S. parent company which controls the hotel's operations.

The lawsuit is an example of the widespread effect of American legal jurisdiction which leading British insurance companies warn could increase future claims.

If the injured victim wins his lawsuit, it is likely to be U.K. liability insurers who will have to meet some of the compensatory damages award. Sources in London say the blast was at the Hilton Hotel during an I.R.A. bomb campaign on several hotels and top restaurants.

Details of such cases involving U.S. jurisdiction are now increas-

ing in the files of the U.K.'s Accident Offices Assn. on behalf of its 80 member companies and its related liaison with Lloyd's underwriters.

Cases cited include a British diver who was killed in the Norwegian section of North Sea oil explorations. His family filed a lawsuit in Texas for \$1.3 million against the French-registered parent company which employed him.

Then there is the example of a U.S. citizen who rented an auto from a London firm while on a visit to the U.K. The driver was involved in an accident in which a U.S. passenger was injured. The auto rental firm is now named as defendant in a liability claim in New York on the ground of "attribution of agency" between

itself and the U.S. travel agents involved in the arrangements.

When a three-year-old child from the U.S. was hurt in an escalator in England, civil action was filed in the U.S. against the U.K. firm which had installed the escalator, against its parent company and against the Italian manufacturers of the escalator and the owner of the U.K. premises.

The Accident Offices Assn. warns the cases make it essential for liability insurance to take into account the potential for claims.

"This includes the potential need for a substantial hardening of rates and underwriting terms in line with current U.S. domestic practice," the association said.

"For there is no doubt that when a U.S. citizen is involved as plaintiff, his state of residence

will normally exercise jurisdiction, as will the state where the defendant has assets.

"It usually needs little for a state to exercise its jurisdiction and only minimum business contacts are necessary before jurisdiction will be exercised."

A draft convention for reciprocal enforcement of judgments between the U.S. and the U.K. will mean that U.K. manufacturers and their insurers will no longer be able to avoid large judgments even if their assets are not located financially in the U.S.

A pooling system for product liability cover to protect the future interests of many U.K. insurers has been suggested by some in the London market.

But the Accident Offices Assn. opposes the idea, even though

scheduling on coinsurance lines might be appropriate in certain cases to meet the needs of British exporters.

"The best assurance of a sensible balance between the legitimate needs of industry and its insurers will be provided by a freely competitive market operating on the basis of up-to-date knowledge of the U.S. domestic scene and how U.S. insurers are dealing with its problems," one of its members said.

The general view of the Accident Offices Assn. in the U.K. is that in some cases very restricted coverage, or only claims handling facilities, have been available in the U.S. and it may become necessary in some situations for U.K. insurers to consider applying similar "non-traditional" approaches. ■

## Vet indicted as a scandal hits racing

MINEOLA, N. Y.—Dr. Mark Gerard, a principal in the Belmont Park betting and insurance fraud scandal involving the false entry of a champion thoroughbred under the identity of a longshot, has been indicted by a Nassau County grand jury for presenting a false insurance claim and on eight other counts.

The Long Island veterinarian is accused of falsely reporting the death of Cinzano, an Uruguayan champion insured by Lloyd's of London for \$150,000 last June.

According to the indictment, Cinzano was entered in a Sept. 23 race under the name of Lebon, a longshot imported from Uruguay by Dr. Gerard along with Cinzano. Cinzano, running as Lebon, came in first, resulting in a \$77,000 betting payoff to Dr. Gerard.

Lebon is believed to have been the dead horse presented to insurance adjusters as Cinzano.

Dr. Joseph Taub, owner of Cinzano and holder of the blood stock policy on the horse, was not indicted in the case. He was, however, recipient of \$137,000 paid off from the policy.

Besides presenting the false insurance claim, Dr. Gerard was charged with two counts of grand larceny, falsifying business records, tampering with a witness, tampering with a sports contest and two counts of "fraudulent entries and practices in contests of speed."

Dr. Gerard pleaded not guilty to the charges and was released on bail of \$100,000 and surrender of his passport. A pretrial conference has been scheduled for Jan. 4. ■



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## M&M position . . .

Continued from page 1

out," Mr. Gibson observed.

But only one risk manager in the survey exhibited much sympathy for the posture maintained by M&M during the trial. This insurance manager, who did not want to be identified, said it is his policy to request his brokers divulge partial quotes only when they encounter stormy weather.

"If they aren't running into any sizable obstacles, I do not expect to hear from them," he went on.

The insurance spokesman for Dart Industries in Los Angeles may have summed up things for most risk managers when he chose the word "disgraceful" to describe M&M's policy of withholding partial quotes.

"I have always demanded information as the insurance package is being put together," responded Paul B. Harvey, manager of insurance at Litton Industries in Berverly Hills.

Mr. Harvey went on to point out that he feels he needs to know where things stand in the acquisition of new or renewal coverage. In line with this conviction, he said he often asks his brokers to supply him by letter with the names of insurance markets they have contacted in their search for coverage.

Likewise, Jim Mazzariello, corporate loss control administrator at Dillingham Corp. in Walnut Creek, Calif., said he believes his department maintains strong rapport with its brokers, so strong that the brokers feel comfortable

about "letting everything hang out."

"My brokers don't keep partial quotes and say 'I'll call when the package is put together,'" he told *Business Insurance*. "We discuss all our coverage as we go along."

Wendy Hamilton, risk manager for Newhall Land & Farming in Valencia, Calif., indicated she also takes issue with the stance argued by M&M during the trial. She takes it for granted, she said, that risk managers have a right to be informed of everything that occurs in the negotiations between a broker and an underwriter regarding coverage for her firm.

As a result, her brokers regularly keep her informed of partial quotes, she said, along with everything else that takes place when Newhall Land & Farming insurance is being placed.

"They even let us know the names of companies that denied us coverage," elaborated Ms. Hamilton. Such insights can be exceedingly helpful, she added, noting there have been instances when armed with this knowledge she has been able to move her company to make changes such as upgrading its loss control program.

Ms. Hamilton was also unshakable in her belief that it is the obligation of the broker, not of the insured, to convey loss information to an oncoming underwriter.

Any broker who did not pursue this course would be guilty of

misrepresentation, she said.

Another Southern California corporate risk manager, who was equally adamant about the division of labor between risk manager and broker, indicated that the problem is deeper than a broker reluctance to let a risk manager in on his negotiations with an underwriter.

"Of course, partial quotes should be revealed," he said. "The trouble is that most risk managers do not recognize their rights and responsibilities to their employers to be personally involved in contract talks over insurance coverage."

This risk manager, who did not want to be identified, related that by dint of step-by-step effort he has managed to make his brokers accept him as an equal partner.

"In my case, I take my broker to the insurance market," he said. "What I mean is that we go on a co-operative basis. I describe my company to the underwriter while the broker talks to him about brokerage matters."

Achieving such a relationship is not easy, he indicated, "because most major brokers bend over backwards to prevent risk managers from setting up rapport with a carrier." Brokers seem to exhibit a sort of territorial imperative about the insurance market, he added.

On the question of who should disclose the bad news to an oncoming carrier, this risk manager said he regards it as a matter of law that a notice by an insured to a brokerage house is, by the same token, a notice to the insurer. ■

## Warner-Lambert . . .

Continued from page 1

nesses from the district attorney's office, he added.

The Queens County district attorney's office began a criminal investigation of the explosion after it had been learned that a former Warner-Lambert safety inspector warned the firm that use of the chemical magnesium stearate, a lubricant, could cause an explosion.

It was believed that inadequate maintenance led to build-up of the chemical and that sparks from a malfunctioning machine ignited the magnesium stearate dust. However, that belief conflicts with the views of Fire Commissioner John T. O'Hagan who said there was no evidence of criminal negligence.

The civil suit, which a Warner-Lambert spokesman said was a "formality" under provisions of the insurance contract, was filed last month in U.S. District Court for the Eastern District of New York in Brooklyn.

Contract provisions state that a lawsuit must be filed if a settlement is not reached within 12 months after filing of the original claims to prevent the claim from lapsing, the spokesman said.

Warner-Lambert's complaint states the company had combined losses of \$48,668,258.34, including \$43,937,300 in lost profits, \$3,296,698.48 in property damage and \$1,434,259.86 in 90-day payroll losses.

To date, the firm has received from Arkwright-Boston \$2 million to cover profit losses and \$1 million for property damage. The policy provides for a \$200,000 deductible, which has been excluded from the suit.

Explaining the large profit recovery figure given in the suit, the spokesman reported that the Long Island City plant, with 1,500 workers, is the largest chewing gum facility in the company and that chewing gum is the largest contributor to the company's consumer product sales, which are in excess of \$1 billion a year.

Chewing gums and mints produced at the plant include popular brands such as Dentyne, Tri-

dent, Chiclets, Clorets, Certs, Adams, Beemans, Freshen-Up and Dynamints. A smaller plant in Rockford, Ill., is the company's only other chewing gum manufacturing facility currently operating.

According to the suit, production was halted or partially interrupted for 46 days throughout the plant and for 215 days in the Freshen-Up section, where the blast occurred.

The suit also noted that Warner-Lambert had filed demand for payment on four occasions for property damage, once for payroll loss and twice for lost profits.

The Warner-Lambert spokesman said negotiations are continuing between the company and the carrier to reach an out-of-court settlement on the claims. However, he said he did not have available information explaining where the differences lay between the firm and Arkwright-Boston.

An Arkwright-Boston spokesman would not comment. ■



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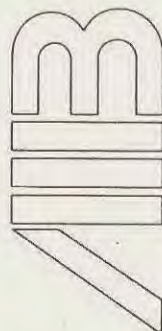
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## Letters

Continued from page 8

than Britain, with the exception of those in Canada, I know absolutely nothing about them. Indeed, I would be most interested in learning something about them and their cost control methods. Are doctors on fee schedules or salaries, are these imposed or negotiated, what are the standards of hospital and medical care, what limitations are there on treatments, how long must a patient wait for treatment and so on? For instance, using the example I did, do all these countries have kidney dialysis programs and if so how do they fund them?

Surely the irony was unintended but I laughed when I read the front page article in the same issue of *Business Insurance* reporting that Michigan doctors were being urged to boycott fee schedules. Even in this comparatively small area we heard one side shouting that the boycott is for the benefit of the patient and the other screaming that such behavior is incredible and irresponsible. But as I implied in the first place, this is just a foretaste of things to come.

Incidentally, if doctors refuse to go along with national plans, how may they be coerced? Should we shoot a few to encourage the rest?

Peter Downes

Manager of Insurance, American Trading & Production Corp., Baltimore, Md.

### Punitive damages

To the editor: Supporting those who have expressed opposition to Insurance Service Office's position in excluding punitive damages, I would like to add the following observations:

The element of a severe conflict of interest develops during the defense in which punitive damages may be a factor.

What extra burden will be on the defense attorney in negotiating a settlement and allocation of insured and non-insured damages?

What burden will the insured have in not even knowing at the outset of a claim that such a possibility may exist?

This would have the effect of forcing an insured to provide his own defense in all cases. That would result in a new adversary relationship between the two defense attorneys as each would endeavor to shift more of the responsibility to the other.

There are many other reasons, both those previously discussed as well as those that some of us haven't even thought of, that demand the retention of punitive damages. Admittedly there is "something wrong" to insure the true punishment exposure. But on the other hand, is it correct to create new problems merely to correct one that is more controllable?

Alan Soskin

Alan Soskin Agency, Southfield, Mich.

### Arson problem

To the editor: I read with interest Rebecca A. Fannin's column (Nov. 14) "Insurers must share the blame for the \$2 billion arson problem."

While I agree that insurance company practices have, in many cases, been slipshod, it was disturbing to see that you had not

taken into consideration things such as the California Fair Claims Practices Act and suits against insurance companies for punitive damages and bad faith wherever they withhold the payment of claims on the ground of suspected arson.

A year ago, we organized the California Arson Prevention Committee which has been working hard on the problem in California. So far, we have made very little progress. The interests of the legislature in the problem, in spite of substantial evi-

dence given before the Fire Services Committee of the State Senate, has been minimal.

I would suggest that the business community should complain to their legislators and to the courts, directly. In California, for example, many judges will permit an arsonist to plead guilty to malicious destruction of property so that he can stay off of the state fire marshal's list of arsonists, which is required by law to be kept by the marshal.

In another recent case, a well known arsonist was caught red

handed burning the Blue Point restaurant in Los Angeles. When he came up for a preliminary hearing in court in Santa Monica, his attorney got up and said to the judge, "Your honor, if you keep the bail at \$5,000 in this case, I will not be able to get a fee;" whereupon the judge reduced it to \$2,500.

The simple fact is that we cannot get support from the courts. If we could try cases with a reasonable chance of winning and of avoiding some over-blown verdict for punitive damages

where arson was pretty strongly evident, we would do so.

While I don't deny that insurance companies are partially responsible for this problem, the fact is that the major responsibility belongs with the courts and with the legislatures and with our people who increasingly believe that something for nothing is really okay.

Kenneth C. Tyler

California Arson Prevention Committee, Santa Ana, Calif.

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## Here are the 10 broad criteria

Judges will assess the accomplishments of risk managers nominated for the *Business Insurance* award based on 10 broad standards. Nominees don't have to fulfill all 10, but the standards provide the framework within which a deserving risk manager can be chosen.

The Risk Manager of the Year will have:

- Technical expertise which affords a solid grasp of the operational aspects of the risk management job.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applied the diverse tools of risk and insurance management.
- Shielded his or her employer from unpleasant surprises.
- Implemented a risk management and insurance program at the optimum cost over

the long run.

- Formulated a workable risk management plan suited to the nature of the given organization.
- Accomplished for the organization the best and most effective program at the optimum cost over the long term.
- A working knowledge of management principles and the skill to have applied these principles within the organization and/or the risk management department.
- Good working communications inside the organization with other managers and outside the company with other risk managers, brokers and insurers in order to keep current on events affecting risk management.
- Advanced the risk management profession and its practice in a manner that establishes him or her as a pacesetter worthy of emulation.

## Deadline is nearing for risk manager award

CHICAGO—When you submit your candidate's name for Risk Manager of the Year, be sure to send along a thorough but concise statement telling why you think your candidate should receive the award.

The reason: Our 10 outstanding judges will make their choice of a winning Risk Manager of the Year based solely on your nominating statement and accompanying details about your candidate.

You're invited to submit nominations through Dec. 31. Don't hesitate if you're a corporate executive to tell us about one of your employees or a colleague you think has done an outstanding job of managing the risks and

buying the necessary insurance for a commercial enterprise. If you're a broker, agent, consultant or underwriter, you might want to nominate one of your clients for this award. Risk managers, you may nominate a peer.

Your candidate can be a manager for a small company or a large one and can be anyone from the chairman of the board on down. All we ask is that he or she have responsibility for managing the risks and buying the insurance for the organization.

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Screening the candidates and choosing the award-winner will be the job of 10 outstanding individuals close to the risk management business themselves. Several are present or former risk and insurance managers including Thomas V. Hallett, director of corporate risk management for Joy Manufacturing Co. in Pittsburgh; Don M. Stuart, insurance manager for Canada Packers Ltd. in Toronto; A. Grant Whitney, risk manager for Belk Stores and executive vp of Belk Stores Insurance Reciprocal Inc. in Charlotte, N.C., and Waller A. Smith, retired insurance manager of United Airlines and now a vp of Rollins Burdick Hunter in Chicago.

Representing the academic community on the panel is Dr. John Hall, chairman of the department of insurance at Georgia State University in Atlanta. George Betterley, managing director of the Betterley Consulting Group, represents the consulting profession.

Two underwriting executives familiar with the best of risk management are on the panel of judges. They are Therese A. Maloney, vp and assistant manager of national accounts for Liberty Mutual Insurance Co. in Boston, and James S. Kemper Jr., president of Kemper Insurance Cos. in Long Grove, Ill.

Rounding out the group of eminent judges to tap a Risk Manager of the Year are two prominent brokerage executives: Allen Middleton, president of J. H. Minet & Co. of Canada in Montreal, and Robert C. Nevins, president of Dinner Levison Co. in San Francisco.

No entry fee is required in order to nominate the person of your choice for Risk Manager of the Year. All you have to do is send a signed letter on your business stationery before Dec. 31 to Susan Alt, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611. Along with your candidate's name, we'll need pertinent details about your nominee including career statistics, a discussion of your candidate's present job and the responsibilities it encompasses.

Accompanying your letter should be a nominating statement no more than five pages long, explaining why and how you think your candidate meets or exceeds our broad standards for judging job performance, with as much documentation as possible.

You're welcome to submit along with this statement backup documentation about your nominee, as long as it doesn't exceed five additional pages. ■

### Business Insurance Employe Benefits Communications Awards Competition



## Award of Excellence presented for outstanding achievement in communicating an employe benefits program

On April 11, 1978, at a luncheon during the Risk and Insurance Management Society's annual conference, *Business Insurance* will present awards for outstanding achievement in communicating employe benefits programs. Awards will also be presented to consultants.

The competition officially opens on **January 1, 1978 for entries to be received** in the New York office of *Business Insurance* (note address below).

There are four categories of communication which will be judged by an independent panel selected by *Business*

*Insurance*. The categories involved are: **Booklets . . . Personalized Correspondence . . . Audio-Visuals . . . Total Communications Program**. The competition is open to all companies and is not limited by the number of employees.

For more information about the competition, to obtain entry forms or to submit your employe benefits program, call . . . Ronnie Drachman, Awards Coordinator, 212/986-5050 or clip the coupon and send it to us as soon as possible.

Note: Entries will not be received after February 20, 1978. If your entry will be delayed, for any reason, please let us know.

### Employe Benefits Communications Awards Competition

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# MMI grows despite action by state regulators

By MARGARET LeROUX

TIBURON, Calif.—Despite action against it by the California insurance regulators, Multihospital Mutual Insurance Co. (MMI), the Bermuda-based malpractice insurance captive has increased the number of its insureds in other states and has spawned the growth of a companion captive in the Cayman Islands to insure physicians.

MMI was charged with illegally soliciting business from physicians in California in 1975 and

1976. (*Business Insurance*, Aug. 9, 1976). The captive is blocked from further expansion in California while both sides prepare to go to trial on the issue Jan. 16, 1978.

Attorneys for both MMI and the insurance department recently noted that the possibility of a settlement exists. "There is always a possibility," Dennis Klimmek, deputy attorney general for California said. He noted that a settlement conference is set for Dec. 19.

"We have hopes someone will

see the light and this thing will be settled," said Al Mour, MMI's attorney.

The captive has not been idly awaiting approval from the California insurance commissioner before expanding operations in other states. MMI has increased in size from 43 hospital members in 11 states to 64 members in 25 states.

"The largest growth has been in Illinois, Minnesota, Utah and Nebraska," said Clifford Schwarberg, consultant with Shared Services Inc., a liaison group formed

here to coordinate services, information and purchasing opportunities among MMI hospitals.

MMI-Cayman was formed in 1976 to insure physicians and offers claims-made malpractice insurance with liability limits of \$1 million-\$3 million, he said.

"Some of the physicians insured by MMI-Cayman are on the staffs of MMI hospitals," Mr. Schwarberg said, "but not all of them are."

MMI still offers hospitals the same limits of liability as available when the captive was formed: \$10 million coverage per occurrence under \$1 million primary and \$9 million excess policies.

"MMI is still very active," noted a spokesman for Ebasco Ser-

vices Inc., the management company that handles both MMI and MMI-Cayman. The spokesman noted that MMI had not increased its capitalization from the minimum \$250,000 required by the Bermuda government, but that reserves have been increased with to the addition of new members.

## No liquid protein suits filed yet; final FDA word on deaths awaited

By REBECCA A. FANNIN

NEW YORK—No suits apparently have been filed yet by relatives of consumers who died after using liquid protein in a diet.

The Food and Drug Administration has warned consumers against using the diet, but hasn't determined whether the deaths of at least 10 people were directly linked to the liquid protein diet.

Lawsuits are probably awaiting this determination, said George Bashow, general counsel for General Nutrition Corp., a producer in Pittsburgh.

"Then the shot-gun approach will begin. They'll sue everyone in sight," Mr. Bashow said.

Litigation may be slowed, however, since all the firms queried said the product was labeled as a

food supplement and never as a sole diet aid. But whether this claim will be an adequate defense in court remains unclear, according to the producers and the FDA.

One producer in New York said no lawsuits are forthcoming against their company. Moses Retowski, president of Solar Nutrition, said, "No one was injured from drinking the liquid and our products were responsibly labeled."

American Diet Aids in Orangeburg, N.Y., also claimed innocence. "It'll wind down to an ordinary thing of abuses," said Mrs. Ruth Cohan, an executive assistant. "Our product has been on the market for years. We've claimed it was a food supplement and it wasn't meant to be used for diets."

The 10 people who died were

obese women between ages 25 and 44 who had lost an average of 90 pounds each after going on the diet for weeks or months, according to the FDA.

Three of the women suffered abnormal heart rhythms, which led to two of their deaths and near death for the third, who was saved by an infrequent treatment administered to correct abnormal heart rhythms.

The dieters were taking the liquid in place of all other food, which made consumption of it hazardous, according to a medical expert.

The suddenly popular diet provides 400 calories a day and is often supplemented by the use of vitamins.

Currently an estimated \$40 million of the liquid protein diet is being sold through drug and grocery stores at \$12 to \$14 a quart. ■

## Madison Garden loses risk chief, but gains coverage in merger

NEW YORK—Madison Square Garden lost a full-time insurance director when it merged with Gulf & Western Industries Inc. in New York last August.

But it gained substantial cost savings and broader coverages after Gulf & Western changed workers compensation and umbrella liability policies for the sports conglomerate.

Managing the Garden's insurance program has become a secondary part of Frank Falzone's job. The former Garden insurance manager now is risk manager for Kaiser Roth, an apparel division of G & W, with part-time responsibilities for the Garden.

Employee benefit positions weren't changed after the merger. But the director of benefits, Marlene Myers and the personnel director Allen Black were brought under G & W's wing.

G & W's "master program" swallowed the Garden's workers compensation and umbrella liability policies. This move gave the smaller firm the "derived benefits" of a major insurance program," said Peter Butler, director of insurance and risk management at G & W.

Mr. Butler said only minor changes were made in Madison Square Garden's coverages following a review of all policies.

"Their program was in very good shape. They had reasonable deductibles and had insurance with major reputable carriers," he said. Mr. Butler declined to tell what deductibles were either before or after the merger.

The carrier for the Garden's workers compensation was changed to Ideal Mutual Insurance Co., which G & W uses, although the Garden had recently dropped the carrier. During the interim, that coverage was provided by Aetna Casualty & Surety Co. in Hartford, according to Garden personnel director Mr. Black.

The Garden's former umbrella policy was with Lloyds. Mr. Butler declined to name the new insurer.

It could not be determined whether the Garden's umbrella policy has been changed to Aetna Life & Casualty, which Mr. Black says provides G & W's "employee benefits, casualty and liability coverages."

Rollins Burdick Hunter brokers the Garden's policies.

Employee benefit practices haven't changed for Madison Square Garden yet. "In most areas," Mr. Black said, "we're a little ahead of them."

But for the future, G & W has recommended that the Garden begin self-insuring its long term disability and travel accident insurance. G & W has also proposed that Garden switch its pension trustee from a Chicago bank to G & W's trustee.

Although Mr. Black said G & W is not "inclined to make us do it their way," the Garden now has to get permission to change insurance carriers. The Garden makes the initial decision to change carriers but can't select the carrier.

The personnel director said G & W "see themselves as consultants" to benefit and insurance managers at Madison Square Garden. "They're just there to make recommendations." ■



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## people

Continued from page 78

Creek, Calif. Dillingham is the parent company of California Liquid Gas Corp. Mr. Scalisi reports to Paul Jones, senior vp for finance. Mr. Scalisi was formerly with Johnson & Higgins in San Francisco for two years.

**Jerry Coletta**, 33, has joined National Semiconductor Corp. in Santa Clara as director of corporate safety, a new position. Previously the safety function was in the risk and loss control department. Mr. Coletta reports to John Nesheim, treasurer. He was employed with Arthur D. Little, a consulting firm in Cambridge, Mass., as a staff consultant for six years prior to his new position.

**L. Robert Wenger**, 45, has been named safety and loss control manager at Thomas J. Lipton Inc. in Englewood Cliffs, N.J. In the new position, Mr. Wenger supervises a staff of three and is responsible for loss control for the entire corporation, including minimizing the cost of insurable risks and accident loss. Mr. Wenger worked for Marsh & McLennan Protection Consultants for eight months. Prior to that, he worked for National Loss Con-

trol Service Corp.

**John B. Arnaiz**, 47, has been named manager of engineering at Willson Products division of ESB Inc. in Reading, Pa. He is responsible for meeting OSHA requirements, supervision of quality control and design of personal protective equipment. Mr. Arnaiz recently was chief engineer, environmental systems of the General Electric Co. in the Philadelphia area. For the past 20 years, he was involved in design and development of nuclear power plants, jet engines, re-entry missile systems and pollution control systems. At Willson Products, Mr. Arnaiz replaces **Daniel Mussel**.

**Christopher Little**, vp and counsel of the Washington Post since March 1976, will add employe relations and The Post's insurance and benefit programs to his responsibilities. Mr. Little has hired a director of benefits, **Tad Bell**, 49, to report to him and take charge of benefits, liability insurance, wage and salary administration, ERISA requirements and workers compensation. The position is effective Jan. 2. Mr. Bell was director of benefits at Aetna Life & Casualty in Hartford for 8½ years, where he has not been replaced.

**John H. Crowley**, 41, was named manager of information systems and product conformance at JI Case, a manufacturer of agricultural and heavy construction equipment in Racine, Wis. Previously Mr. Crowley was a corporate product safety manager for four years at the same company and hasn't been replaced. Responsibilities of the product safety manager include preventing product related accidents and litigation defense.

**Gaylord Mason**, 43, has been promoted to safety supervisor at Admiral Group, a division of Rockwell International in Galesburg, Ill. He reports to Sam Wrigley, director of safety and security, assists in OSHA compliance, preventive programs, incident investigation and facility security analysis. Previously, Mr. Mason was a foreman.

**Charles F. Scheid** has joined Aircro Inc. in Montvale, N.J., as manager of product safety, with

responsibilities in liability control, product safety training, information and safety precautions. He reports to insurance manager, William Morrison in the new position. Previously, Mr. Scheid was manager of product safety and liability for seven years at Addressograph-Multigraph Corp. in Mt. Prospect, Ill. There his duties have been split between **Stan Kizior** and **Karl Casey**, both in the product assurance department.

**Richard Hundza**, 39, has joined Southdown Inc. in Houston as risk manager in a new position. Mr. Hundza reports to Charles Schriber, financial vp. Previously, Mr. Hundza was manager of corporate insurance at CNA Financial Corp. in Chicago for one year, where he has been replaced by **Robert R. Dibble**.

**Peter A. Burke**, first managing director of the Risk Insurance & Management Society (RIMS), died Nov. 21 in Manhasset, N.Y. He helped develop the society from five chapters in 1950 to its current 39 chapters. Mr. Burke also organized the first national conference for risk managers in New Orleans in 1963.

**Muriel Jones**, 25, has joined Baroid Petroleum Services in Houston as insurance assistant, a new position. Ms. Jones handles workers compensation and reports to Jim Anne, insurance manager. Previously, Ms. Jones was a general liability underwriter for approximately one year with Myron Steven & Co., a surplus lines agency in Houston.

**Judith A. Hiltenbrand**, 29, has been named manager of qualified benefit plans at Gould Inc. in Chicago, replacing **Donald Lehman**, who left the company. Ms. Hiltenbrand is responsible for corporate benefit disclosure reports to the federal government, legal plan documents and benefit materials. She has been with Gould Inc. since March 1977 as benefit analyst, where **Sharen Recommenes**, previously an administrative assistant, replaces her. Gould Inc. is an international developer and manufacturer of electrical and industrial products with annual sales of \$1.6 billion.

**Rhonda S. Sebastian**, 24, has been named corporate benefits supervisor at Hanes Corp. in Winston-Salem, N.C. She is primarily responsible for the administration of retirement savings plan and group insurance plan, reporting to R.T. Williams, corporate benefits manager. Ms. Sebastian previously was employed with Ciba-Geigy Corp. in Greensboro, N.C., as a benefit specialist where she has been replaced by **Susan Littlefield**. In her current position, Ms. Sebastian replaces **Joseph Buss**, 33, who has joined Gilbert Associates Inc. in Reading, Pa. as benefits manager in charge of pensions, reporting to Arthur Dougherty, employe relations director. Mr. Buss worked for Hanes for three years.

**John E. Mutchler**, 37, has joined Quaker Oats Co. in Chicago as director of corporate health and safety, a new position reporting to J. J. Calderini, director of industrial relations. Mr. Mutchler is in charge of industrial hygiene, medical surveillance programs, regulatory requirements as well as traditional safety areas. Previously, Mr. Mutchler was vp-engineering at Clayton Environmental Consultants Inc. in South Field, Mich., for eight years.

**John Holdun**, 43, has joined the

Hertz Corp. in New York as insurance manager, reporting to Warren VanGelder, divisional vp of general insurance and casualty insurance. Mr. Holdun is in charge of third-party recovery activities, analysis of self-insured accounts, contract reviews, self-insurance certificates and approval of accident repair bills. Previously, Mr. Holdun was employed at Pratt & Whitney as insurance coordinator for 1½ years.

**"Skip" Bray**, 30, has been named corporate loss prevention manager at G. D. Searle & Co. in Skokie, Ill., to replace **Gene Bader**, who was named manager of corporate insurance and loss prevention at the same company. Mr. Bray will assist Mr. Bader. Previously, Mr. Bray worked at Protection Mutual Insurance Co. in Park Ridge, Ill., for five years.

Two persons have been appointed in the risk and insurance department of the Upjohn Co. in Kalamazoo, Mich. **Larry B. Long**, 21, is a property liability specialist, a new position. Mr. Long is a recent graduate of the University of Georgia with a degree in risk management and insurance. Also new to the staff is **Neil C. Carter**, 32, as specialist for employe benefit financing. Previously, he was a benefits accounting supervisor at Federal Mogul Corp. in Detroit. Mr. Long and Mr. Carter report to Lou Pape, who directs a staff of four as manager of the risk and insurance department.

**Wendy Hamilton**, 25, has been named corporate risk manager for Newhall Land & Farming Co. in Valencia, Calif., replacing **Ed Sweeney** who resigned last fall to become director of finance for the Great Adventure Amusement Park, Jackson, N.J. Ms. Hamilton reports to the manager of financial plans. Newhall Land & Farming's major enterprise is the Magic Mountain amusement park in Valencia, Calif., north of Los Angeles. Ms. Hamilton had been serving since 1974 as insurance administrator for Newhall Land & Farming and was Mr. Sweeney's assistant. Prior to that, she worked in the Los Angeles office of Marsh & McLennan.

**J. Al Friday**, 36, rejoined Colonial Stores Inc. in Atlanta in the newly created position of vp-insurance administration, after leaving Colonial in 1973 to join Corroon & Black in Nashville. Mr. Friday has taken charge of the

three-person Colonial Stores risk management department after a year during which the key insurance management spot was unfilled after **Dennis McGovern** left Colonial in December of 1976 for personal reasons. Mr. McGovern later joined Gold Kist, as reported. Mr. Friday is responsible for property, casualty, employe benefits and safety. He was formerly Colonial's insurance administrator for seven years prior to 1973, when he became a vp with Armistead, Miller, Wallace (later Corroon & Black) in the national accounts division. At Colonial Stores, Mr. Friday expects to add a new corporate director of safety to his insurance department staff.

**David Laing** has been named compensation/benefits manager for Toyota Motor Sales USA in Torrance, Calif. Mr. Laing was formerly compensation/benefits manager for OMS Systems in Detroit. He reports to the national personnel director.

We'd like to report on staff changes in your risk management or employe benefits department. Just drop a note to **Rebecca A. Fannin**, Business Insurance, 708 Third Ave., N.Y., N.Y. 10017 or call 212-986-5050. We'd also like to receive photographs of those persons involved in changes in your risk management and employe benefit departments.

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# SELF-INSURANCE... CAPTIVES REVIEW a special issue JANUARY 9, 1978

This special report by the editors of *Business Insurance* represents a first in the magazine's ten year history. While countless news stories have dealt with the subjects of self-insurance and captive insurance companies, no special issue has ever been published on these alternative risk funding methods.

The highlights of this review will include:

- a wrap-up of significant happenings affecting captive and self-insured programs in both property and casualty as well as employe benefits areas;
- reports of discussions with risk managers and benefits executives about their success or failures with captive insurance companies or self-funded programs;
- a look at the impact of "going bare" programs on corporations and professionals who turned to that alternative during the past two years;
- a review of smaller firms using self-insurance and the impact of such programs on their companies;
- a thorough review of workers' compensation self-insurance...how many companies are now self-insured for comp in the states that allow it;
- a look at self-insured health plans and the use of 501 (c) (9) trusts;
- an examination of the reinsurance market for captive insurance companies and the rates being charged;
- and, among other subjects to be covered will be a story on the impact of these alternative risk financing trends on the insurance industry and an assessment of the changing underwriting environment.

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## people

## Husbands to Gelco; Olsen leaves Ingersoll-Rand

**Bill Husbands** has been named risk manager at Gelco Corp., replacing **Carole Magnuson**, 32, who held that position for two years. Ms. Magnuson has joined Alexander & Alexander in Minneapolis as account executive. At Gelco, Mr. Husbands reports to Bill Bauler, director of insurance. Mr. Husbands previously worked at Britton Motor Service in St. Paul as vp, director of safety, for 4½ years. Prior to that, he worked for Allstate Insurance Co. and Zurich Insurance Co.

**John P. Olsen**, director of insurance and safety at Ingersoll-Rand Co. in Woodcliff Lake, N.J., for thirteen years, has joined Fred S. James & Co. in New York as a vp. Ingersoll-Rand hasn't hired a new director yet. At Fred S. James, Mr. Olsen will consult and assist in servicing of existing accounts, particularly relating to risk management, product liability and legal matters relating to insurance. Mr. Olsen has been a frequent contributor to *Business Insurance*.

**W. Stacy Branum**, 57, has joined American Frozen Foods Institute in Virginia as director of insurance services after working in Bermuda five years as vp and general manager of Universal Marine Insurance Co. Mr. Branum reports to president Thomas B. House in the new position. At the institute, Mr. Branum is in the process of organizing a captive insurance company to write general liability insurance for members of the trade group. The captive will be wholly owned by the institute and active next year.

**Harold T. Mantel**, 50, has been named corporate director of safety and risk management for Sea World, responsible for overall coordination of safety and risk programs in Sea World parks in San Diego, Aurora, Ohio, and Orlando, Fla. The position is a new one, reporting to Robert Foster, vp for legal/administration. Mr. Mantel, since 1975, was safety administrator for New York News Inc. A decision there hasn't been made whether to replace him or to split up his former

duties. Prior to 1975, Mr. Mantel served a number of diversified New York companies with corporate staff responsibilities in such areas as occupational safety and health, environmental affairs, casualty and property insurance engineering and claims.

**Dorothy P. Romaine**, risk manager of the United Presbyterian Church in the U.S., has been named the first New Jersey Insurance Woman of the Year and given the Ada Doyle & Claire McCurry Award for upholding the goals of the National Assn. of Insurance Women (NAIW) and for her leadership and achievements. Mrs. Romaine has long been active in New Jersey insurance circles. She is a charter member and past president of the Insurance Women of Northern New Jersey, which



John P. Olsen

named her its first Insurance Woman of the Year in 1972. She has served the national group as director of region I, which comprises the six New England states, New York, New Jersey and



Dorothy P. Romaine

Pennsylvania with 46 clubs and 3,500 members.

**John McKenna** has been named corporate director of compensation and benefits for Max Fac-

tor & Co. in Hollywood, Calif. Mr. McKenna who was formerly director of employee relations for International Playtex Corp. in New York, reports to the senior vp of personnel and industrial relations. He replaces benefits manager Peter Goie who resigned last summer after joining Max Factor in early 1977. Mr. McKenna said that he has been "in and out" of the employee benefits area since 1961. His last job involving benefits was as director of benefits for ITT-Grinnell in Providence, R. I.

**Bernard Scalisi**, 34, has been named risk manager for California Liquid Gas Corp. in Sacramento, replacing Pam Rainey, who became assistant risk manager for Dillingham Corp. in Walnut

Continued on page 76

## classified advertising

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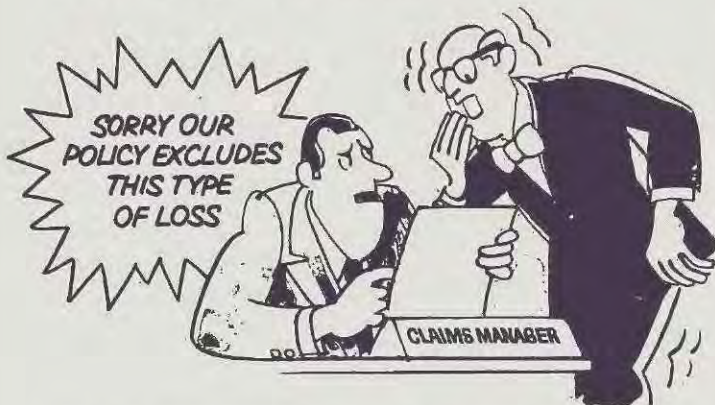
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SEE OUR AD ON PAGE 3

# The sad history of an insurance broker who sold a fiduciary liability policy based on price.



1. "All Fiduciary policies are just about alike. The differences are insignificant. With this one, the price is right and you'll save a few bucks too."



3. "What do you mean it's excluded? Do you realize what this means? Now I have to tell my Board of Directors and everyone else named in the suit that we have no coverage."



5. "Gentlemen, I'm sorry but it looks like you're stuck for an uninsured loss. We depended on our broker's advice and apparently, he was wrong."



2. "Glad I bought that Fiduciary Liability policy. It gives my company just the protection it needs."



4. "You're the guy who told me that all Fiduciary policies are just about alike. I depended on you as my expert. You had better report this to your E & O carrier. We aren't going to stand for a loss. Especially when it was your fault."



6. "Would you send someone down to review our entire account? We just had a Fiduciary loss which wasn't covered by the policy sold to us by our old broker. Our premiums are substantial and we're looking to have another broker take over the entire account."

Why have the majority of Fortune's 500 purchased the PIA form? The answer is simple. It's because their brokers and their attorneys have recommended the PIA form. Everyone knows that all insurance contracts are equal except for price. That is, until you have a loss. If you are not currently covered for your Fiduciary Liability under the PIA broad form, you should give it serious consideration. There may be a difference in cost; but the difference becomes very minimal when you have a loss. It's *protection* that you want—the more the better.

We don't deal directly with insureds so why not ask your broker or agent to contact us for full details. Our facility can provide up to \$20,000,000 in coverage, with defense costs in addition to these high limits.

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