Employers lay down the law on health costs

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update

Hull war risk rates double for ships bound for Iran

LONDON—Some Lloyd's of London hull war risk underwriters are doubling rates for ships heading to Iranian oil terminals on Kharg Island in the Persian Gulf after unconfirmed reports that at least three commercial vessels near the island were damaged last week in an Iraqi attack.

The Lloyd's of London Underwriters Assn. says many hull war risk underwriters have raised the sur-

Continued on next page

Grounded

Cuts in health programs could hike airlines' costs

By DOUGLAS McLEOD

NEW YORK—Major airlines may be faced with millions of dollars in additional costs as a result of cutbacks in programs designed to monitor pilots' health, some industry experts say.

In the wave of cost-cutting that followed airline deregulation, several large air carriers have eliminated or reduced in-house medical departments and preventive health programs that included regular physical examinations of flight crews.

Today, the twice-yearly exams required for pilot certification by the Federal Aviation Administration are the only regular source of information many airlines have on their pilots' condition.

But aeromedical experts, including at least one FAA doctor, call the FAA exam "cursory" and unsuitable for keeping track of pilots' long-term health risks.

The result could be millions of dollars in additional expenses for:

● Disability payments. A pilot becomes "disabled" when he or she cannot meet minimum medical standards set by the FAA. While some experts question the adequacy of the standards, they are still strict enough for pilots to be classified as disabled for conditions that wouldn't be considered disabling for most other workers.

Most airlines now pay disabled pilots 50% of their yearly salaries, which run close to $100,000 for many pilots and even more for jumbo jet captains. Some place a cap on the maximum wage for disability purposes. The top wage for disability purposes at Eastern Air Lines Inc., for instance, is $127,000.

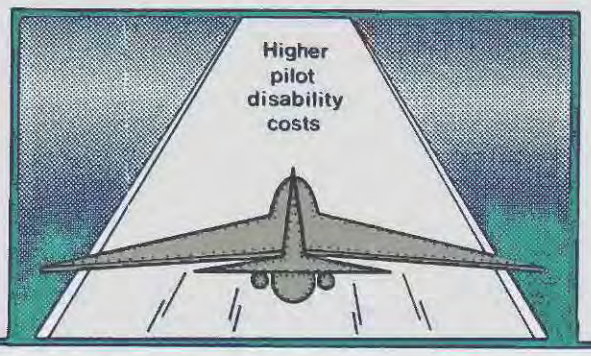
● Retraining costs. Every time a pilot is lost, an airline must promote the next most senior pilot and move up all other pilots down the line, retraining them to fly larger jets where necessary. At the bottom of this daisy chain, new pilots must be hired and trained.

One study conducted at Trans World Airlines found that the medical department's activities saved the company nearly $74 million in disability payments and training costs over an 18-year period.

However, TWA closed its medical services department in 1981.

Poor pilot health has rarely been the cause of accidents, but some medical experts worry that safety problems could arise as airlines lower their guard against pilot disability.

Others, however, feel that the FAA exams, the diligence of the pilots themselves and other safeguards are adequate to ensure safety.



Graphic: Amy Palmer

Aeromedical experts agree that pilots are generally far healthier than the rest of the population. Most are drawn from military service, where stringent health standards are enforced. And, most are given a thorough medical screening before being hired by an

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House, Senate step up attacks on benefit plans

By JERRY GEISEL

WASHINGTON—House and Senate committees are stepping up their attack on employee benefit programs and, when the battle is finally over, employers could emerge with heavy losses.

The House Ways and Means Committee has already approved and sent to the House floor a $50 billion deficit-reduction bill that proposes several major changes in the way employers finance and structure their benefit plans.

And, the Senate Finance Committee is still holding hearings on revenue proposals, some of which could affect employee benefit plans even more severely than the House legislation.

For example, one senator has suggested that Section 125 of the Internal Revenue Code, which governs cafeteria benefit plans and flexible spending accounts, should be repealed.

Committees approve proposal to bar deductions for self-insured comp reserves. See story, page 2.

In completing action on its deficit reduction bill, H.R. 4170, the House Ways and Means Committee, among other things, agreed to:

● Place fixed limits on the contributions employers can make to reserves held by a tax-exempt 501(c)(9) benefit trust. Currently, there is no limit on how much an employer can contribute.

Under the House proposal, reserves held by a trust cannot exceed 75% of the average benefits paid out during an employer's previous and current tax years.

For example, if a trust paid out $100,000 in benefits in 1983 and $150,000 this year, new contributions would be barred if they boosted the trust's reserves to more than $93,750.

In addition, no more than 25% of the benefits funded by a 501(c)(9)

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Cause of injury is 'occurrence': Court

By STEPHEN TARNOFF

CINCINNATI—The cause of an accident and not the property damage or the number of claims it triggers is the barometer for calculating the number of occurrences to be covered under a comprehensive general liability policy, a federal appeals court says.

In Michigan Chemical Co. vs. American Home Assurance Co., the 6th U.S. Circuit Court of Appeals by a 2-1 margin ruled that Michigan Chemical's shipment of livestock feed containing the toxic chemical PBB was the occurrence to be covered by its liability insurers, not the property damage or multiple claims the tainted shipment prompted.

As a result, Michigan Chemical can recover only $28 million of coverage rather than the $56 million it had sought, unless additional shipments of tainted livestock feed can be proven, the court said.

Michigan Chemical, a subsidiary of Northwest Industries, and Farm Bureau Services, a co-operative that sold the contaminated feed to dairy farmers, already have paid more than $45 million in claims stemming from hundreds of suits filed against them after the animals that ate the tainted feed had to be destroyed.

The March 1 decision overturned a ruling by a U.S. District Court in Michigan that held the definition of "occurrence" in the policies was ambiguous and, therefore, should be construed against the insurers and in favor of Michigan Chemical.

The appellate court, which was hearing just the controversy over the definition of occurrence, has sent the case back to the lower court to determine how many shipments took place.

The case originated in 1973 when Michigan Chemical accidentally shipped the toxic polybrominated biphenyl (PBB) to Farm Bureau Services, which then mixed it with livestock feed and sold the feed to dairy farmers.

Michigan Chemical was supposed to have shipped Farm Bureau Services a magnesium oxide feed supplement but sent the PBB, which was in similar packaging, by mistake.

When the contamination was discovered, more than 40,000 farm animals had to be destroyed.

Since the claims against Michigan Chemical occurred in both in 1973 and 1974, Michigan Chemical contends in its coverage lawsuit that it is entitled to $56 million in coverage, or the aggregate limits for both years.

The insurers, however, argue that they should pay only $28 million for policy year 1973 because that is when the shipment of the PBB took place.

In both 1973 and 1974, the limits on Michigan Chemical's liability coverage, under-

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NEWSPAPER

update

Kharg Island war risk rates rise

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charge for ships heading toward Kharg Island to $1.50 per $100 of insured value from 75 cents per $100. However, vessels quoted the higher rate are insured for 14 days.

Last month, underwriters had cut hull war risk policy periods for ships sailing to Kharg Island to seven days from the normal 14 days (*BI*, March 5).

However, not all hull war risk underwriters are increasing their rates, notes leading Lloyd's war risk underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C. "Rates are still subject to individual negotiation," he said.

"We are not underwriting much business at the moment (for ships en route to Kharg Island and the surrounding area)," said Mr. Merrett, who is charging the higher rates. "We tend to get undercut by other underwriters."

OSHA chief Auchter resigns

WASHINGTON—The Reagan administration's top safety official is leaving government service this month to return to the private sector.

Thorne Auchter, who heads the Occupational Safety and Health Administration, will become president of B.B. Anderson Cos., a large Kansas construction company.

Mr. Auchter, 39, said he had accomplished his goals of reducing the nation's workplace injury rate and getting OSHA to cooperate with instead of confronting employers.

Insco's future in doubt

HAMILTON, Bermuda—The future of Insco Ltd., the Bermuda-based insurance subsidiary of Gulf Oil Co., is unclear in the wake of Standard Oil Co. of California's bid to acquire Gulf and the April 30 retirement of Insco President Leslie Dew.

SOCAL has its own Bermuda insurance subsidiary, Bermaco, which generated $28 million in gross premium and $16 million in net premium in 1982. Bermaco, with $237 million in assets at year-end 1982, writes almost exclusively the risks of its parent.

Insco, which wrote $140.5 million in gross premium in 1982, writes more than 50% non-related business. No discussions regarding the future of Insco or Bermaco have been held.

Mr. Dew, 69, developed Insco, which has grown into one of the leading insurance and reinsurance underwriters in Bermuda.

A former deputy chairman of Lloyd's of London, Mr. Dew became a director of Insco in 1977 and was the first professional underwriter with a worldwide reputation to move to Bermuda.

He is credited by Bermuda reinsurance underwriters with putting Bermuda on the map as an insurance and reinsurance market.

His successor has not yet been named.

Court to rule on waste cleanup

WASHINGTON—The Supreme Court will decide if a company or a corporate official can avoid an obligation to clean up a hazardous waste site by filing for bankruptcy.

The high court decided to take the case, Ohio vs. Kovacs, after the state of Ohio requested the review of a decision by the 6th U.S. Circuit Court of Appeals.

Thirty other states and the federal government also urged the court to take the case.

The 6th Circuit's decision said Ohio could not enforce an order from a state court requiring an officer of the Chem-Dyne Corp. to remove all hazardous waste from the company's dump site in Hamilton, Ohio. The officer filed for bankruptcy in 1980 shortly after he signed the agreement to clean up the dump site.

The states and federal government argued that the appellate court decision could cripple efforts to enforce environmental laws.

Multiemployer change offered

WASHINGTON—The Senate Finance Committee last week tentatively approved an amendment by Sen. John Danforth, R-Mo., that would push back the effective date of the controversial withdrawal liability provisions in the Multiemployer Pension Plan Amendments Act of 1980.

The amendment, attached to a deficit-reduction bill, would move the effective date from April 29, 1980, to Sept. 26, 1980, the date President Carter signed the act.

If the amendment is enacted, dozens of employers that withdrew from underfunded multiemployer plans during that five-month period in 1980 would not have to pay for the plans' unfunded vested benefits (*BI*, Oct. 24, 1983).

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Industry officials criticize NAIC report on ratemaking

By LEN STRAZEWSKI

PORTLAND, Ore.—Competition, not theoretical ratemaking models created by state regulators, should be the ultimate regulator of insurer profitability, insurance industry representatives contend.

This argument, made by several insurance industry trade groups and individual insurers, came in response to a draft report by a National Assn. of Insurance Commissioners' task force on the use of insurers' investment income in ratemaking (*BI*, Jan. 30).

The draft report, released for industry comment in January, attacked regulator-approved rates in many states that guarantee an underwriting profit for insurers. It advised state regulators to abandon underwriting profit margins as a measure of insurer profitability.

Instead, the task force, chaired by William P. Davies of the Texas State Board of Insurance, recommended that state regulators develop a new "actual rate of return" ratemaking model that considers anticipated net investment income yields, likely capital gains and the influence of the industry's financial leverage.

This type of model would allow regulators to calculate rates based upon negative underwriting income that is offset by insurers' positive investment gains.

In a joint statement released prior to a March 7 hearing held by the NAIC's Investment Income Task Force at the organization's spring meeting in Portland, industry representatives voiced their disapproval of the draft report.

In general, the representatives charged that the report misrepresented the economics of the property/casualty insurance industry and "presented an unnecessary and inappropriate solution to a non-existent problem."

"Have insurers earned excessive profits? Is it reasonable to expect that they will earn excessive profits? Why does the task force insist that it is time for regulators to make a change?" asked Mavis A. Walters, senior vp of the Insurance Services Office, the industry's rate and policy advisory organization.

"The entire argument seems to be based on a discussion of theoretical models and hypothetical situations, none of which squares with reality."

Ms. Walters says that the NAIC has demonstrated no evidence of excessive insurer profits, adding that there is simply no need for a change in traditional rate regulation.

Natural market competition, other industry representatives note, has already prevented excessive in-

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BI conference set for July

The 1984 *Business Insurance* Communicating Employee Benefits Conference will be held July 30-31 at the Grand Hyatt Hotel in New York City.

This year's conference sessions will lead participants through the entire benefit communications process, from planning to maximum utilization of the benefits program.

For program details and to receive a registration form, contact Ann Vazquez, *Business Insurance* Conference Registrar, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0137.

Lawyers malpractice insurer fails

By LEN STRAZEWSKI

TALLAHASSEE, Fla.—Low rates and shrinking market share have driven Lawyers Professional Liability Insurance Co., a Florida malpractice insurer, into liquidation, according to state regulators.

LPLIC, which insured an estimated 1,200 Florida attorneys, was ordered into voluntary liquidation late last month when company officials and the state Insurance Department determined that outstanding claims significantly surpassed the insurer's assets.

"Lawyers Professional Liability wrote approximately $5 million in premiums in 1983, yet two claims alone for that one year totaled $5 million," notes Florida Insurance Commissioner Bill Gunter. "Based on our preliminary examination, we estimate the company to be from $1.2 million to $1.5 million in the red."

Outstanding claims, which currently number about 400, will be paid by the Florida Insurance Guaranty Assn., the state's property/casualty insurance guaranty fund, Mr. Gunter adds.

The insurer's records are being shipped to the Florida Insurance Department's division of rehabilitation and liquidation, officials say. The department does not yet know how much reinsurance may be applied to the outstanding claims.

As part of the liquidation order, all LPLIC policies will be canceled effective April 8, though policyholders will have until Feb. 23, 1985, to file claims under the policies.

The guaranty fund, which will absorb the insurer's remaining assets, then will pay up to a maximum of $300,000 per claim. All claims will be subject to a $100 deductible.

"Lawyers Professional Liability has cooperated with us from the start in our efforts to safeguard the company's policyholders," Mr. Gunter says. "The company sought our help in attempting to head off financial instability and again came to us when it became evident that our joint efforts just weren't going to pay off."

St. Petersburg-based LPLIC's biggest problem, according to Insurance Department officials, was pricing.

"The company just wasn't charging enough for the risks it was accepting," explained Dennis Threadgill, chief attorney for the department's division of rehabilitation and liquidation. "And by the time it made corrections, it was too late."

LPLIC first sought out the Insurance Department last spring when it realized that claims were mounting much faster than reserves. Although Mr. Threadgill could not provide examples of LPLIC's rates, he says that the insurer needed a "massive rate increase" to balance its finances.

The new rates, announced last September, did not boost income; rather they lost market share for the company. Attorneys switched their coverage to cheaper markets as soon as the increase went into effect, Mr. Threadgill said.

LPLIC had also been offering two types of coverage, practicing attorney malpractice insurance and so-called "tail insurance," Mr. Threadgill explained. "The tail in-

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Committees approve nixing deduction for comp reserves

By DOUGLAS McLEOD

WASHINGTON—Two congressional committees have approved a measure that would bar self-insurers from taking tax deductions for reserves established to pay workers compensation claims.

The tax advantages of structured settlements covering general liability awards might also be eliminated if the measure is enacted, observers say (*BI*, March 5).

The measure, formulated by the Treasury Department, was one of several revenue-raising proposals under review by the House Ways and Means Committee and the Senate Finance Committee.

Although the Senate committee is still marking up its package of revenue proposals, sources say it already has approved the provision that would bar deductions of self-insured workers compensation reserves.

Meanwhile, the House revenue package has been reported favorably by the Ways and Means Committee and will be considered by the full House.

Observers suggest that only a defeat of the entire package of tax proposals will forestall the measure affecting workers compensation self-insurers and structured settlements.

"It looks like it's going to be enacted this year if any tax bill is enacted," said Walter Vinyard, an attorney with the Washington firm of Zuckert, Scoutt & Rasenberger.

The measure, as proposed by the Treasury Department, would change the rules for accrual tax accounting by amending the current "all-events" test with a so-called "economic performance" test.

Courts have interpreted the all-events test as entitling self-insured employers to deduct uncontested workers compensation reserves if:

- All events governing the fact of the employer's liability occur during the tax year. For workers compensation, courts have said that the only event determining liability is the worker's injury.
- The amount of the liability can be determined with "reasonable accuracy." In a decision affecting Kaiser Steel Corp. last October, the 9th U.S. Circuit Court of Appeals held that aggregate reserve accuracy —rather than accuracy on a case-by-case basis—is sufficient to meet this requirement.

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Controlling costs

Employers write benefit commandments

By LORRIE GIBSON

The first commandment for employers struggling to fight the evil of rising health care costs is to make employees pay for their sins.

The prescribed penance:

- Make them pay a larger share of health care costs.
- Make them learn to be wiser consumers of health care.
- Make them take better care of themselves to prevent illness.

This is the health care cost-containment sermon delivered in the most recent survey of the *Business Insurance* Employee Benefit Board.

As part of an overall survey on changes made in benefit plans to control health care costs, board members were asked to list the "most effective" measures employers can take to control costs. From a tally of their suggestions, *BI* compiled a list of the 10 most effective cost-containment techniques.

On top of the list—and mentioned at least twice as often as any other techniques—are redesigning benefit plans to make employees share more of the cost of health care and educating employees to be wise consumers.

Next in line—and still significantly ahead of other suggested cost-containment methods—is developing a wellness program to keep employees healthy.

Increasing employee cost-sharing and educating employees each received 46 votes as the most effective cost-containment step. This compares with 23 votes for wellness programs and 15 or fewer for the seven remaining techniques in the top 10. The last seven include:

- Requiring second surgical opinions, 15 votes.
- Encouraging use of outpatient care, including pre-admission testing and ambulatory surgery, 15.
- Monitoring hospital care through utilization reviews, concurrent reviews and pre-certification, 15.
- Using monetary incentives to encourage employees to curb their use of health care, 14.
- Offering coverage for alternative forms of health care, including health maintenance organizations and preferred provider organizations, 13.
- Acquiring an adequate data base to analyze health care usage, 7.
- Auditing claims, 6.

The *Business Insurance* Employee Benefit Board includes 270 benefit managers from various industries and government entities who have agreed to answer four surveys a year. The most recent survey was returned by 126 benefit managers, for a 47% response rate.

While other sections of the board survey clearly show that the Employee Benefit Board is heeding its own advice and passing more costs onto employees in the form of higher deductibles, more coinsurance and larger payments toward health insurance premiums (see story, page 16), board members commented most on the need to educate employees to question health care providers if health care costs are to be controlled.

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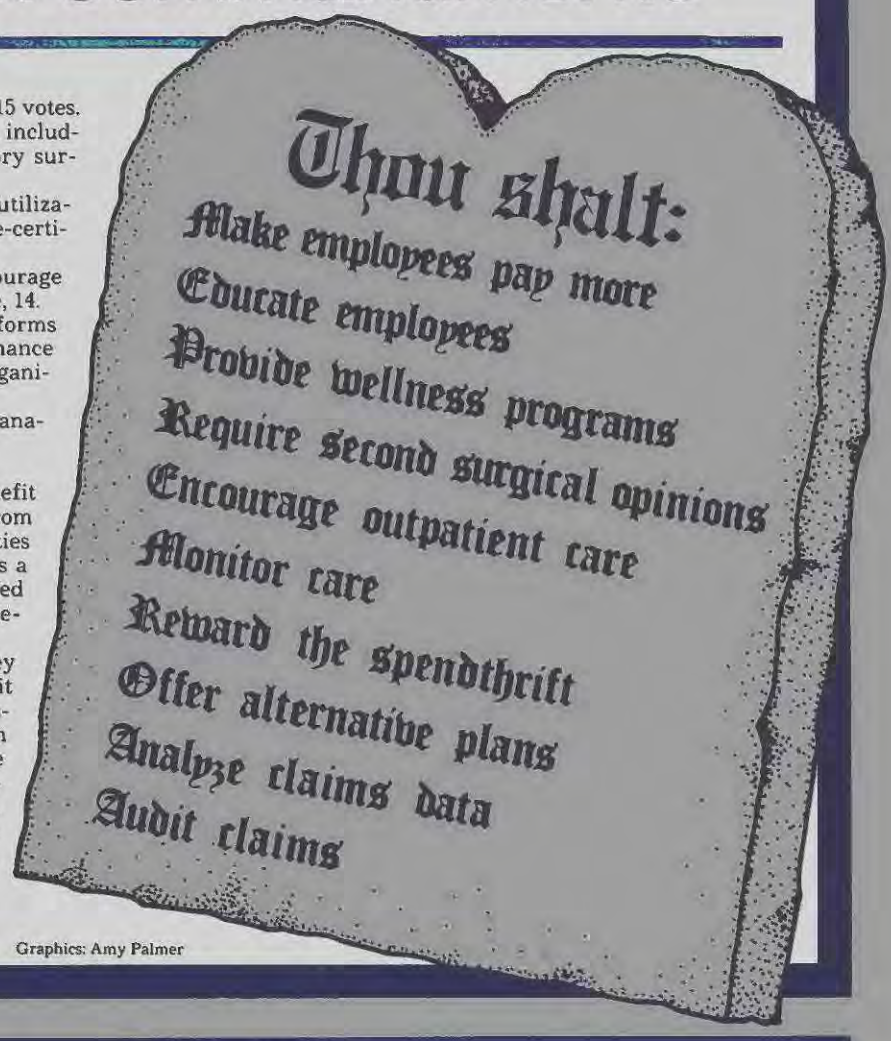

Graphics: Amy Palmer

High-tech firms redesigning high-cost plans

By STEVE TARAVELLA

SANTA CLARA VALLEY, Calif.—Employers in this high-tech community are no longer touting the rich health care benefit plans they used three or four years ago to attract new talent.

Silicon Valley employers, who once extended the red carpet in medical and dental benefits, have come full circle and are now concentrating on benefit reduction, cost shifting, cost containment and health promotion.

Employers and industry observers say Silicon Valley companies began reassessing the generosity of their benefits in late 1982, and that now nearly every electronics firm in the area has made cost-saving or cost-shifting adjustments to their medical or dental plans.

From about 1975 through 1981, bigger-and-better benefits was the buzzword of Silicon Valley employers, who used these lucrative benefits as a tool to lure employees from competing companies (*BI*, Sept. 29, 1980).

Talented workers were catered to by employers during the infancy of the booming electronics and telecommunications industry, where innovations still occur so frequently that today's breakthrough soon becomes only yesterday's standard.

To attract employees, companies as recently as three years ago advertised their benefit plans' largesse in bold display advertisements in the San Jose Mercury News, a local newspaper, one benefit manager recalls.

Today, the help-wanted ads are unassuming—subdued descriptions of the positions that might close with a flat acknowledgement that the company is an equal opportunity employer, he notes.

But cost containment appears to be limited to the health care section of the benefit pie. Silicon Valley employers still offer some of the expensive, glamorous extras—like on-site fitness centers—that make other employers and employees marvel.

Instead of health benefits, employees are being drawn toward more immediate rewards, like cash performance bonuses, profit-sharing dividends and hefty salaries, and by deferred income arrangements, either through a 401(k) or other retirement plan.

And, stock option plans apparently are an eye-catcher for job-shoppers.

"It's not the medical plan that's taking people away from me—it's the stock options," one employer laments.

Indeed, the medical plans are becoming more run-of-the-mill. Like the majority of employers across the country, many of the Silicon Valley employers have increased deductibles and employee contributions to the cost of the plan. And, many companies are offering incentives to encourage employees to use less expensive care options, such as outpatient treatment.

They are also increasing their cost-containment efforts through peer review organizations and utilization review programs.

And, they are beginning education

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Retirees begin to feel the ax

Some cost-conscious employers are turning their attention to retiree health benefits. But, passing health costs onto retirees may not be as easy as it looks. See story, page 18.

PPOs offer more than discounts

Employers using preferred provider organizations advise judging PPOs on efficiency and data capabilities rather than promises of discounted rates. See story, page 23.

Good data can be hard to find

Employers report they have followed a variety of strategies to contain health cost increases, but few say they are able to get utilization data from insurers or administrators. See story, page 27.

High-tech firms scaling back benefits

Continued from page 3
programs, aimed at making employees better consumers by showing them how costly medical care can be today. They also are providing health promotion or wellness programs, such as classes in proper nutrition, exercise, weight loss and smoking cessation.

"What's happened in the last three years or so is a gradual maturing process in companies in the Silicon Valley. Their approach to—and perception of—benefits is quickly changing," explains J. Paul Tom, a principal at William M. Mercer-Meidinger Inc. in San Francisco.

"In the past, rich benefits were regarded as the less an employee paid out of pocket, the better. That's no longer the case."

"Benefits as an attraction tool just don't exist today. The peer comparison is no longer the planning method," he says.

"Just about everybody either has made changes to their benefit plans, or will by the end of this calendar year. We're no longer giving away the store," says Bob Lee, vp-personnel at Plantronics, Inc., a San Jose-based telecommunications company with about 850 of its 1,500 employees in California.

"All of the companies I know of today are a lot more concerned about controlling benefit costs and are, to that end, making a lot of design changes. That's the issue rather than using the benefit plan to attract the employee," he adds.

Laurie N. Pecchenino, benefits specialist at Shugart Associates, a Xerox Corp. subsidiary that manufactures computer components, agrees.

"Two years ago, you would have offered the moon and the stars just to get bodies," she recalls. About 2,000 of Shugart's 2,500 employees work at the company's Sunnyvale, Calif., headquarters.

Now, she says, cost-shifting and cost-containment measures are helping employers return "to the realm of reality."

Chris H. Smith, compensation and benefits manager for Electromagnetic Systems Laboratories Inc., calls the current approach toward providing health care benefits "a complete reversal from the laissez-faire market where no benefit was big enough to attract an employee." ESL is the Sunnyvale-based subsidiary of TRW Inc. with about 2,400 employees working in the Silicon Valley.

The use of health care benefits to gain a competitive edge has decreased by more than 75% since late 1982, Mr. Smith estimates.

Today, instead of adding benefit options to an already generous plan, Silicon Valley employers are trying to design new ones within existing cost boundaries, "which means, to some extent, you're reducing benefits," Mr. Smith explains.

"People are looking to produce the same image of benefits within a limited budget," he explains.

And much of the rivalry over benefit plans has ended.

Instead, Silicon Valley employers are working together to solve mutual problems through such organizations as the Santa Clara County Manufacturers Group. "Maturity has led considerably to a far more stable benefit environment," Mr. Smith notes.

He says the electronic industry as a whole wants employers to share a quarter to a half of the cost of benefits, with the exception of catastrophic needs. In January 1983, ESL tripled its employee deductible for major medical coverage, raising it to $150 from $50, a move that saved the company 10% to 15% in medical costs last year, Mr. Smith estimates. That move was one of the first such attempts at cost containment in the Silicon Valley, he believes.

At the same time, the company contracted with two additional health maintenance organizations in California, bringing to three the total number of HMOs it offers in California and contracted with an HMO in Utah and Maryland. It also joined a dental HMO in California.

For every $1 spent on payroll, ESL spends an additional 29.8 cents on benefits—about 24% of an employee's total compensation.

That percentage has been dropping about 0.5% annually over the past three years, Mr. Smith notes.

To reduce costs more, ESL is trying to shift employees from the company's self-insured medical plan to one of the HMOs, Mr. Smith says.

This January, ESL also implemented an incentive for employees to receive outpatient treatment when possible. The patient is reimbursed for 100% of costs if he or she is treated as an outpatient; however, if a procedure that could be performed on an outpatient basis is performed in the hospital, only 80% of eligible expenses are covered.

Other employers are taking similar steps.

National Semiconductor Corp., for example, with about 8,000 employees at its Santa Clara headquarters, raised its employee medical deductible in January 1983 for the first time in more than 10 years, notes Gary Bahr, director of compensation and benefits.

The major medical deductible was hiked to $150 from $100. After that point, the employee pays 20% coinsurance until his out-of-pocket expenses reach $1,000 and then the company pays 100% of expenses.

Last June, National Semiconductor also implemented a $100 deductible on hospital coverage, after which the company pays 100% of expenses up to $1 million.

"Every time you turn around, we seem to be trimming something out of it," Mr. Bahr observes.

National Semiconductor last June also increased weekly employee premium contributions. Employees who previously paid $2 for family coverage now pay $4 and those who received individual coverage at no charge now pay $1.

The company is projecting that the changes will save more than $1 million after one year.

Shugart, where about half of the employees are HMO members and about half are enrolled in one of two insurance plans, has likewise responded.

For 10 years, from it founding in 1973 until January 1983, the company required no premium contribution from employees.

Today, Shugart offers two medical insurance plans. One deducts $3.30 from biweekly paychecks for individual employee coverage and $7.10 for family coverage, which Ms. Pecchenino calls "still very reasonable." After employees satisfy a $50 individual deductible and $150 family deductible, Shugart will pay 80% of costs until em-

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BI-3

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Benefit communication appeases valley employees

SANTA CLARA VALLEY, Calif.—Benefit managers who are looking to control their health care spending by cost shifting or other cost-containment measures face a problem: How will they do it without alienating employees.

The solution in the Silicon Valley appears to be clear communication to employees of the changes that will affect them.

"It's extremely hard to take away from employees who've had everything," notes Chris H. Smith, compensation and benefits manager for Electromagnetic Systems Laboratories Inc., a subsidiary of TRW Inc.

Others echo Mr. Smith's observation, explaining that employees in the Silicon Valley have come to view rich benefit plans as something of an entitlement.

"The key to the whole process is upfront communication. We explain what we're doing and why we're doing it. It's worked well for us," he says.

ESL recently made several changes in its benefit package (see story, page 3) that were designed to taper the company's rich plan to the scale of other employers' programs, he says.

It is important for workers to realize that "employers are not looking to turn their backs on employee benefits and become insensitive to employee needs," he says.

"Employers are still very, very concerned about employee reaction to changing benefits. There's a nervousness that reducing benefits will drive people away," Mr. Smith notes.

"They're spending a lot more money on communication now," J. Paul Tom, a principal at William M. Mercer-Meidinger Inc. in San Francisco, says of his Silicon Valley clients.

Mr. Tom says health care plan changes have received "fairly positive" reactions, partly because employees, aware of current medical expenses, have come to expect some cost shifting.

"Most employees are far more enlightened (about health care costs) than employers tend to give them credit for," he says.

Bob Lee, vp-personnel at Plantronics Inc. in San Jose, says the telecommunications company has received a "very favorable" reaction from its employees about benefit plan changes.

This year, the company began hospital preadmission screening, utilization reviews and an audit program that rewards employees who catch billing errors by giving them 25% of the overcharge, up to $200. The company educates employees about current medical expenses and informs them about the most cost-effective hospitals in the area.

"They can appreciate you for trusting their good judgment. We find a lot of respect for us for treating them that way," he says.

"It's a very different approach we're taking by calling on them to assist and to become good consumers. We think our employees accept it and understand it. We're convinced they're our best hope," he says.

High-tech firms redesign plans

Continued from page 4

ployee out-of-pocket expenses reach $1,000 for individuals and $2,000 for families.

The second plan, implemented in January 1983, is free to employees, but carries higher deductibles: $150 per individual and $450 per family. Less than 10% of the company's employees are enrolled in this plan.

Varian Associates Inc., a Palo Alto-based electronics firm with almost 8,000 employees in California, has taken several steps toward controlling its benefit costs.

Before October 1983, the company reimbursed 80% of an employee's costs for out-patient surgery, pre-admission tests, home health care, second surgical opinions and use of birthing centers. Today, the company hopes to attract employees to use these less costly forms of treatment by reimbursing them for 90% of these charges, with an out-of-pocket maximum of $500.

And, until October, Varian paid 50% of eligible outpatient pyschiatric expenses, up to $1,000 a year. Today, the company pays 80% up to $2,000 a year with a $150,000 lifetime limit.

"Early intervention on mental nervous disorders" is a sound benefit management practice, notes Brian D. Lowe, administrator of health and group insurance programs.

Varian employees must pay about 10% of the company's medical plan costs and about 30% of its dental plan costs, Mr. Lowe estimates. Both plans are self-insured.

"We're sensitive that our changes not affect the quality of care," Mr. Lowe says, a sentiment echoed by the other benefit managers.

All of these cost-cutting steps are the result not only of spiraling health care costs, but also—possibly to a larger degree—the result of the maturing of these companies.

Small to medium-sized employers, without parent company support, had no corporate experience to rely on when setting up benefit plans and, for about five years, offered very generous programs, these benefit managers explain.

But that created a problem. Employers increased their benefits to keep up with each other to the point at which the plans became "equally as rich and set an expensive standard," according to one benefit manager.

"I don't think they saw the cost of benefits at first as a real cost of doing business at all," says another. "But that's shifting—there's a new awareness."

Employers now say they have shed their initial naivete, and are more aware of how the cost of financing health care benefits affects the cost of doing business.

As one benefit manager quipped, "Now we're competing to see who can provide less."

Employers are quick to point out, however, that despite cost-containment moves, they aren't spending any less on benefits than they did three or four years ago. In fact, they are spending considerably more because of rising employee salaries and health care costs.

The typical Silicon Valley employer, who probably does not offer a pension plan, may now spend about 30 cents on benefits for each $1 of payroll, estimates Mercer-Meidinger's Mr. Tom.

That is about 10 cents—or 50%—more than what he estimates was typical three or four years ago.

One employer's figures are somewhat higher. She suggests that in 1980, average benefits in the Silicon Valley represented 25% to 28% of total compensation, and that today they represent 38% to 40%. ■

WHY SHOULD HE CARE WHAT IT COSTS? THE COMPANY'S BUYING.

Expense account psychology isn't limited to executive lunches. It is, unfortunately, alive and well in employees who find themselves ill.

And a corporation's best laid plans for containing medical costs often don't stand a chance against, "I'm covered for it."

With this in mind, we at Connecticut General, a CIGNA company, approach the issue of rising medical costs not only as a financial problem, but as an educational one.

It isn't enough, for example, to offer a second opinion on elective surgery. Or one-day surgery. Or pre-admission testing.

Employees have to know these things are available.

Even a high deductible and co-payment aren't enough. Because they supply an incentive to reduce costs, not the means.

So we provide brochures, mailers, promotional material, videotapes, and advise our clients on how to use these to motivate their employees.

Not surprisingly, we've discovered most employees don't realize there are alternatives to long hospital stays.

When it's feasible, many would prefer a nurse at home to a week in the hospital.

And when they're offered, many are also willing to take advantage of preventive medicine programs such as blood pressure screening.

Of course, we're not suggesting that employee education is the single answer to a problem as serious as this one.

In fact, our programs cover a range of approaches. From funding business coalitions working to reduce local costs, to providing companies with data to track the effectiveness of their own cost containment activities.

But it remains true that even a plan as sophisticated as our cost containment package can't be completely effective unless employees are involved in the effort.

So if you'd like more information about reducing group medical expenses, write to Connecticut General, Dept. A-141-A, Hartford, CT 06152.

Or if you'd like to know how we can specifically help reduce your company's costs, call your broker or your local Connecticut General representative.

After all, this may well be an area in which management could benefit from a little education, itself.

CIGNA

opinions

Hang in there

"IN ALL MY YEARS of experience, I've never seen a topic provoke so much talk and so little action.

"The federal government is the single largest purchaser of health care. . .as long as the government doesn't curb spending, providers will charge what the market will bear. It's the democratic way of business and it works.

"Personally, I'm tiring of community meetings on the topic of health care cost containment."

This comment, attached to the end of a recent *Business Insurance* Employee Benefit Board survey on health care cost containment, came from the director of compensation and benefits for a manufacturer with 1,200 employees, who has seen his firm's health care costs rise 36% since 1982.

We can understand the sense of frustration he and other benefit managers must feel when they wage a brave war against rising health care costs by implementing cost-containment measures in their benefit plans and making a concerted effort to educate employees to be wise health care consumers—only to see their health plan costs continue to increase, sometimes drastically.

But to this weary director of compensation and benefits and all the other benefit managers out there we plead: Hang in there.

Don't give up the fight now. Believe it or not, we think you might be winning:

• **Exhibit A:** A recent survey by the Health Research Institute in Walnut Creek, Calif., shows that employers that actively promoted cost-containment or wellness programs were able to hold their health care costs well below the survey average (see story, page 27).

Employers that reported they had taken more than six significant cost-containment steps said their health expenditures per employee in 1982 totaled only $966, 27.1% less than the $1,366 average reported by all survey respondents. The employers that did not take more than six cost-containment measures reported health care costs per employee of $1,438.

And those that initiated more than four wellness efforts said their costs per employee totaled $1,061, compared with $1,456 for those that did not initiate a high level of wellness programs.

• **Exhibit B:** The preliminary results of a health care cost-containment survey by consultant Hewitt Associates in Lincolnshire, Ill., shows that companies that believe their cost-containment efforts have been a significant or moderate success are predicting their health care costs will rise only 4% this year, compared with 14% in 1983 (see story, page 30).

Conversely, those companies that say their cost-containment efforts have met with little success are predicting that health costs will rise even more steeply this year than in 1983. They are anticipating a 15% cost increase, compared with 13% last year.

• **Exhibit C:** Your employees are warming to the idea of health care cost containment. In the most recent *BI* Employee Benefit Board survey (see stories beginning on page 3), benefit managers were asked how their employees reacted when more health care costs were passed onto them or cost-containment measures were added to benefit plans.

Overwhelmingly, they said their employees did not necessarily like the changes, but accepted them with understanding. Only four of 126 respondents said plan changes sparked a hostile response.

Three board members said their employees not only accepted the changes, but welcomed them as solutions to the growing health care cost problem.

This means your efforts to educate workers about health care costs and the need to contain them are paying off. The message is sinking in.

Sure, it's a slow process. But after all the effort you have already poured into this battle, it would be a shame to retreat now and lose the ground you gained.

Instead, hang in there.

letters

Dental malpractice program's data base defended

To the editor: Our response to Bartholomew G. Nyhan's letter (*BI*, Feb. 27) regarding your recent article on dental professional liability insurance is based upon 11 years of work with the Chubb Group of Insurance Companies.

First, to our knowledge, the Chubb-ADA program was written on an occurrence basis policy and the St. Paul, managed by Mr. Nyhan, is written on a claims-made policy form.

During our 11-year relationship with Chubb, we found that the actuarial, claims and the underwriting departments were thoroughly committed to sound premium and loss data and cause-of-loss claim information.

Our monthly activity reports on behalf of the American College of Emergency Physicians' program were, and still are, the most complete data in the insurance industry. Each claim is analyzed in both time frame and cause-of-loss methodology, which creates a risk management source of data second to none.

In addition, the Chubb actuarial department provides monthly data runs enumerating claim detail and paid and reserved dollar amounts.

On many occasions we have disagreed with Chubb actuarial projections, but we have never found an inconsistency in its risk management or claim data base information.

I. David Gordon
President
EPT Enterprises Inc.
New York

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Reporting weekly for corporate risk, employee benefit and financial executives

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J&H thinks you'll get better control of medical costs by getting better control of your data.

What do you think?

If you think insurance claims information on hospital usage is not specific enough to be decisive in a cost-control dialogue with hospitals and physicians, we agree.

For example, there are 13 different coded types of hysterectomies. If your claims data cannot differentiate among them, you may not be talking the same clinical and cost language as the medical provider.

The J&H Health Care Data Management System can solve this problem. Among other things, it categorizes specific hospital confinement information by the proper Diagnosis Related Group (DRG), using sophisticated diagnosis and treatment classifications.

And, while concentrating on the costly area of hospitalization, the System gathers and analyzes data on all types of medical expenditures.

The J&H Health Care Data Management System: the sophisticated tool for corporations and business coalitions to help control medical plan usage and costs.

We'd like to talk with you about this.

Johnson&Higgins

We answer only to you.

EMPLOYEE BENEFIT AND ACTUARIAL CONSULTING; RISK AND INSURANCE MANAGEMENT SERVICES THROUGHOUT THE WORLD.

employee benefit board

Cost-control commandments

Continued from page 3

"The education of employees is the No. 1 area all companies need to face in order to see any type of savings in their health care costs," wrote the assistant personnel director for an automotive retail parts and service firm with 529 employees. "This is not a one-time activity but a constant reminder to all employees on ways and needs of containing costs."

"I don't believe a 'real' reduction in health care costs will be realized until employees start questioning their doctors about the necessity for some services in addition to their developing an attitude of 'efficient shopping' for health care. . . ," said the manager of benefits administration for a bank with 7,200 employees.

The director of human resources for a valve and instrumentation sales and service company with about 200 employees described why it is so important to re-educate employees who were raised to live in awe of the medical profession:

"Our employees are no different from other people. The M.D. is god and the patient fears to challenge him. (The) M.D. says, 'We'll put you into the hospital to run these tests so that you can rest and so that the insurance company will pay for the services.' People fear saying, 'Hell no! I won't go. Let's do it on an outpatient basis.'

"(The) M.D. profession has to be educated, too, that bills will be paid if appropriate and not because the person is in a hospital bed," the benefit manager adds.

Some have found their employees very responsive to this re-education.

"In the past year, we have continually stressed the need to question physicians and hospitals on costs in advance of treatment, and we have been very pleasantly surprised at the response. Most of our folks are becoming aware of the true cost of medical care," said the benefits coordinator for a chemical manufacturer with 2,600 U.S. employees.

In 1983, this company increased salaried employees' deductibles and their share of health insurance premium, added coverage for home health care and hospice care, added a mandate for second surgical opinions and joined a business coalition.

Others, however, have found that their top management has not been responsive to their suggestion to educate employees and implement cost-savings programs:

"I do not feel increased deductibles, contributions or coinsurance levels are cost-saving incentives to the employee (once the deductible has been satisfied, there is no need to be a wise consumer of medical service)," wrote the manager of insurance, benefits and risk management for a retail firm with 650 employees eligible for benefits.

"I believe the solution is twofold: first, the education of employees through effective communication, wellness programs, self-care, etc. For example, employees must realize the need to understand and question their physician's advice. (Can services be provided on an outpatient basis? Is a generic drug available?)

"Second, the implementation of cost-savings programs (such as second surgical opinions, outpatient surgery, pre-admission testing), which are encouraged through increased benefits for utilization and penalties for non-utilization.

"Unfortunately, so far upper management is not convinced that this is the proper course to follow."

Although this company's health care costs increased by 55% from 1982 to 1983, it took no cost-containment steps in 1983, according to the survey response form.

But so far this year, it has raised salaried employees' deductibles from $100 per individual and $300 per family to $200 and $600, increased reimbursement levels for ambulatory care and mandates second surgical opinions before elective surgery for full coverage.

Although the effectiveness of wellness programs to fight rising health care costs received only half as many votes (23) as cost sharing and employee education, the Employee Benefit Board's confidence in this technique is obvious by the number that are implementing wellness programs. According to another section of the survey, creation of a wellness program was the third most popular cost-containment step taken in 1983 and is the third most popular step expected to be taken this year.

In 1983, 26% of the board respondents instituted a wellness program, and another 26% plan to institute one this year. By 1985, 66 of the 126 respondents—or 52%—will have a wellness program in place.

Likewise, the board's faith in the use of outpatient care to curb rising costs is obvious in the number of managers whose firms increased reimbursement levels for ambulatory care in 1983 or plan to in 1984.

(The encouragement of outpatient care tied with second surgical opinions and monitoring of care as the most effective cost-saving techniques after wellness programs.)

By 1985, almost 40% of the survey respondents will have increased reimbursement levels for ambulatory care. In 1983, 20% of the survey respondents increased reimbursement levels and this year, 17% either have increased reimbursement levels or plan to do so.

In the area of alternative care plans, the eighth most effective cost-saving technique, cited by 13 respondents, only two respondents offered PPOs in 1983, but 21, or 17%, plan to do so in 1984.

Two-thirds of the respondents also offer HMOs, but it is impossible to determine how many took this step to save money or just because federal law mandates that anyone that employs 25 or more people must offer an HMO if a federally qualified one is available in their area and approaches the company.

Claims auditing ranks at the bottom of the list of the most effective cost-control techniques with six benefit managers citing it, and it also is at the bottom of the list of cost-containment steps expected to be taken in 1984. Fourteen percent of the survey respondents expect to hire a claims auditor this year to review doctor and hospital bills for inaccurate or exorbitant charges.

Fifteen percent of the survey respondents hired a claims auditor in 1983.

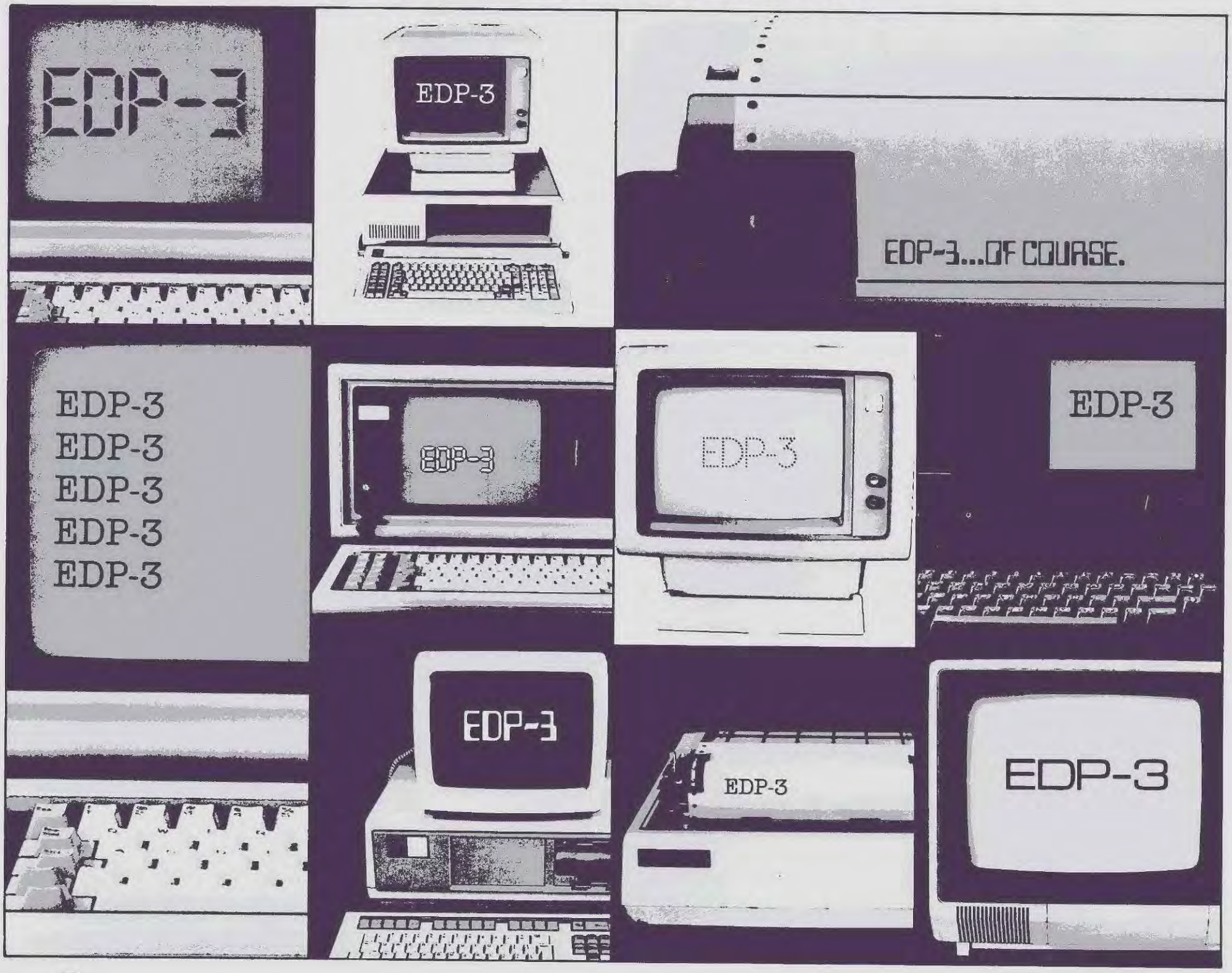
On the other hand, 25% of the survey respondents plan this year, either through a coalition or as an individual employer, to analyze hospital and doctor charges to encourage employees to use the most economical health care provider.

Seventeen percent said they took such action in 1983.

•

Employee benefit managers and buyers of employee benefit plans are invited to join the Business Insurance Employee Benefit Board. Just send a card with your name, title, company and address to Kathryn J. McIntyre, Editor, Business Insurance, 740 Rush St., Chicago, Ill. 60611. You will receive four surveys during the year on benefit issues.

We asked some famous computers which policy they would choose for themselves.



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Uncertainty over FSAs may affect cost strategy

The uncertainty over the future of flexible spending accounts, prompted by an Internal Revenue Service press release in early February and fueled this month by congressmen looking for ways to reduce the federal deficit, may be messing up the cost-containment plans of many employers.

Flexible spending accounts—also called flexible reimbursement accounts, employee spending accounts, benefit banks or flex accounts—are individual accounts that let employees spend pretax dollars on certain non-taxable benefit expenses (*BI*, Jan. 9, Feb. 20 and 27, March 5).

The most recent *Business Insurance* Employee Benefit Board survey asked respondents to list what cost-containment measures they took in 1983 and so far in 1984 and what measures they still plan to implement in 1984.

While only three listed the establishment of an FSA as a cost-containment move in 1983, five respondents said they already had established one this year and another 30, or 24%, said they plan to establish one before year-end to help control costs.

In fact, the use of FSAs to contain health costs in 1984 ranked second out of 11 cost-containment measures proposed in the survey. Only the establishment of mandatory second surgical opinion programs was ranked above FSAs, and then only by one vote.

Thirty-six respondents, or 29%, said they either had already or planned to institute a second surgical opinion program in 1984 and 35, or 28%, said they had already or planned to establish an FSA this year.

In contrast, in 1983, the use of FSAs ranked second to the last on the cost-containment list. And, while 25% of the respondents instituted second surgical opinion programs in 1983, the use of second surgical opinions only ranked as the fourth most popular form of cost containment in 1983, compared with the first in 1984.

Instead last year, members of the Employee Benefit Board flocked to business coalitions in an attempt to find some solutions to the problem of rising health care costs.

Fifty-one respondents, or 40%, joined a business coalition to study health care costs last year, making that the most popular of the cost-containment techniques listed. However, that surge of interest in coalitions appears to have leveled off this year. Only 19 respondents, or 15%, have or plan to join a coalition this year.

After coalitions, the second most popular cost-containment step in 1983 was instituting a wellness program or wellness benefit and adding coverage for home health care. Twenty-six, or 21%, of the survey respondents said they had taken both steps in 1983. Wellness programs also are even more popular this year with 26% of the respondents planning to establish one.

Other cost-containment steps taken in 1983 included:

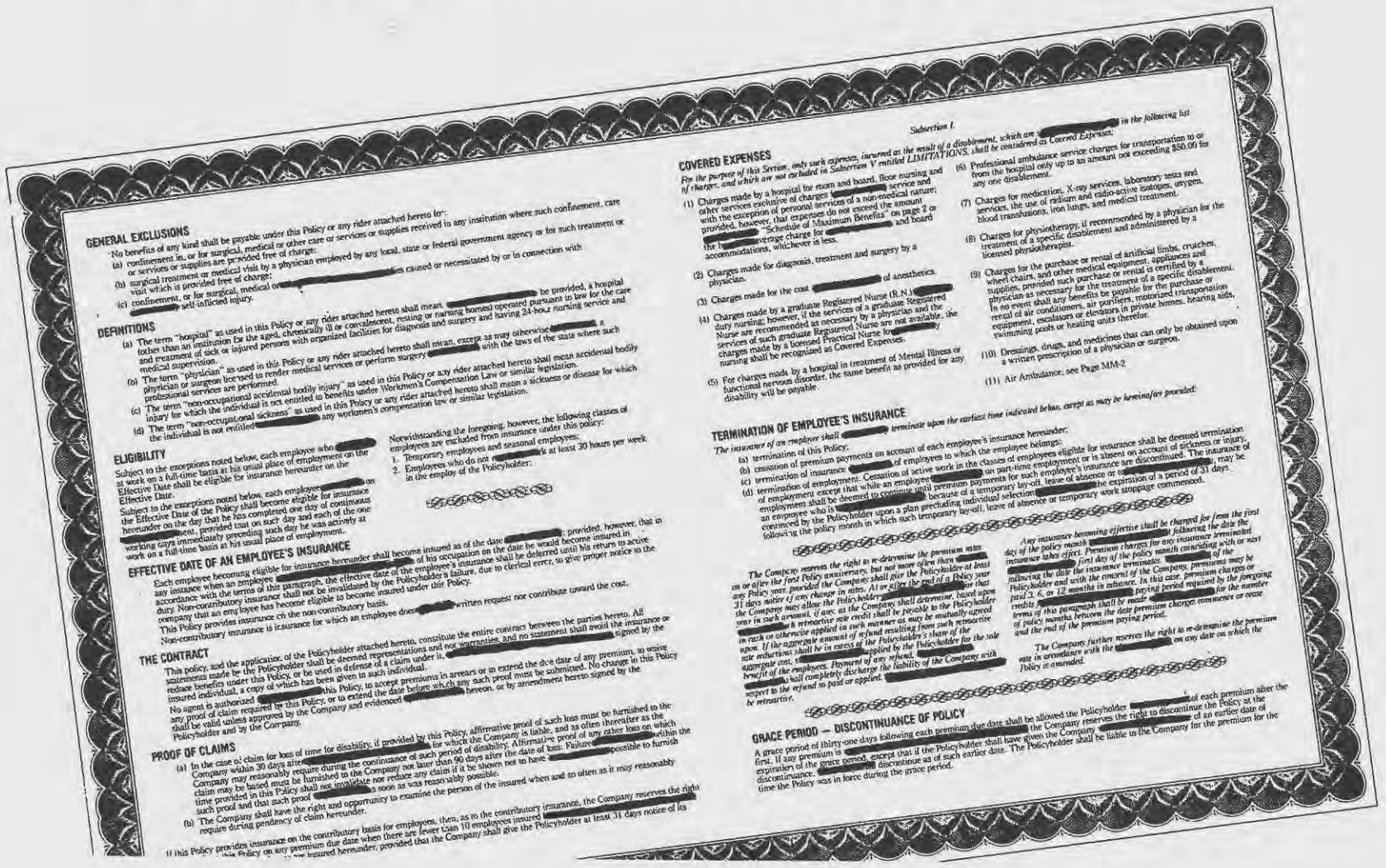
- Adding coverage for hospice care, 21%.
- Increasing reimbursement levels for ambulatory care, 20%.
- Analyzing hospital and doctor charges, either through a coalition or as an individual employer, to encourage employees to use the most economical health care providers, 17%.
- Hiring a claims auditor to review bills for inaccurate or exorbitant charges, 15%.
- Joining a preferred provider organization, 1.5%.

Cost-containment steps ranked behind second surgical opinion programs, FSAs and wellness programs in 1984 are:

- Analyzing hospital and doctor charges either through a coalition or as an individual employer, 25%.
- Adding hospice coverage, 24%.
- Increasing reimbursement levels for ambulatory care, 17%.
- Adding coverage for home health care, 17%.
- Joining a preferred provider organization, 17%.
- Joining a business coalition, 15%.
- Hiring a claims auditor, 14%.

The majority of the survey respondents also offer health maintenance organizations, but because of federal requirements, it is impossible to gauge how many employers offer them to contain costs. ■

Eliminate the INFLATION NOTATION.



GENERAL EXCLUSIONS

No benefits of any kind shall be payable under this Policy or any rider attached hereto for:
(a) confinement in, or for surgical, medical or other care or services or supplies received in any institution where such confinement, care or services or supplies are provided free of charge;
(b) surgical treatment or medical visit by a physician employed by any local, state or federal government agency or for such treatment or visit which is provided free of charge;
(c) confinement, or for surgical, medical or [redacted] caused or necessitated by or in connection with [redacted] self-inflicted injury.

DEFINITIONS

(a) The term "hospital" as used in this Policy or any rider attached hereto shall mean, [redacted] be provided, a hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or injured persons with organized facilities for diagnosis and surgery and having 24-hour nursing service and medical supervision.
(b) The term "physician" as used in this Policy or any rider attached hereto shall mean, except as may otherwise [redacted] with the laws of the state where such physician or surgeon licensed to render medical services or perform surgery [redacted], a professional services are performed.
(c) The term "non-occupational accidental bodily injury" as used in this Policy or any rider attached hereto shall mean accidental bodily injury for which the individual is not entitled to benefits under Workmen's Compensation Law or similar legislation.
(d) The term "non-occupational sickness" as used in this Policy or any rider attached hereto shall mean a sickness or disease for which the individual is not entitled [redacted] any workmen's compensation law or similar legislation.

ELIGIBILITY

Subject to the exceptions noted below, each employee who [redacted] at work on a full-time basis at his usual place of employment on the Effective Date shall be eligible for insurance hereunder on the Effective Date.
Subject to the exceptions noted below, each employee [redacted] on the Effective Date of the Policy shall become eligible for insurance hereunder on the day that he has completed one day of continuous [redacted]ment, provided that on such day and each of the one working days immediately preceding such day he was actively at work on a full-time basis at his usual place of employment.

Notwithstanding the foregoing, however, the following classes of employees are excluded from insurance under this policy:
1. Temporary employees and seasonal employees;
2. Employees who do not [redacted]k at least 30 hours per week in the employ of the Policyholder;

EFFECTIVE DATE OF AN EMPLOYEE'S INSURANCE

Each employee becoming eligible for insurance hereunder shall become insured as of the date [redacted]; provided, however, that in any instance when an employee [redacted] of his occupation on the date he would become insured in accordance with the terms of this paragraph, the effective date of the employee's insurance shall be deferred until his return to active duty. Non-contributory insurance shall not be invalidated by the Policyholder's failure, due to clerical error, to give proper notice to the company that an employee has become eligible to become insured under this Policy.
This Policy provides insurance on the non-contributory basis.
Non-contributory insurance is insurance for which an employee does [redacted] written request nor contribute toward the cost.

THE CONTRACT

This policy, and the application, of the Policyholder attached hereto, constitute the entire contract between the parties hereto. All statements made be the Policyholder shall be deemed representations and not warranties, and no statement shall avoid the insurance or reduce benefits under this Policy, or be used in defense of a claim under it, [redacted] signed by the insured individual, a copy of which has been given to such individual.
No agent is authorized [redacted] this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any proof of claim required by this Policy, or to extend the date before which any such proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced [redacted] hereon, or by amendment hereto signed by the Policyholder and by the Company.

PROOF OF CLAIMS

(a) In the case of claim for loss of time for disability, if provided by this Policy, affirmative proof of such loss must be furnished to the Company within 30 days after [redacted] for which the Company is liable, and as often thereafter as the Company may reasonably require during the continuance of such period of disability. Affirmative proof of any other loss on which claim may be based must be furnished to the Company not later than 90 days after the date of loss. Failure [redacted] within the time provided in this Policy shall not invalidate nor reduce any claim if it be shown not to have been possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.
(b) The Company shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during pendency of claim hereunder.

If this Policy provides insurance on the contributory basis for employees, then, as to the contributory insurance, the Company reserves the right [redacted] Policy on any premium due date when there are fewer than 10 employees insured [redacted] the insured hereunder, provided that the Company shall give the Policyholder at least 31 days notice of its

Subsection I.

COVERED EXPENSES

For the purpose of this Section, only such expenses, incurred as the result of a disablement, which are [redacted] *in the following list of charges, and which are not excluded in Subsection V entitled LIMITATIONS, shall be considered as Covered Expenses:*

(1) Charges made by a hospital for room and board, floor nursing and other services exclusive of charges [redacted] service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the amount [redacted] "Schedule of Maximum Benefits" on page 2 or the [redacted] average charge for [redacted] and board accommodations, whichever is less.
(2) Charges made for diagnosis, treatment and surgery by a physician.
(3) Charges made for the cost [redacted] of anesthetics.
(4) Charges made by a graduate Registered Nurse (R.N.) [redacted] duty nursing; however, if the services of a graduate Registered Nurse are recommended as necessary by a physician and the services of such graduate Registered Nurse for [redacted] are not available, the charges made by a licensed Practical Nurse for [redacted] nursing shall be recognized as Covered Expenses.
(5) For charges made by a hospital in treatment of Mental Illness or functional nervous disorder, the same benefit as provided for any disability will be payable.
(6) Professional ambulance service charges for transportation to or from the hospital only up to an amount not exceeding $50.00 for any one disablement.
(7) Charges for medication, X-ray services, laboratory tests and services, the use of radium and radio-active isotopes, oxygen, blood transfusions, iron lungs, and medical treatment.
(8) Charges for physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist.
(9) Charges for the purchase or rental of artificial limbs, crutches, wheel chairs, and other medical equipment, appliances and supplies, provided such purchase or rental is certified by a physician as necessary for the treatment of a specific disablement. In no event shall any benefits be payable for the purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, hearing aids, swimming pools or heating units therefor.
(10) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a physician or surgeon.
(11) Air Ambulance; see Page MM-2

TERMINATION OF EMPLOYEE'S INSURANCE

The insurance of an employee shall [redacted] *terminate upon the earliest time indicated below, except as may be herein/after provided:*
(a) termination of this Policy;
(b) cessation of premium payments on account of each employee's insurance hereunder;
(c) termination of insurance [redacted] of employees to which the employee belongs;
(d) termination of employment: Cessation of employee [redacted] of active work in the classes of employees eligible for insurance hereunder on the day of employment except that while an employee [redacted] on part-time employment or is absent on account of sickness or injury, an employee who is [redacted] because of a temporary lay-off, leave of absence or [redacted] employment shall be deemed to continue until premium payments for such employee's insurance are discontinued. The insurance of such employee [redacted] continued by the Policyholder upon a plan precluding individual selection [redacted] the expiration of a period of 31 days following the policy month in which such temporary lay-off, leave of absence or temporary work stoppage commenced.

The Company reserves the right to re-determine the premium rates on or after the first Policy anniversary, but not more often than [redacted] *any Policy year, provided the Company shall give the Policyholder at least 31 days notice of any change in rates. At or after the end of a Policy year the Company may allow the Policyholder* [redacted] *for that year in such amount, if any, as the Company shall determine, based upon* [redacted] *a retroactive rate credit shall be payable to the Policyholder in cash or otherwise applied in such manner as may be mutually agreed upon. If the aggregate amount of refund resulting from such retroactive rate reductions shall be in excess of the Policyholder's share of the aggregate cost, [redacted] applied by the Policyholder for the sole benefit of the employees. Payment of any refund, [redacted] shall completely discharge the liability of the Company with respect to the refund so paid or applied. [redacted] be retroactive.*

Any insurance becoming effective shall be charged for from the first day of the policy month [redacted] *following the date the insurance takes effect. Premium charges for any insurance terminated [redacted] first day of the policy month coinciding with or next following the date the insurance terminates.* [redacted] *of the Policyholder and with the consent of the Company, premiums may be paid 3, 6, or 12 months in advance. In this case, premium charges or credits [redacted] paying period required by the foregoing terms of this paragraph shall be made [redacted] for the number of policy months between the date premium charges commence or cease and the end of the premium paying period.*

The Company further reserves the right to re-determine the premium rate in accordance with the [redacted] *on any date on which the Policy is amended.*

GRACE PERIOD — DISCONTINUANCE OF POLICY

A grace period of thirty-one days following each premium due date shall be allowed the Policyholder [redacted] of each premium after the first. If any premium is [redacted] the Company, except that if the Policyholder shall have given the Company [redacted] expiration of the grace period, [redacted] of an earlier date of discontinuance. The Policyholder shall be liable to the Company for the premium for the [redacted] discontinue as of such earlier date.
time the Policy was in force during the grace period.

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Benefit managers expect costs to moderate

Health plan cost increases

% of increase	Percent of employers 1983	1984*
0-5%	11%	9%
6%-10%	17%	32%
11%-15%	15%	29%
16%-20%	25%	22%
21%-30%	25%	6%
31%-40%	4%	1%
40%-50%	3%	0%
over 50%	3%	1%

*projected

Benefit managers expect the cost of their health care plans to continue to rise in 1984, but they don't expect the increases to be as drastic as they were in 1983.

In a recent survey of the *Business Insurance* Employee Benefit Board, 76% of the respondents said their health costs had increased during the last year and 78% of the respondents expect their costs to increase this year.

But, this year the majority of the respondents expect the cost of their plans to increase 15% or less while last year the majority experienced increases of more than 15%.

During the last year, 50% of the survey respondents whose costs rose experienced increases of 16% to 30%. Costs for one-half of these respondents (24) rose 16% to 20% and costs for the other half rose 21% to 30%.

In contrast, only 28% of the survey respondents that expect their costs to increase this year predict hikes of 16% to 30%.

Although 22% predict their costs will rise 16% to 20% again this year, only 6% think increases will hit the 21% to 30% bracket, a major contrast to the 25% that saw rates increase that much last year.

Furthermore, 10% of those whose costs increased in 1983 said they rose more than 30%. Four respondents said their costs rose 31% to 40% over the last 12 months, three said they rose 40% to 50% and three said they rose more than 50%.

But this year, almost none of the respondents expects cost increases to creep above 30%. Only one is predicting costs will increase 31% to 40% this year, none expects increases of 41% to 50% and one is predicting increases above 50%.

Instead, this year 70% of the benefit managers who expect their health plan costs to rise are predicting an increase of 15% or less. If their predictions are right, it will be a nice change from last year when only about 40% of the survey respondents who experienced increases were lucky enough to hold them to 15%.

In fact, this year the largest percentage of survey respondents—32%—expect their costs to increase only 6% to 10%. Last year only 17% saw such a small increase.

Almost 90% of the survey respondents either self-fund their health benefits or have a minimum premium plan or other loss-sensitive plan underwritten by an insurer. Another 17% have guaranteed-cost health insurance.

(The total equals more than 100% because some firms, especially those with unions or several divisions, have more than one health plan and they may self-fund one and buy insurance for another.)

The largest increase in health costs last year among survey respondents was recorded by a publishing and cable television firm with only 700 employees.

The cost of its minimum premium health care plan zoomed 90% in 1983 and is expected to rise 90% again this year.

But this employer is not taking such a blow sitting down. It recently restructured its entire benefit plan to introduce flexible benefits that allow the employee to choose between high and low health coverage.

Under the high-coverage option, which contains many cost-containment features, employees must pay a $200 deductible and 85% coinsurance for major medical expenses, and a $50 deductible for hospitalization after which the company pays 100% of all costs up to $5,000 and 85% of costs beyond that.

Under the low-coverage option, the employee gets no major medical coverage and pays a $50 deductible for hospitalization and 30% of all covered charges.

The plan also includes a flexible spending account to allow the employee to pay his health and child care expenses with pretax dollars.

A real estate investment trust with 200 employees recorded the second largest cost increase in 1983: 64%. It is fighting spiraling costs by adding coverage for outpatient surgery, encouraging second surgical opinions and the use of birthing centers and pre-admission testing and "plain ol' communication" with employees about the rising costs. It expects its costs to remain even this year.

A commercial banker with 1,400 employees recorded a 54% increase in health plan costs in 1983, the third highest increase among survey respondents. It is also predicting its rates will increase 35% again this year.

Its benefit manager believes that a good wellness program and education program for employees could help cap these costs.

"Only about 40% of our employees received any benefits at all in each of the last two plan years," the benefits manager wrote. "It's obvious that the costs are incurred by a small number of people. I think a strong emphasis on wellness and being a wise health care consumer are the most promising means of saving costs."

However, this benefit manager did not indicate on his survey that his company has started a wellness or education program. ■

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Many employers hike deductibles, premiums

How much cost should employees share?

If you have decided to pass more health care costs onto your employees, how do you determine what is an appropriate deductible, coinsurance level or premium contribution?

Data from the most recent *Business Insurance* Employee Benefit Board survey might help.

For deductibles, the largest number of respondents—46%—said the most appropriate is $200 to $500. The next most popular deductible was $100 to $200, with 42% of the respondents marking that choice.

Only 3% of the respondents thought deductibles should be $50 to $100 and none thought they should be lower than $50.

On the other end of the scale, only one respondent thought deductibles should be between $500 and $1,000. Eight percent thought deductibles should be a percentage of salary.

The most appropriate coinsurance level, according to survey respondents, is 20% of all costs after the deductible, but with a stop-loss cap of $2,000. Almost 40% of the benefit managers polled marked this choice. Another 35% think the best coinsurance level is 20% of all costs after the deductible, but capped at less than $1,000.

Seven respondents, or 6%, suggested that the cap on out-of-the-pocket expenses should be higher than $2,000, with several suggesting a $5,000 cap. And 7% thought employees should pay 20% of all costs without a cap.

Another 6% thought the coinsurance level should be based on employees' salary.

Respondents listed a wide variety of "appropriate" employee contributions to premiums, but the most popular appears to be 25% of the employers' cost, cited by 16% of respondents.

By LORRIE GIBSON

Employers that want to pass more health care costs onto their employees are more likely to increase deductibles or employees' contributions to premium costs than tamper with coinsurance levels.

And, employers are as likely to increase the deductibles of union workers as they are those of salaried workers, but apparently are less successful in getting unions to approve increases in contributions to premiums.

According to the most recent *Business Insurance* Employee Benefit Board survey, 36% of the employers that have union workers increased those employees' deductibles in 1983 and another 27% already have or say they will increase them in 1984.

Likewise, 34% of the survey respondents increased deductibles for salaried workers in 1983 and another 32% have or will increase them in 1984.

However, when it comes to making employees share a larger portion of the cost of health coverage, salaried workers are made to carry a heavier load. (In filling out the survey, even those that self-fund their health plans referred to employees' contributions to the cost of coverage as their share of the "premium.")

In 1983, 35% of the survey respondents increased salaried employees' premium contributions while only 26% of those that have union workers increased their share. Similarly, this year another 35% of the survey respondents expect to increase salaried workers' contributions to premiums, while only 21% of those with union workers intend to impose increases.

But not many union or salaried workers are being asked to contribute more toward the cost of the claims they submit.

Only 10% of the survey respondents increased coinsurance levels for salaried workers last year and only 9% of those with union workers increased their coinsurance in 1983. This year, 9% of respondents will increase salaried workers' coinsurance, while only 6% of respondents with union workers will pass more claims costs onto their union employees.

In responding to another question on the board survey, respondents said the two most effective ways of controlling spiraling health care costs are to redesign benefit plans to pass more costs onto the employee and to educate employees to be wise consumers (see story, page 3).

Heeding their own advice, the respondents that increased employee deductibles and contributions to premiums in most cases made sure they passed a significant amount of the cost onto employees by doubling their costs.

For example, of the 43 respondents that increased salaried employees' deductibles last year, 44% increased them by 100% or more. Another 40% increased them by 50%. And this year, of the 19 respondents that have already increased deductibles, 42% doubled them. Of the 22 respondents that still have deductible increases on the board for this year, 50% are planning an increase of 100% or more.

In 1983, respondents with union workers imposed more 50% increases in deductibles than 100% increases, but the story will change this year.

Of the 16 respondents that plan to increase union workers' deductibles this year, 50% are targeting increases of 100% or more.

In some cases, employers even quadrupled the deductible. For example, the deductible in one union plan was raised from $50 per individual and $100 per family to $200 per individual and $400 per family.

In other cases, employees that were hit with significant increases in 1983 will be tapped again in 1984 with still larger deductibles.

In the case of an engineering and construction firm with 5,800 employees, the deductible was raised in 1983 from a $100 lifetime deductible for individuals and a $200 lifetime family deductible to $100 and $200 annually. And then, earlier this year, deductibles were increased again to $250 annually per individual and $500 annually per family.

In one case, the employer in-

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creased the deductible only for employees hired after Jan. 1, 1984. Employees hired before that date pay deductibles of $100 per individual and $200 per family while new hirees pay $250 per individual and $500 per family.

Because a wide variety of deductibles—ranging from as little as $50 for individual coverage and $75 for family coverage to as much as $250 for individuals and $500 for families—are imposed by the survey respondents, it is impossible to target a "common" deductible.

However, the two most popular increases were raising the deductible from $100 for individuals and $300 for families to $150 for individuals and $450 for families and raising deductibles from $100 for individuals and $200 for families to $150 for individuals and $300 for families.

Often, new deductibles were imposed because the employers decided to move from a base plan with major medical provisions to a comprehensive plan that includes deductibles for hospitalization and surgery.

The story of increases in employee contributions to premiums in 1983 is similar to the tale of rising deductibles that year.

Last year, 49% of the respondents that imposed larger premium contributions on union workers increased the workers' share by 100% or more. It is interesting to note, however, that the employees' contributions are still very moderate in most cases even after the amount was doubled.

Some 35% of the respondents expect to increase salaried workers' share of premiums this year.

Similarly, of the 44 survey respondents that increased salaried employees' premium contributions in 1983, 43% increased the premium contribution by 100% or more. In fact, in 58% of these cases, the employees formerly contributed nothing to the premium.

However, this year employers seem to be requesting more moderate increases in employee contibutions. For example, only three of the 19 respondents with union workers that will increase employees' premium contributions in 1984 are doubling the employees' share.

Likewise, only 25% of the survey respondents that plan to increase salaried workers' premium contributions this year are asking for increases of 100% or more.

But, in some cases, employees that swallowed sizable premium increases in 1983 are being asked to take another bite this year.

For example, a manufacturing firm with 7,000 employees almost doubled premium contributions in 1983, raising them from $8 to $14 a month for individual coverage and $15 to $30 a month for family coverage. And, already this year, it has increased contributions again to $17 a month for individuals and $35 a month for family coverage.

Similarly, a property/casualty insurer has just about doubled its employees' contributions for individual coverage by increasing their share of premiums from $10.50 to $15 a month in 1983 and raising them again to $20 a month already this year. Contributions for family coverage were increased from $29.25 to $39 a month in 1983 and again to $45 a month this year.

Despite the round of increases in deductibles and premium contributions, survey respondents have not encountered much hostility from employees.

In fact, 71 respondents said employees did not like the changes but accepted them with understanding and three pointed out that their employees had a very positive response to the changes because they felt their company was trying to find a solution to a serious, growing problem.

Only four survey respondents said their employees reacted with hostility when changes were implemented.

However, the corporate benefits planning administrator for an electric and gas utility with 13,200 employees, whose firm increased deductibles and premium contributions for both union and salaried employees in 1983, questions whether the shifting of more costs to employees really helps stem rising health care costs:

"Until we all realize that only a basic change in the health care delivery system will really control costs, we are just playing games, shifting costs in circles." ■

Employers turning attention to retiree plans

By CAROL CAIN

Employers that have spent the past several years whittling down their health care costs for current employees are beginning to put the knife to their retirees' medical benefits.

But, altering retiree plans isn't so easy, consultants note.

Introducing or increasing retiree premium contributions, deductibles and other cost-sharing measures is an agonizing process for most employers, consultants say.

And, in some cases, it has resulted in legal confrontations in which retirees, through their unions, argue they have a right to lifetime medical benefits (see story, page 21).

Although not a widespread trend, cutting retiree medical benefits is the logical next step for employers in their struggle with runaway health care costs, benefit managers and consultants say.

And, several major companies—including Borden Inc., The BFGoodrich Co. and Bethlehem Steel Corp.—have already taken that first step.

"(Retiree medical benefits) represent an enormous corporate liability that has been ignored," said David Glueck, vp and head of the group benefits practice in the New York office of consultant Towers, Perrin, Forster & Crosby.

More and more employers are now starting to take note of their retiree benefits for several reasons, including:

- A proposed rule by the Financial Accounting Standards Board that would move unfunded liabilities for post-retirement health care and life insurance benefits onto corporate balance sheets.
- More prevalent data showing that retirees are disproportionately heavy users of medical plans, with retiree health care costs running as high as 50% of the cost of pension plans.
- The ever-increasing retiree population.
- The decreasing amounts that the federal Medicare program will pay.

"This is a very tough issue . . .It's a painful thing for employers to shift costs to retirees who can least afford it, but a lot of costs that companies are facing are astronomical," said John Hickey, a partner with consultant Kwasha Lipton in Fort Lee, N.J.

"There's a fair amount of agonizing when that issue is put on the table," explained Joe Gayda, a partner with benefit consultant Hewitt Associates in the firm's Dayton, Ohio, office.

In many cases "employers just don't know how much these medical plans (for retirees) are costing. If they did know they would be amazed," said Leslie Strassberg, a consultant with A.S. Hansen Inc. in New York.

But as data collection and utilization review programs improve, more information about retiree health care costs is being made available to employers, Mr. Glueck noted.

"Employers may not have been interested in (retirees' utilization), but they are hearing about it. And as that happens, they are beginning to review (retiree) medical benefits and are cutting back," Mr. Glueck said.

The proposed FASB rules on accounting for post-retirement benefits are causing even more employers to take another look at their retiree health packages (*BI*, May 30, 1983).

"If the FASB ruling becomes official, it will be the beginning of serious costs problems for employers," TPF&C's Mr. Glueck predicts.

"The liability for unfunded retiree medical benefits may exceed the unfunded pension liabilities."

Most employers do not pre-fund their retiree medical benefits. Instead, they handle them as they handle health benefits for active employees—on a pay-as-you-go basis, Mr. Glueck said.

Employers are anxiously awaiting further FASB communication regarding the accounting for post-retirement benefits, said Hansen's Mr. Strassberg.

"Should the value of these benefits move onto the corporation or trust fund balance sheet, many would show a negative net worth," he said, adding that "there are several actions that a corporation or board of trustees may take to limit exposure in this area.

"For example, many retiree benefit plans are currently designed to keep pace either with medical inflation or with Medicare benefits or both. Freezing such benefits at current levels could reduce (liabilities) by 50% or more without significantly exposing the corporation or fund to participant legal action over 'vesting' rights."

In addition, Mr. Strassberg suggests that companies will someday require that an employee work a certain number of years before qualifying for post-retirement health benefits.

"The bottom line is that these medical plans will start to resemble pension plans, where there will be a service test," he said.

During the next five years, he predicts that more and more employers will want to know how much post-retirement benefits cost them.

"And then there will be a push for an ERISA-type vesting," Mr. Strassberg said.

There also may be a push for some sort of vehicle, like individual retirement accounts for medical expenses, that will help employers cut their costs, said Kwasha Lipton's Mr. Hickey.

The National Center for Policy Analysis, a think tank based in Dallas, has proposed a medical IRA program to a Social Security Administration study committee (*BI*, Jan. 23).

Employers are beginning to recognize the need for employees to plan for retiree medical expenses, just like other retirement expenses, but currently there is no tax-effective vehicle to do so, Mr. Hickey noted.

The employers that have already altered their retiree medical packages say the most common changes seem to be the introduction of retiree premium contributions and deductibles.

"The magnitude of the changes, in my mind, is modest. . .$100 (for a deductible) is not going to bankrupt anybody," said Hewitt's Mr. Gayda.

And, some plan changes are even further toned-down. For instance, recent retiree plan changes at Borden Inc. in Columbus, Ohio, will only affect future retirees.

At Borden, employees who retire after Jan. 1, 1984, will share in pre-

Continued on page 20

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Retiree benefits

Continued from page 18
miums: $10 per month for an individual and $20 per month for a family for retirees younger than 65 years old, and $7.50 per month for an individual and $15 per month for a family for retirees older than 65.

Borden employees retiring before Jan. 1 do not have to pay a portion of their premium, though.

Other changes in Borden's retiree health care program parallel the changes made for active employees, explained Michael Miller, director of employee benefits at Borden, which self-insures and self-administers its program.

Borden initially "reshaped" its benefits program in July 1982, Mr. Miller said. At that time, it told non-union retirees that their plan would be changed so that they would receive the same coverage levels as active employees.

"We went out to retirees and said they will have virtually the same coverage as the active employees, but (for retirees) we would be using a carve-out (system) rather than coordination of benefits," Mr. Miller said. "With coordination of benefits, retirees wound up doing better than active employees."

Under a coordination of benefits program, retirees can use any reimbursements they receive from Medicare to pay deductibles or coinsurance charges required by the employer's health care plan. The result is that 100% of the retirees' health costs are paid, either by Medicare or the employer; there is no cost sharing on the part of the retirees.

Under the carve-out program, any Medicare reimbursement is "carved out" of the retiree's health care bill before deductibles or coinsurance are applied. Thus, retirees are still responsible for some cost sharing, even after Medicare.

Borden has stuck with the policy it made in 1982: "Whenever a change in the health care plan for active employees is made, the same changes are made in the retirees' plan, Mr. Miller noted.

For instance, in March 1983, when basic health plan deductibles were raised to $200 from $150, that change applied to the 7,000 non-union retirees, too.

And, in January, retirees were also affected by an increase in the additional deductibles Borden requires for hospital stays. Workers and retirees must pay a separate $125 deductible for the first day in the hospital, up from $100; they must pay a $75 deductible for the second day, up from $50; and there is a new $50 deductible for the third day.

Other employers have also made changes in their benefit plans that affect both active and retired employees.

The BFGoodrich Co. in Akron, Ohio, introduced new deductibles and coinsurance payments in May 1983 when it switched to a comprehensive health care plan. The switch, the company says, was in response to its annual medical expenses of $64 million, of which more than $20 million was attributable to retirees.

Prior to the new plan, employees and retirees received first-dollar hospitalization coverage, though a deductible was required for major medical benefits, said Gary Habegger, Goodrich's manager of benefits administration and planning. The plan covers about 12,000 non-union employees and 5,500 non-union retirees.

"We felt there was a need for doing some of the same cost-containment measures for retirees as well as for active employees," Mr. Habegger said. "In the past, any (positive) changes made for active employees also applied for retirees."

Under the new comprehensive plan, there is an annual deductible of $100 per individual or $200 per family. The company then will pay 80% of the next $2,000 in expenses, capping employee and retiree out-of-pocket expenses at $500 per individual per year, including the deductible, and $600 per family.

After the out-of-pocket limit is reached, the company then will pay 100% of covered charges.

The new plan also includes a reimbursement account of $300 for active employees, but retirees were not offered this part of the plan because it would be difficult to administer, Mr. Habegger said, stressing the company would have a hard time dealing with retirees who may have moved away from Goodrich facilities.

Consultants agree with Mr. Habegger that it is very difficult to administer a retiree health plan with flexible features.

"The trend toward flexible benefit and reimbursement accounts gave many employers the impetus to cut back in their active employee program. The big question was 'What do you do with retirees?'" said Mac Regan, an associate in the Boston office of William M. Mercer-Meidinger Inc.

"There seems to be a limited number of things that companies are willing to do in this area, mainly because of administrative cost. Some (features), like choice-making, can't apply to retirees because they're spread all over the United States," Hewitt's Mr. Gayda said.

Bethlehem Steel Corp. in Bethlehem, Pa., last month made health care benefit changes that affect 19,000 retirees as well as 15,000 salaried, non-union workers. In some instances, the retirees will pay more than active employees (see story, page 39).

For instance, the company will continue to pay the entire premium for active employees, but retirees will have to contribute $7 per month toward their coverage if they're eligible for Medicare and $12 per month if they're not.

"Bethlehem feels that pensioners as well as the active employees should share in our cost-containment measures," said Charles Collins, director of insurance administration in the company's employee benefits program division.

Employees and retirees at Bethlehem in the past had first-dollar coverage for basic hospitalization expenses. But with the company's new comprehensive plan, they must pay a $356 deductible per admission in a hospital and a $178 deductible per admission in a non-hospital facility. There also is a $50 deductible per emergency room visit.

For all other medical expenses, like surgery and office visits, there is a $300 deductible.

After the deductibles are satisfied, the company will pay 80% of the remaining costs, until the employees and retirees reach an out-of-pocket maximum. For employees that limit is $1,000, and for retirees it's $800.

Retirees were informed about the changes through the mail, while the company's active employees learned about the new plan features at in-house meetings, Mr. Collins said. ■

Some retirees fight to retain benefits

By CAROL CAIN

Some employers that have cut retiree medical benefits are winding up in court trying to prove that workers don't have a right to these benefits.

Retired workers affected by benefit cuts, usually those represented by labor unions, are crying "foul." The workers say they earned their benefits through many years of employment and that, in many cases, employers "promised" these benefits.

Several lawsuits on the issue have already been settled, and more are pending. But consultants and attorneys are warning employers that the outcome of the pending cases probably will vary from state to state, keeping the issue as unclear as it is now.

In the cases that already have been settled, one point appears to have emerged: Retirees have an earned right to their medical benefits when the employer's right to amend or terminate the plan has not been clearly set forth in writing or communicated to employees.

"The question is whether once these benefits are granted if they can be taken away. It's a sticky legal issue. . . .It depends on collective bargaining agreements and what's communicated in written form or in a summary plan description," said Mac Regan, an associate with consultant William M. Mercer-Meidinger Inc. in Boston.

"The lawsuits will hinge around the issue of 'implied contract,'" noted Joe Gayda, a partner with Hewitt Associates' Dayton, Ohio, office.

Most of the court decisions dealt with issues prior to the Employee Retirement Income Security Act. There is nothing in ERISA that mandates retiree health benefit vesting, consultants say.

"There are no laws or rules that require pre-funding for medical benefits. One reason is because they (the benefits) are not vested. . .but employers create a vesting by the way they communicate," said David Glueck, vp and head of the group benefits practice with the New York office of Towers, Perrin, Forster & Crosby Inc.

"For employers, the signal is strong: To retain the ability to modify post-retirement welfare benefits, any insurance policies, labor agreements, plan documents or SPDs must be written and communicated with utmost care. Too close a link with pension benefits may be unwise. ERISA standards for reporting and disclosure should be scrupulously met," noted TPF&C to its staff.

A 1977 federal appellate court decision supports that philosophy. In that case, involving Erie Lackawanna Railway Co. of Cleveland, non-union, white-collar retirees petitioned a bankruptcy court to force the employer's estate to continue to indefinitely provide retirees with group life benefits, as outlined in an employee benefit handbook.

The court held that the retirees had a vested legal right to the group benefits because of the implied contact-of-emloyement theory and because Erie Lackawanna had an obligation to continue the benefits. However, the estate did not have to pay the benefits because under the reorganization provisions of the 1974 Rail Act, which assigned priorities to claims against a bankrupt railroad, other creditors' claims were paid first.

A separate case took an another view. In Schlosser vs. Allis-Chalmers, decided by the Wisconsin Supreme Court in 1978, the court ruled that the company could not unilaterally change a group life plan provided to retirees even though the company had specifically reserved the right to amend or terminate the plan.

"It's a real hairy issue," said Mercer-Meidinger's Mr. Regan, stressing that one court may rule the benefits are vested and then other courts will differ.

Among the retiree benefit lawsuits pending today, many involve union contracts.

In one case, Colt Industries Inc. was pressured by the United Steelworkers of America, representing retired steelworkers from Colt's Crucible Steel division in Midland, Pa., to reduce—rather than eliminate—medical benefits for some 7,466 retirees and their families.

When Colt closed its Crucible Steel division in 1982, it said it was no longer obligated to pay retiree medical benefits. The union took the company to court, though that suit has been put on hold until next year since both sides negotiated an interim program last month that will run through June 30, 1985, said Dan McIntyre, an attorney with the Pittsburgh-based union.

The interim benefit program requires retirees and their spouses to contribute toward physician and hospital coverage: Those eligible for Medicare will pay $5 per month and those not eligible will pay $12.50. Retirees already had been paying, and will continue to pay, for major medical coverage, which costs retirees about $50 per month.

Under the interim program, those not eligible for Medicare also must pay a first-day hospital deductible of $100, plus a $25 deductible for every emergency room visit. These deductibles have a $300 annual cap, Mr. McIntyre said.

"Retiree insurance is a matter of great significance to the steelworkers. We've negotiated what we think is good retiree coverage. . .once you qualify for it, you get it, notwithstanding things like the shutdown of a plant or the expiration of a current contract," said Howard Kline, assistant director of the union's pension and insurance department.

The action at Colt, according to Mr. Kline, is "an unwarranted attempt by the company to evade that obligation."Colt refused to comment or elaborate on the matter.

The Glass, Pottery, Plastics & Allied Workers union is also in court trying to win the retention of medical benefits for 243 retired workers at Liberty Glass Co. of Sapulpa, Okla.

In this case, however, the benefits were taken away because of a strike at the plant, the union says in a suit filed in U.S. District Court

Continued on next page

Retirees fight to keep benefits

Continued from previous page
last month.

"The international union's lawsuit on behalf of the retirees holds that the retirees ought not to be penalized as the result of the labor dispute in which they, as retired employees, are uninvolved," said Richard Kline, a spokesman with the GPPAW in Media, Pa.

"Our contention is that the company is remiss in its breach of trust. The retirees that are party to this suit will state that they were to be provided these benefits for life."

Liberty Glass Co. officials could not be reached for comment.

Other suits, both pending and settled, involve the United Auto Workers.

"We contended that retiree insurance is a right that is vested when a retiree leaves," said Leonard Page, an associate general counsel with the UAW in Detroit.

He said that employers usually try to take away medical benefits for retirees under two circumstances: either a plant closing, where no contract is renewed, or in a strike situation.

In two recently court-settled cases—one involving Auto Specialites Corp. in Benton Harbor, Mich., and the other involving Roblin Industries in Battle Creek, Mich.,—UAW retirees were hit with a substantial reduction in their medical benefits. For example, hospital stays were restricted and new coinsurance levels implemented, but a prescription drug plan stayed intact, Mr. Page noted.

"As a general rule in these settlements, we agree to reduced benefits, but we have it spelled out that they are for the lifetime of the retirees," Mr. Page said. ■

Some plans feel the ax

Reducing medical benefits provided to retirees is not one of the biggest health care cost-containment techniques used by the *Business Insurance* Employee Benefit Board, but there is some interest.

The most recent survey of the board reveals that 89, or 71%, of the 126 respondents provide medical benefits for retirees. But, 15% have reduced these benefits by expecting retirees to share more of the premium cost or more of claims costs through higher deductibles and higher coinsurance.

And, one firm plans to cut health benefits entirely for employees that retire after Oct. 1.

(Other reports from the Employee Benefit Board survey begin on page 3.)

Four of the respondents plan to pass more costs onto retirees by converting plans from first-dollar coverage to comprehensive plans that include deductibles and coinsurance provisions for hospitalization and surgical procedures.

Two others intend to increase deductibles, one by 50% from $100 for an individual and $200 for family coverage to $150 for an individual to $300 for a family.

Three will cut costs for retiree benefits by making retirees share premium costs.

The employee benefits manager for a manufacturer that employs 25,000 says his firm will pass onto retirees any increases in deductibles, coinsurance, premium costs or other cost-containment measures imposed on active employees.

When it comes to cutting retirees' health benefits, it does not seem to matter how large or small the employer is. In the Employee Benefit Board survey, the employers cutting back on benefits ranged from a manufacturer with 5,000 employees to a manufacturer with 25,000 employees and another with 9,000 employees in the United States and 20,000 worldwide.

Although 85% of the Employee Benefit Board survey respondents that offer health benefits for retirees have not cut them, one board member suggests it might be only a matter of time until they do.

"We have not cut these benefits yet, but this is an area of extreme concern for fear that Congress will make Medicare secondary here also. We might consider a co-pay up to the time Medicare starts for a retiree."

Congress said in the Tax Equity and Fiscal Responsibility Act of 1982 that employees over the age of 65 must be given the choice of their company's health plan or Medicare as primary coverage. In most cases, older employees chose the company plans. ■

Stouffer says it is not seeking PPO discounts

By SALLIE J. DRURY

SOLON, Ohio—Stouffer Corp. has scratched some of the common features of preferred provider organizations but still is writing in cost savings.

The PPOs Stouffer uses do not offer discounted rates. And, Stouffer employees must decide ahead of time if they want to participate in a particular PPO, rather than deciding each time care is needed whether to use the PPO or another provider.

Stouffer employees may choose from two medical PPOs, an HMO or Stouffer's traditional fee-for-service medical plan. But, an employee who selects a PPO is committed to participate for a year and will not have medical expenses covered if treatment is received from a non-preferred provider.

This way, Stouffer is assured of a certain level of PPO participation and a certain degree of savings.

But the savings on medical care do not come from discounts from providers that want to attract employers looking for alternative delivery systems to offer in their group plans.

"Our medical PPOs don't have discounts and we don't believe in discounts," said Donald C. Flagg, vp of human resources and corporate relations at Stouffer, a hotel, restuarant and frozen food company based in Solon, Ohio. "We have sought out the most efficient providers, and are rewarding them with our business.

"Rather than negotiate a discounted rate, we choose the lowest cost-per-case hospital in the area...You always have to ask, 'Discounted from what?' A 20% discount from a provider that's 20% more expensive than anyone else is no bargain.

"Discounts imply a lower-quality care," he continued. "I don't like telling my employees they are going to get discount medical care.

"I don't even think employers (interested in PPOs) should concentrate on price too much; at this point, the savings are going to come from utilization review. Talk about price two years down the road, after you get good data."

However, discounts are a part of the dental PPOs in which Stouffer participates. In fact, Stouffer became involved in dental PPOs before it joined any medical PPOs.

In 1980, Stouffer was approached by a group of dentists who asked to be designated a preferred panel in exchange for discounted rates.

Stouffer now is involved in two dental PPOs, which offer greater benefits than the company's traditional dental plan. Almost a quarter of Stouffer's Cleveland employees participate in the dental PPOs.

Meanwhile, Stouffer has been involved in medical PPOs only since April 1983. More than half the Stouffer employees in the geographical area covered by two PPOs participate in them. This represents 12% of Stouffer's work force of 12,000 U.S. employees.

Although in this first year Stouffer has not yet accumulated much hard data on the savings generated from the medical PPOs, Mr. Flagg says the trend so far is "encouraging."

"I don't know that our preliminary figures are that reliable, but we find our medical costs are reduced by 23% among PPO participants," Mr. Flagg said. "But even if that's not statistically reliable, there's no question that the trend is exceedingly positive.

"Our dental costs," he continued, "which are more reliable since we've measured them for two years now, are reduced 35% by one dental PPO and 20% by the other."

Mr. Flagg owed the success of Stouffer's PPOs in part to the health care provider climate in Cleveland.

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Stouffer not seeking discount

Continued from previous page

"This area has an excessive capacity (of hospital facilities and numbers of physicians) and a high utilization rate, so it's fairly easy to bring it down with cost-containment strategy, such as a PPO," he said.

"But I'm convinced savings can also be achieved anywhere."

But, Stouffer's strategy for operating within PPOs also is part of the success formula, Mr. Flagg explained.

"Each PPO has a medical director who conducts a utilization review on any hospitalized patient and physician office visits," Mr. Flagg continued. "He deals with the physicians in the PPO if he feels admission or treatment is unnecessary and makes sure the quality of care is appropriate."

For example, the utilization review could reveal such "trouble spots" as emergency room use for a non-emergency.

"When the medical director discovers this misuse, he sends us an outstanding (form) letter he has written, addressed to the employee involved, pointing out how the employee's actions are not really in his best interest.

"It's then up to us to give the letter to the employee if we want to, and in most cases we do," Mr. Flagg said. "We think the letter has more impact coming from a medical director than from us."

Stouffer initiated the formation of the PPOs with the providers.

"In the beginning, we approached the providers with the concept. We started with an individual doctor who, in turn, got some of his buddies together and talked about it," Mr. Flagg said.

"Then two other companies in the Cleveland area (AmeriTrust Corp. in Euclid, Ohio, and Mannesmann DeMag Corp. in Cleveland) and Stouffer approached a hospital and asked it to discuss the PPO concept."

When hospitals began to get involved, it became "politically" evident, Mr. Flagg said, to offer participation in a PPO program to all of the hospital's physicians, although Stouffer theoretically wanted only the most conservative physicians participating.

Even when the opportunity to participate is opened up to all physicians at a hospital, the inefficient physicians will be weeded out, either by peer pressure when their practice style is revealed in the utilization review or because they have been approached by the PPO medical director, Mr. Flagg said.

Based on these initial discussions, Stouffer joined two PPOs: one physician-based and one hospital-based. The hospital-based PPO allows treatment only at the hospital's one facility, but the physician-based PPO is represented at five hospitals in the area.

These two PPOs will be joining a network of four more hospital-based PPOs that encircle Cleveland. When the network's formation is complete, the physician-based PPO will become hospital-based.

Members of the network share marketing and administrative practices so an employee can be treated by more than one provider in the network, yet utilization will be tracked uniformly.

Although Stouffer's two current PPOs are not in direct competition, Mr. Flagg said, a certain amount of "indirect" competition still exists among them. And, this competition has worked to Stouffer's advantage.

"When we started working with two PPOs and looked at the utilization figures for the first three months, we found one PPO was working more efficiently than the other," Mr. Flagg said.

"So, we notified the efficient one, which is hospital-based, and said, 'Congratulations on what you're doing. Good job.' To the other group, which is physician-based, we said, 'You have got a problem. Look at what the other group has done.'

"The physician-based group had not been as organized in the beginning as the hospital-based PPO," he said, "and it had not yet hired a medical director. When we pointed out the discrepancy between the two PPOs, the second one immediately attacked the problem in great detail.

"They held weekly meetings, hired a medical director, set up a new system so bills would be reviewed sooner and examined every case to bring their house in order. It was quite a massive overhaul."

After that, he said, the efficiency of the two PPOs was roughly equal.

"We didn't have direct competition, but it was healthy, indirect competition," Mr. Flagg said. "I also believe that, for this competition, we're better off having more small PPOs rather than getting involved in large city- or statewide organizations."

As an incentive for a Stouffer employee to sign up for PPO participation, the traditional medical plan's $100 deductible for physician office visits is waived. Under both the PPO and the traditional medical plan, expenses are reimbursed at 80% of cost.

Mr. Flagg admitted that this incentive did not constitute a strong drive to increase PPO participation, but said it is a place to begin. "The incentive, and our whole communications program, is low-key. We stress that this (PPO enrollment period) is an opportunity to pick a family doctor."

However, PPO physicians found the 80/20 coinsurance feature "inconvenient," so Stouffer will modify its plan later this year: Employees will pay $5 per office visit.

"To start out, we just overlaid the PPO plan on our basic coverage. But ultimately," he said, "we are moving toward an approach whereby the savings generated by using a PPO instead of another provider will go into a Section 125 (flexible spending account) plan. We are piloting that now with a small group of 175 employees and hope to expand it in the beginning of 1985."

In that pilot plan in California, employees may choose among the base plan, a comprehensive plan, two HMOs and a PPO, or no coverage at all.

Other employers interested in savings through PPOs should initiate their formation, Mr. Flagg advised. "The employers should take the lead, targeting the efficient providers and letting them know their needs, but the providers have to actually put together the PPO," he said.

But, he said the PPO should have a strong utilization review program and the participating doctors and hospitals should be proven efficient providers. "But don't focus on any promised discount," he said. "Look at (the hospital's or physician's) efficiency in treatment. Your PPO will only be as good as the (providers) in it," he said.

"But, just signing up for a PPO is not a panacea. We are doing a thousand things for cost-containment; PPOs are just one of them," Mr. Flagg said. "I'm sure they're not for everybody in every location, but for us it's been an exciting opportunity. I think PPOs are worth serious consideration by everyone." ■

Employers pick PPO data over discounts

By SALLIE J. DRURY

No matter what kind of preferred provider organization an employer considers, data collection is a PPO's most important feature, benefit managers agree.

"The main thing is not discounts; it's your data base," said Robert Blettenberg, coordinator of healthcare cost containment for Boise Cascade Corp. in Boise, Idaho. "The pre-admission certification, the concurrent review—that is the most important thing."

Boise Cascade is currently involved in a three-state dental PPO and is studying the feasibility of a medical PPO.

"Our two review procedures are as integral in our cost-containment efforts as our PPO discount," notes Alfred W. Stoess, chairman of the state of Nevada's Committee on Group Insurance for state employees. The state conducts both preadmission and concurrent utilization reviews, he explains.

"We wanted more information on our health care costs," says Arthur J. Young, benefits manager with Hewlett-Packard Co. in Palo Alto, Calif. That desire for hard data drove Hewlett-Packard to PPO discussions.

"We started talking with hospitals about where our health care dollars were going," he continues. "As a result, we have tried to figure out which hospitals have a lower daily rate and reasonable lengths of stay. That's how we've determined our preferred providers, not through discounts."

Hewlett-Packard is one company that is putting together its own PPO by collecting data and searching out efficient providers. "We now have one preferred hospital, which is a couple hundred dollars a day under the community average, and about 270 preferred physicians," Mr. Young says. "The treatment will be reviewed by El Camino Preferred Physicians Utilization Review, which also has a committee to keep providers in line, and then U.S. Administrators Inc. audits their review procedures."

Hewlett-Packard expects to sign its PPO contract in the next few weeks. The PPO will then be made available to its 17,000 Santa Clara County employees.

"About 8,500 are potentially interested in the PPO because they're not already in HMOs," Mr. Young says. "Based on that, we expect to see savings of anywhere from $100,000 to $700,000."

Employees will be given an incentive to use the preferred providers by decreased cost-sharing; the company will pay 90% of PPO costs, compared with 80% under its traditional plan.

Hewlett-Packard first became involved in PPO discussions about three years ago when the Santa Clara County Manufacturing Group, a local business coalition, began discussing the PPO concept with some local hospitals, although the group eventually abandoned its efforts.

Although the coalition did not pursue the matter, Hewlett-Packard and El Camino Hospital in Mountain View, Calif., decided to negotiate their own contract.

"We wanted to contract with an efficient hospital that would provide us utilization data and would be willing to consider some kind of ceiling on cost increases in the future," Mr. Young says.

Since the planning for H-P's PPO has been in the works for about three years, Mr. Young's initial piece of advice for companies interested in PPOs is "give it plenty of time."

Nevada's Mr. Stoess shares that opinion.

"Don't try to implement it too rapidly," he said. "Do it over a long period so you will have plenty of time for employee questions. Communications is very important."

Nevada began talking with hospitals in June 1983 and had its PPO operating by September, which Mr. Stoess says was too soon. "We did not have enough time to do a good communications job because we were concerned with getting the cost containment as soon as possible."

The state's 14,000 employees and dependents who choose to use the PPO may choose among three hospitals, two surgical centers and their attending physicians. The hospitals offer discounts of 10%, 11% and 13%. William M. Mercer-Meidinger Inc. collects and analyzes utilization data

The first report from Mercer-Meidinger Inc. analyzed the cost-effectiveness of the state's three cost-containment programs during the last quarter of 1983. The discounted PPO rates saved approximately $110,947; the concurrent review program saved 267 hospital days or $213,890; and the pre-admission review program saved 212 hospital days or $158,200.

However, there were also instances when use of the PPO did not save money for the company or employees, Mr. Stoess pointed out. "If an employee in a rural area drives all the way into the city to a PPO, he's paying more money and we're paying more money because city hospitals are more expensive than rural hospitals." So, the state also dropped its $100 deductible for hospitals outside a 50-mile radius of the PPO facilities.

Security Pacific Corp. in Los Angeles is one company that is seeing less PPO utilization in the first few months of its program than it had hoped, although it thinks that trend will turn around.

Employees using the PPO do not have to pay deductibles or coinsurance, unlike employees tapping the company's traditional plan.

Although Security Pacific did not expect much PPO activity from September to December, because of employee commitments to other providers or HMO contracts, it expected PPO activity to increase after Jan. 1.

Last year, Alan M. Jeffery, vp of employee benefits for Security Pacific, estimated that about 40% of the bank holding company's health care claims over a 12-month period would come through its PPO (*BI*, May 30, 1983). However, in January, only 20% of claims were for PPO care.

"This is only a month's activity and people don't plan on being sick, so I think we'll see an increase in PPO volume as the year goes on," he says. "However, if utilization three or four months from now is still about 20%, then I would say we'd need to rethink the plan because the PPO would not be saving us enough money to pay for itself."

Mr. Jeffery says the company would be reluctant to abandon the PPO so long as it did not cost the company money to operate since employee feedback has been positive. ■

PPO only part of employers' cost-control effort

By SALLIE J. DRURY

JACKSONVILLE, Fla.—Employers in Jacksonville didn't wait for their insurers to lower their health insurance premiums. They didn't wait for hospitals and doctors to lower their prices. Faced with the problem of skyrocketing health costs, they knew they had but one choice: Take the initiative.

Executives at seven companies made that choice in June 1983. They began by forming an employer-only coalition, Medcom Services Inc.

Within eight months, the new coalition expanded to become a registered third-party administrator that now administers claims for 19 companies with 8,000 employees in the Jacksonville area and more than 20,000 dependents.

And recently, Medcom has formed its own employer-sponsored preferred provider organization: the Florida Health Alliance Corp.

Florida Health Alliance is still in its formative stages. So far, one hospital—St. Vincent's Medical Center—150 physicians and 19 employers in the Jacksonville area have agreed to participate.

"We will have one more hospital by the end of March, and April 1 we will be ready for our first patient," said Tyler Potterfield, president of Medcom Services Inc. and of Potterfield Planning Associates, a coalition member.

To save money, the PPO will negotiate discounts with hospitals and physicians the employers determine are cost-effective.

The providers will be guaranteed greater volume of patients and more prompt payment of claims; employers will receive utilization data as well as savings from lower cost-per-case service.

And, employees will be encouraged to use the preferred providers through broader benefit coverage and lower cost-sharing. However, employees can choose a non-preferred provider.

Mr. Potterfield expects these efforts to produce a 10% savings for participating companies.

And, to have a greater impact on area providers, Medcom hopes to attract a greater number of companies to participate in the PPO by offering a number of support services, including:

- Helping employers revise their benefit plan design to encourage PPO use.
- Communicating the PPO to a company's employees or assisting in communication.
- Helping a company set up a self-insured program to cut costs.
- Administering claims through its TPA for self-insured employers, and providing computer support.
- Conducting utilization reviews.
- Providing a forum for communication between provider and purchaser.
- Monitoring the success of the program.

"Keeping employees out of the hospital will be the first order of business," Mr. Potterfield said.

"And, it will be the (family) doctor's job to help us control utilization. He will work with us to help us avoid increased utilization by making sure admission is necessary," he said.

To handle the utilization monitoring, the alliance will hire a medical director and a utilization coordinator and have a medical advisory board. The director, coordinator and board will monitor physician and hospital performance to make sure it is staying on course for efficient, quality care.

"We are not setting up an antagonistic relationship; we are asking for assistance from physicians and hospitals." Mr. Potterfield said.

The specific services of the PPO are still being fine-tuned, but additional procedures covered through the PPO will work to "encourage preventive, rather than reactive, medicine," Mr. Potterfield said.

"We are considering postnatal care, smoking cessation and weight reduction as covered expenses," he said. "We want to see a change in the less than 3% of health care dollars being spent on preventive care and 97% on reactive, hospital care.

"We hope, through the alliance, to move in the next three to five years to 20% prevention and 80% reaction."

The alliance is just one of the cost-containment projects Medcom hopes to tackle, he said.

"We're committed to cost containment. When Medcom was forming last year, seven (employers) got together to talk about the problems we were having with health care costs. Some of our rates were going up from 15% to 100%," Mr. Potterfield said. "We decided we couldn't sit back any longer and wait for change; we had to join together to attack those costs through increased buying power."

Although Medcom has achieved many of its goals already—it has formed a self-insurance pool, gained access to reinsurance contracts for its members, set up a TPA and a PPO, begun collecting data and set up a system for its analysis—it still has more plans on the drawing board.

For one thing, it is looking into health maintenance organizations as another cost containment tool.

"We are very pro-HMO, and we (at Medcom) will choose an HMO collectively," Mr. Potterfield said. "We will probably choose two and try to educate employees on what their choices consist of."

Medcom also is involved in traditional benefit plans.

"We hope to develop a reasonably common benefit plan among our members," he said. "If we get it as close to commonality as we can, we can share more services and the data base will be more accurate, which is more cost effective."

And, Medcom will become more active on legislative issues.

"We anticipate later this year to become politically involved," Mr. Potterfield said. "As third-party payers we want to help, for example, the problem of malpractice.

"In Florida, 30% of each health care dollar is related to medical malpractice (insurance costs). We have had some unbelievable jury awards in this state, so we see ourselves getting in that arena (to fight those things that drive up malpractice insurance rates). We're not saying malpractice insurance does not have a place, but it's grown out of hand.

"With our PPO, on the one hand, we are taking something away from the medical community through our discounts and lower utilization," he said. "But we are contributing something to them as well because we will be working to help them lower their costs. That's why we call it an alliance." ■

Few employers say they obtain utilization data

By JAMES M. BURCKE

WALNUT CREEK, Calif.—Employers have bolstered their defenses against assaults by runaway health insurance costs since 1981, a new nationwide survey shows.

Among other things, they have increased scrutiny of claims for non-covered charges, encouraged the use of second opinions, outpatient care and alternative health care systems and increased employee deductibles and coinsurance.

However, employers haven't been successful on all fronts, notes the survey conducted by the Health Research Institute of Walnut Creek, Calif., a non-profit health care research organization.

For instance, few of the employers responding to the survey said they were able to obtain data on employee health care utilization in order to track where their health expenditures are going.

The lack of data is a major weakness in employers' campaign against health care inflation, and "something that just drives employers crazy," according to HRI Director William E. Hembree.

"In order to deal with long-term costs, you need to know what causes the costs," Mr. Hembree pointed out.

Acording to the survey, only 12.6% of employers receive diagnostic-specific utilization data from their health insurers or third-party administrators. And, only 12.1% reported they received utilization data that details the types of medical procedures their employees are receiving.

But, Mr. Hembree notes, some respondents receive both types—diagnostic-specific and procedure-specific—of data. Because of this duplication, he says that less than 20% of the employers surveyed receive any type of utilization data at all.

The lack of utilization data is ironic because employers participating in the survey said by a wide margin that their top cost-containment priority is to obtain accurate utilization data.

"Working without data is like driving through fog without lights —but the fog is beginning to lift," Mr. Hembree notes.

To determine how employers are containing health care costs, the HRI surveyed 1,500 organizations, including the Fortune 1,000 industrials and large financial services organizations, utilities, retailers, government entities, universities and hospitals.

The survey is based on 602 responses, for a response rate of 40.1%.

The latest HRI survey, conducted during 1983, follows similar surveys that were taken in 1981 and 1979.

Despite the many cost-containment strategies utilized by the employers participating in the latest survey, the respondents noted that their health care costs are escalating well above the nation's general inflation rate.

The respondents reported they spent an average of $1,366 per employee for health care in 1982, up 17.9% over the $1,159 spent per employee in 1981. In 1981, employers' health care costs rose only 14.2%.

Not only did health care costs rise more sharply in 1982, but they consumed a larger chunk of the responding companies' payroll, earnings and sales. For instance, health care costs equaled 8.6% of payroll in 1982, compared with 7.8% in 1981.

Employers' health care expenditures totaled 1.6% of sales in 1982, compared with only 1.1% of sales in 1981. And, the amount companies spent on health care equaled a whopping 78.1% of their net earnings in 1982, compared with only 62.1% in 1981.

However, the HRI survey points out, employers that actively promoted health care cost containment or wellness programs were able to

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Data missing

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hold their health costs well below the survey average.

For instance, employers that reported they had taken more than six significant cost-containment steps said their health expenditures per employee in 1982 totaled only $966, 27.1% less than the $1,366 average reported by all survey respondents. These employers noted that health costs equaled 6.7% of their payrolls, compared with 8.6% of payroll for all respondents.

The employers that did not take more than six cost-containment measures reported health care costs per employee of $1,438, or 9.1% of payroll.

Likewise, employers who reported initiating more than four health promotion or wellness efforts in 1982 said their health costs per employee totaled only $1,061, or 6.9% of payroll. The employers that did not initiate a high level of wellness programs said their health costs per employee totaled $1,456, or 9.3% of payroll (see story, page 30).

The survey noted that having an active cost-containment and/or wellness program reaped other benefits than simply lower health care expenditures. "This reward (also includes) higher productivity while employees are at work, decreased absenteeism, decreased incidence of disability and premature death, etc."

What are these successful companies doing to contain health care costs? How successful are individual cost-containment strategies?

According to the survey, administrative actions, like claims processing controls and utilization reviews, can result in significant savings, though Mr. Hembree notes that relatively few employers are taking many of these actions.

For instance, employers that had their insurers or administrators review health claims for non-covered charges reported that they saved an amount equal to 10.7% of annual paid claims.

However, only 27.9% of the responding employers said they received reports from their insurers or administrators on savings recovered by rejecting claims for non-covered charges.

"This means about three-fourths of the companies have no way of knowing if their administrators are checking for uncovered charges," Mr. Hembree notes. "This is terrible, but true."

Likewise, the 25.6% of the respondents that said they received reports on the applicability of coinsurance requirements reported that checking for these abuses saved them an amount equal to 6.4% of paid claims.

Making sure that deductibles were properly applied saved employers 6.2% of paid claims, though only 23.9% received information on deductibles from their insurers or administrators.

And, 16.9% of the surveyed employers said they received reports on claims filed by ineligible persons. Rejecting such claims saved these employers an amount equal to 5.5% of their paid claims.

Although less than a third of the employers receive any of these reports, the survey noted that there "has been a marked increase in the proportion of respondents who receive carrier and administrator 'standard' reports of controls and savings. In nearly all categories, about twice as many companies received reports in 1983 as in 1981."

Another area of health care savings that has been virtually untapped so far by most employers is utilization reviews.

The 17.3% of the survey respondents that noted they had initiated concurrent utilization reviews said the reviews netted them savings equal to 6.1% of paid claims.

And, the number of employers using concurrent utilization reviews is increasing. Only 10.6% of the employers surveyed in the 1981 survey performed utilization reviews.

Another 18.8% of the respondents in the latest survey said they used retrospective utilization reviews, but these reviews were much less effective than concurrent reviews as they generated savings equal to only 1.2% of paid claims.

Almost all of the employers said, however, that they had included a coordination-of-benefits provision in their plans. The 97.6% of respondents with such a provision said coordination-of-benefits savings equaled 9.3% of paid claims. That's up from the 1981 survey, when such savings equaled only 7.3% of paid claims.

More than half of the coordination-of-benefits savings reported, or 5.8% of paid claims, were derivied from the identification of duplicate group coverages. The identification of Medicare coverage contributed savings of 2.3% of paid claims.

Another cost-containment strategy used by a significant number of employers is second opinions. More than 73% of the respondents said their health plans would cover the cost of obtaining a second opinion, up form 66.9% in the 1981 survey.

The survey did not specify whether the second opinion was required just for surgery or for other medical care, too.

Some 3.6% of the employers said they required their employees to obtain a second opinion for all non-emergency procedures, up from 2.1% in 1981. That strategy generated a savings equal to 2.8% of paid claims, they reported.

Another 34.3% of the surveyed employers said they required employees to obtain a second opinion for at least some procedures. These employers reported savings totaling 1.8% of paid claims. (This question was not asked in 1981.)

About 16.3% of the respondents said they required pre-certification of non-emergency hospital admissions to determine how long the hospital stay should last. This provision generated a savings of 3.6% of paid claims, the employers noted.

Nearly 54% of the employers encourage employees to review their hospital bills, and 3.2% said they would share a portion of any savings found with the employee. Although not enough employers reported savings from this strategy to make a total statistically reliable, most of the employers that did report savings from employee reviews said the savings equaled from 1% to 5% of paid claims.

The HRI noted that the number of employers that encourage outpatient or ambulatory care has increased substantially. In the 1983 survey, 75.7% of the respondents said they, in some way, encourage the use of ambulatory care, compared with 64% of those responding to the 1981 survey and 59% in 1979.

For instance, 10.1% of the respondents now say they will cover outpatient procedures at a higher level than inpatient care, compared with only 4.2% in 1981.

Also, 91.8% of those surveyed say they now cover pre-admission testing, compared with about 76% in both the previous surveys. Savings from pre-admission testing rose to 1.4% of paid claims, from 0.8% in 1981.

In addition, 98% say they provide coverage for ambulatory surgery, compared with 92.3% in 1981. And, 20.7% will reimburse employees for ambulatory surgery at a higher rate than for inpatient surgery; only 6.4% of the 1981 respondents said they pursued such a strategy.

"This shift is noteworthy," the survey points out, "since the pro-

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portion of responding employers providing higher levels of coverage for outpatient surgery has more than tripled over the two-year survey period.

"This shift reflects employer awareness that inducements beyond equal payment may be necessary to change employers' purchasing behavior and, especially, providers' practice patterns."

The use of ambulatory surgery netted employers participating in the 1981 survey savings equal to 3.1% of paid claims, compared with only 1.9% in 1981.

Employers also reported they are now more likely to provide full coverage for a variety of health care alternatives than they were in 1981, although the HRI could not document how much the use of these alternatives is saving employers.

Among the alternatives that employers are now more likely to cover are:

- Home health care. About 46.5% now provide full coverage for this alternative, compared with 32.6% in 1981.
- Extended care facilities. More than 44% now fully cover this type of health care, compared with 30% in the last survey.
- Disability rehabilitation. More than 34% now provide full coverage for rehabilitation costs, compared with just 20% in 1982.
- Home birthing care. Almost 21% now provide full coverage for deliveries in the home, compared with 11.7% in 1982.

Although the HRI could not compute how much these types of alternative health care are saving employers, it did compute how much employers are saving from the use of alternative delivery systems, like health maintenance organizations and preferred provider organizations. And, interestingly, they are not saving as much now as they did several years ago.

The respondents noted they reaped savings equal to 2.4% of paid claims through the use of alternative delivery systems, mainly HMOs. However, in the 1981 survey, the respondents noted an 8.5% savings in this area. The survey does not note why savings from alternative delivery systems have declined.

Although employers say alternative delivery systems are saving them less, they are still eager to expand their participation in these health care alternatives.

For instance, 67.4% of the employers report they now use HMOs, and another 11.6% say they expect to begin HMO use in the next two years.

Even more notable, 26.6% of the employers say they expect to participate in a PPO within the next two years, though only 2.3% reported in the 1983 survey that they currently belonged to a PPO.

Another 4% say they expect to join an efficient provider organization in the next two years, up from the 1.3% who say they now belong to an EPO.

Mr. Hembree of the HRI describes an EPO as an organization much like a PPO, except that employers contract with providers on the basis of their efficiency rather than just rates. He points out that in order to form an EPO, an employer must have accurate utilization data to judge the providers' efficiency.

Finally, as has been reported many times before, employers are containing their health care expenditures by shifting some of their health costs onto employees. However, the data collected in the HRI survey were insufficient to report the employers' estimated savings from cost shifting.

More than 38% of the employers surveyed said they had increased deductibles for individual coverage within the past two years, while 35.2% said they had hiked deductibles for family coverage.

Some 19.6% said they had increased employees' coinsurance responsibilities, while 18.9% increased the out-of-pocket-amount employees could have to pay in a year.

More than 18% said they had increased the amount that employees had to pay toward premiums for individual coverage, while 24.3% increased the amount workers have to pay toward family coverage.

Interestingly, some employees singled out hospital care when shifting costs onto their employees.

For instance, 13% said they had instituted additional deductibles that must be paid for hospital care; 9.6% said they increased coinsurance requirements for hospitalization; and 8.6% instituted restrictions or penalties on weekend hospitalizations.

Although some employers made their workers pay additional out-of-pocket costs for hospitalization, more employers are combining hospitalization and major medical coverages into a comprehensive health care plan.

Some 53.6% of the responding employers say they offer a comprehensive plan, up from 39.1% in 1981. Conversely, 46.4% said in the 1983 survey that they offer separate hospitalization and major medical plans, down from 60.9%.

More than 77% of the respondents also offered a dental plan, 19.3% offered a vision care plan and 18.3% offered a separate prescription drug program.

Other findings reported in the 1983 HRI survey include:

- Almost 62% of the employers report they have joined an employer health care coalition. The respondents belonged, on average, to 2.1 coalitions.
- Almost 19% say they have begun a joint labor/management effort to contain health costs. Of these employers, 68.4% say the union has generally been cooperative.
- Only 17.3% of the respondents report they have a fully insured, insurer-administrated plan, down from 27.8% in 1981. Almost 43% say they have a minimum-premium plan with an insurer or use an insurer on an administrative services only basis. About 25% have a self-funded, third-party administered plan, while 10.7% administer their self-funded plan themselves. About 4% said they had some other type of plan.

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For a free summary of the HRI's "1983 Health Care Cost Containment Survey," write to the Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596.

Some employers say health inflation subsiding

LINCOLNSHIRE, Ill.—Health care costs are still rising, but the rate of increase should decline significantly this year, according to the preliminary results of a survey by benefit consultant Hewitt Associates.

Many of the employers surveyed by Hewitt noted that they expect the health care cost-containment efforts that they have been making in the past several years to pay off this year.

According to the 500 employers surveyed by Hewitt, health care costs rose 17% in 1983 to $1,338 per employee from $1,173 in 1982. But, the employers are predicting their costs will rise by only a relatively modest 9% in 1984 to $1,459 per employee.

Companies that believe their cost-containment efforts have been a significant or moderate success are predicting a very modest 4% increase in costs in 1984, compared with a 14% increase in 1983.

But, those companies that say their cost-containment efforts have met with little success are predicting that health costs will rise even more steeply this year than in 1983. These employers are projecting a 15% health cost increase for 1984, compared with a 13% actual increase last year.

Interestingly, manufacturing companies are doing a better job of holding the line on health cost increases than non-manufacturers, the survey notes, though manufacturers spend more on health care per employee than other companies.

Manufacturers reported that health costs rose just 13% in 1983 to $1,512 from $1,359 in 1982. And, they're projecting only a 7% increase to $1,643 in 1984.

On the other hand, non-manufacturers said their health expenditures rose 20% in 1983 to $1,137 from $950. For 1984, these companies are predicting a 10% increase to $1,243.

Of the companies pleased with their cost-containment strategies, 68% said changes in plan design have had a significant impact on health care costs.

Forty-seven percent of these companies said that changing deductibles has had a significant effect. 32% cited increased copayments and 27% cited a switch in financing or administrative policy as affecting health costs.

Nineteen percent of the respondents said health costs were significantly impacted by "other" cost-containment actions, like second opinion requirements, home health care programs, ambulatory surgery plans, preferred provider organizations and health maintenance organizations.

Fourteen percent said they significantly affected health care inflation through health education and communication programs.

The full results of the Hewitt survey will be available about May 1.

Firms also use wellness plans to contain costs

WALNUT CREEK, Calif.—Besides making design and administrative changes in their health plans, employers also are relying on health improvement or wellness programs to contain rising health costs.

The Health Research Institute's 1983 cost-containment survey noted that companies that have large-scale wellness programs have held their health care expenditures well below the average reported by all respondents (see story, page 27).

A significant number of these employers reported they provide their employees with health risk assessments.

For instance, 21.6% of the employers provided on-site early detection screening for a number of illnesses. Another 7.6% reimbursed employees who underwent early detection tests elsewhere.

More than 10% of those surveyed said they assessed employees' lifestyles for good health practices at the work site, while another 1.3% reimbursed employees for similar assessments provided elsewhere.

Other employers said they thought they could contain health costs by teaching employers how to prevent accidents and disease. The vast majority of these programs are conducted at the worksite, the survey notes.

About 67% of the surveyed employers, for example, say they offer first-aid programs at the workplace. About 52% offer accident prevention or safety instruction, 27.6% help employers to stop smoking, 23.3% offer stress management classes and 17.9% offer either nutrition education or weight control instruction.

While the survey noted the number of employers offering health education programs has remained stable over the past two years, it did note that fewer employers are offering physical fitness programs. These programs were likely victims of the recession, the survey notes.

About 17% of the respondents said they offer an on-site exercise facility, while 8.2% say they reimburse employees for exercise programs taken outside the workplace or membership in a health club.

Some companies went so far as to offer rewards for good health practices. Seven percent of the respondents said they offer time off or cash to reward employees for not taking sick days. About 5% said they offer incentives for employees to quit smoking, while 4% issue rewards if employees lose weight.

Employers also are adopting worksite policies to encourage good health. More than 12% say they serve health foods in the company cafeteria, 6.7% say they have instituted no-smoking policies and 0.5% have gone so far as to ban junk food in vending machines in the workplace.

Although the number of employers offering some types of health improvement programs has declined since the 1981 survey, employers are still interested in increasing their wellness activities.

More than 38% of the respondents say they plan to expand their current wellness programs, while only 0.3% are planning a cutback.

Employers, even if they do not sponsor a wellness program, are trying to communicate good health, the survey notes. For instance, 38.2% use posters to promote health educations, 34.6% promoted good health through company publications and 19.6% used audiovisual presentations. ■

Wisconsin employers not sure about PPOs

By CAROL CAIN

BROOKFIELD, Wis.—Preferred provider organizations, multiplying in California and planting seeds for growth in other states, are not attracting employers in Wisconsin, according to a recent survey.

Some 94% of the Wisconsin employers don't offer PPOs in their medical plans, and 52% said "maybe" when asked if they would offer a PPO if it met their criteria of "good care." Another 38% said "yes," while 0.04% said "no." The rest had no opinion.

And 30% of employers said a PPO would have to achieve an 11% to 15% reduction in medical costs to make this alternate form of health care attractive to them, while another 13% said the reduction would have to be even higher. Some 21% said it would consider a PPO that could trim medical costs by 6% to 10%, while another 8% of the employers said they would look at one that cuts costs by less than 5%. The rest had no opinion.

Employers ranked "quality of providers" as the most important feature of a PPO. "Accessibility and availability to a large number of employees" was ranked second as an important feature, and "a low relative cost" was ranked third.

"Discounts on services" was ranked fourth, followed by an "effective utilization review program," "a broad choice among providers" and "large membership among local employers."

PPOs are groups of health care providers—like physicians, hospitals or dentists—that contract with employers, insurers or other third-party payers to deliver health care services at reduced fees.

Some 135 Wisconsin employers responded to the survey conducted by Meidinger Inc., the benefit consulting firm based in Louisville, Ky. Meidinger recently merged with William M. Mercer Inc.

The survey was sent to all employers in the state with more than 200 employees. Of those responding, 45 employers had more than 1,000 employees and the remaining 90 had fewer than 1,000.

Wisconsin's 1983-85 Budget Act, adopted last summer, requires that employers with more than 250 workers offer at least two health care plans, one of which must be a PPO or a health maintenance organization, if such plans are available. A U.S. District Court judge ruled last month that this provision of the budget act does not apply to employers that self-insure their health care benefits, since those plans are regulated by the federal Employee Retirement Income Security Act (*BI*, March 5).

"Employers are skeptical (of PPOs). They see them as a case not proven; they're looking for data to compare the cost of PPO providers," said Wallace J. Gaarsoe, director of group benefits services in Meidinger's Milwaukee office.

Besides PPOs, the survey also asked Wisconsin employers about their other health care and cost-containment practices.

Some 41% said the costs of their medical plans over the past three plan years increased annually by between 0% and 20%, but 32% of employers said health costs have increased between 20% and 29% a year. Another 4% said their costs increased between 30% to 39%, and 6% of the respondents said costs have increased more than 40%.

The rest of the employers didn't give an answer.

The greatest interest in medical plan changes appears to be in increased deductibles and increased maximum out-of-pocket limits, according to the survey results.

For instance, some 38% said they increased deductibles recently for salaried employees and another 30% are considering such a move. And, 33% increased deductibles for hourly workers, while another 28% are thinking about it.

About 21% of employers recently raised salaried employees' maximum out-of-pocket limits, and another 21% were considering such a move. About 18% of employers increased these limits for hourly workers, while another 18% are considering it.

Employers' responses fell in the same 17%-to-22% range when they were asked about increasing or adding employee and dependent contributions or changing the company's plan to a comprehensive plan.

Only 4% of the employers, however, indicated that they had started medical reimbursement accounts for their employees. Between 7% and 13% said they are considering such a move.

Other cost-containment practices, including concurrent reviews of hospital admissions, audits of claims paid and voluntary second surgical opinions, are being used by fewer than 20% of the respondents.

Most employers believe communication of their benefits programs is necessary to be successful in reducing health care costs. Some 75% "significantly" believe in communications programs, while 18% "moderately" believe in their success and 5% believe "very little" in the effectiveness of benefit communications.

Most of the employers say they have implemented a special communications effort. For instance, 55% have aimed a communications program at educating the employee on the company's health policies, procedures and programs. Some 47% have created a special communications package for increasing employee health awareness, while 43% created a special program to gain employees' help in containing costs.

Forty-two percent created a special communications effort to promote employees' understanding of their own roles as health care consumers in reducing excessive costs.

Employers also were asked to rank groups they felt "should and can" bring health care costs under control.

Interestingly, 58% of employers ranked coalitions of employers and providers first in this list but, according to another survey question, only 33% of the respondents indicated that they belong to a coalition or similar group.

Other groups that "should and can" control health costs were: doctors (cited by 45% of the employers), coalitions of employers (named by 32%), hospitals (also named by 32%), individual consumers (named by 29%), HMOs, (named by 22%), PPOs (named by 21%), insurers or third-party administrators (also named by 21%), government (named by 11%), unions (named by 8%) and individual employers (named by 16%). ■

Don't blame us, most individuals say

WASHINGTON—Employers that are moving toward greater health care cost sharing with employees are picking on the wrong people, according to a recent survey of health care consumers.

Most Americans blame the high cost of health care on doctors, health insurers, public and private health facilities and the federal government, but not themselves, according to a survey by the Health Insurance Assn. of America.

And most of those surveyed believe that cost-containment measures should be aimed at these groups rather than at individuals.

Specifically, the survey respondents blamed high health care costs on:

- Hospitals, 79%.
- Physicians, 75%.
- Health insurers, 57%.
- Drug companies, 52%.
- Federal government, 49%.

A majority of those surveyed added that hospitals should take several steps to cut their own costs, rather than continue to pass on the costs to consumers. Most frequently recommended cost-containment measures were:

- Annual hospital management audits, 82%.
- Eliminating duplication of services in close geographical areas, 74%.
- Prospective budgeting with patient charges based on estimated costs, 58%.

About 86% of the respondents also suggested that hospitals publish price information for room rates and service and 83% of respondents suggested that doctors also publish fee schedules.

Survey respondents suggested that:

- People who receive medical care under federal programs such as Medicaid should use clinics or health maintenance organizations, 66%.
- Physicians and patients would work harder to cut costs if health insurers did not pay most expenses, 52%.

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Single copies of the survey report are available free from the Health Insurance Assn. of America, 1850 K St. N.W. Washington, D.C. 20006.

Employers differ on which strategy is most effective

By LEN STRAZEWSKI

WASHINGTON—American industry is marching steadily toward health care cost-containment goals, but individual employers are taking very different paths, according to a survey conducted by the Machinery & Allied Products Institute.

TheMAPI, a national economic research organization funded by industrial companies, recently surveyed 200 member employers on their plans and goals for health care cost containment.

Some 143 companies representing more than 2 million employees, or about 11% of the total manufacturing work force in the United States, responded to the survey. Nearly all of the respondents—95%—indicated that they already have undertaken health benefit plan redesign or plan to redesign benefits soon.

However, among those employers that already had taken steps toward health care cost containment—approximately 77% of the respondents—no single cost-containment approach proved to be dominant.

In fact, according to the MAPI analysis of the survey results, employers seem to be trying a wide variety of techniques based on several different cost-containment philosophies.

Health benefit plan changes already taken by respondents fell into three general categories, though respondents frequently chose techniques from all categories:

- Changes intended to redirect employee incentives to use health care in general and hospital care in particular.
- Changes specifically limiting or restricting the use of some services.
- Changes representing a major reorganization and restructuring of the employer's health insurance benefit plans.

The first category of changes, primarily benefit plan design modifications shifting some health care costs to employees and directing incentives toward lower hospital utilization, were the most popular among the respondents who have instituted some cost-containment measures, according to the survey.

More than 70% of the approximately 110 respondents who have attempted cost containment used techniques in this category and about 40% of the 110 respondents used several of these techniques.

The most popular changes in this first category included:

- Increased deductibles (85%). Of all plan changes, higher deductibles was most popular. For those respondents whose health plans originally included no deductible, the range of the new deductible was $100 to $200 for individual employees. Overall, the deductibles ranged from $75 to $500.

Some employers applied deductibles only against hospital coverage, with a few setting deductibles on days in the hospital rather than total hospital bills. For example, one employer charged employees a $25 per day deductible for the first five days in a hospital.

- Changed stop-loss maximums on medical expenses paid by employees (67%). Stop-loss maximums ranged from $500 to $3,000, but individual changes varied. Some employers added a stop-loss provision when moving from a first-dollar insurance plan to a comprehensive insurance plan and others increased stop-loss requirements based on employees' salaries.

Some employees decreased stop-loss requirements to reflect increases in deductibles or copayment schedules.

- Differing copayment schedules (57%). Many employers, especially those with comprehensive health insurance plans, moved to an 80% employer/20% employee copayment plan and added more re-

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strictive copayments for more expensive alternative treatments.

For example, several respondents reported changing their plans to pay 100% for selected outpatient treatments, but added a 50%/50% copayment requirement for the same treatments if they were performed during a hospital stay.

- Increased employee premiums (40%). Some respondents reported introducing employee or dependent premiums for the first time. Others based employee contributions on a percentage of the employer's overall cost of care or a percentage of the employer's annual cost increases.

Also in the first general category of cost-containment techniques, many of the respondents reported increasing coverage for more economical treatment. Most common additions included:

- Introducing outpatient pre-hospitalization testing (71%).
- Including coverage for alternative treatment centers such as health maintenance organizations, home health care, hospices, drug and alcohol abuse treatment centers, birthing clinics and outpatient psychiatric care (61%).

In the second category of cost-containment techniques, respondents limited coverages in some areas through plan design changes. Most popular restrictions included:

- Limiting benefits to those judged reasonable and customary (52%).
- Making second opinions on elective surgery mandatory (50%).
- Eliminating weekend non-emergency admissions to hospitals (24%).

Although the MAPI survey did not seek totals on how many employers are completely restructuring their employee benefit plans, the survey analysis noted three techniques in its third general cost-containment category.

These techniques are adding health maintenance organizations, initiating preferred provider organizations and adding cash incentives or Section 125 flexible compensation plans that provide financial benefit for employees who do not overuse medical benefits.

"The survey results make it clear that respondent companies are not in 'lock step' in their efforts to contain health care costs," the survey analysis concludes. "Some employers emphaisze the 'carrot,' with new incentives offered to employees to use lower-cost alternatives and to improve the administration of the plans offered. Others are deliberately moving to shift costs to employees through major plan revisions."

Survey results and additional comments by respondents represent several lines of thinking, the survey analysis also notes. These are:

- Cost-sharing will reduce demand for health care services because employees will use fewer services if they have to pay a share of the costs out of their pocket.

- Maximizing the availability of lower-cost options to employees with certain built-in incentives to take advantage of such options will effectively contain health care costs.

- When given a choice and trained to be cost-conscious consumers, employees will opt for lower-cost benefits.

- Benefit redesign is at best only part of the answer and emphasis on other cost-containment measures, including wellness programs, community involvement and education programs, should not be overlooked.

'(Some firms) are deliberately moving to shift costs through plan revisions,' the study notes.

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For further information on the MAPI Survey on Health Care Cost Containment, contact Machinery & Allied Products Institute, 1200 18th St. N.W., Washington, D.C. 20036; 202-331-8430.

Retirees fare well economically: Study

By DAVID R. FRANCIS

Companies often hear complaints from their retirees that it's hard to live on pension and Social Security benefits alone.

In many cases, the retirees' financial situations may indeed be bleak. But a recent study shows that the elderly, as a group, have fared quite well economically, despite the double-digit inflation of the late '70s and early '80s.

In fact, the elderly most likely added slightly to their real wealth in the past decade.

The study, principally conducted by economists John B. Shoven of Stanford University in Palo Alto, Calif., and Michael D. Hurd of State University of New York at Stony Brook, shows that:

- Whether measured on a per-household or per-capita basis, the incomes of the elderly have been rising faster than those of the non-elderly.
- Inflation has affected all age groups equally, not just the elderly.
- The proportion of income the elderly received from working has dropped, while the proportion received from Social Security and pension benefits has increased.

The study concluded, that on a per-capita basis, the pretax incomes of the elderly are higher on average than those for the total population, despite a significant drop in the percentage of the elderly who continue to work.

In 1970, 27% of men over age 65 worked, as compared with about 18% today, and many of those have quit working because of the higher pension and Social Security benefits that are currently being paid, the study notes.

After taxes, the income advantage for much of the elderly population is even greater, because they pay no taxes on Social Security benefits. Also, persons over age 65 receive two personal exemptions when they fill out their federal income tax forms.

And, since many elderly people own their own homes, they benefit from what economists term "the implicit income" on those homes. In other words, they pay less for housing than if they rented like many younger people.

As compared with 20 years ago, a much smaller proportion of the elderly are now poor. Only 7.6% of the nation's elderly population fell below the government's official poverty line in 1978, compared with almost 27% of the elderly households in 1959.

"While it may have risen slightly since, most of the impact of the recession in 1981-82 was. . .borne by the non-elderly," says the study by Messrs. Shoven and Hurd.

The study also discounts complaints by the elderly that they are hit harder by inflation than the rest of the population.

Indeed, many elderly people benefited from the tendency of the official Consumer Price Index to overweigh the cost of owner-occupied housing, an area where prices soared in the 1970s. Economists note that the elderly's housing costs probably did not rise as steeply as the housing component of the CPI, even though their Social Security benefits were indexed to the overall inflation rate.

To look more closely at the economic position of the elderly, Messrs. Shoven and Hurd tabulated detailed income statements and balance sheets for participants in a survey conducted by the Social Security Administration.

Some 11,153 heads of households born between 1906 and 1911 were interviewed in 1969, when their ages ranged from 58 to 64. The survivors of this group were interviewed every two years thereafter until 1979.

The results of the study show how the incomes of a typical group of the elderly have evolved over time.

The household income of this group in constant 1968 dollars averaged $8,246 for 1968, $7,230 for 1974 and $6,768 for 1978, though their 1978 income averaged $12,280 if stated in current dollars.

These numbers, the study notes, take account of government-provided health care or insurance programs and the real implicit return on owner-occupied housing (calculated at 3% of the market value of the home).

However, the decline in the elderly's real income is due solely to the fact that fewer of those surveyed were working as they got older. Income derived from working in 1968 amounted to 76% of the income of all those surveyed; a decade later, job-related earnings accounted for only 17%, the study notes.

And, the study reveals, the poorest 10% of those surveyed actually *increased* their real income. This real increase came between 1968 and 1974 as more of the elderly became eligible for such government programs as Medicare and Social Security.

The well-to-do tend to work longer, so the wealthiest 10% of the surveyed households derived a larger proportion of their income from labor earnings. For instance, 28% of the income of the wealthiest people surveyed came from labor earnings in 1978, compared with 17% in the overall sample.

Conversely, income from pensions and Social Security increased dramatically over that decade studied.

The economists made several other findings from their survey:

- Some 26.6% of households surveyed in 1979 received a private pension and 15.5% a government pension (not including Social Security). Government pensions are indexed fully against inflation; private pension benefits were raised to offset on average about two-fifths of inflation.
- Government programs—like Social Security, other supplemental benefits and Medicare—tend to reduce income inequality among the elderly, while private pensions do not. The poorest 10% of those surveyed get only 4% of their wealth from private pensions and annuities; the richest 10% get 15%.
- Roughly 70% of those surveyed (a group probably typical for the elderly) owned their own homes during all 10 years of the survey. The market value of their homes grew by 123% between 1969 and 1979.
- Some one-fifth of the elderly were participants in the stock and bond markets during the decade, with an average of $30,000 invested in 1979.
- The median income of the elderly—meaning there is an equal number with incomes greater and with incomes lower than the me-

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dian—was substantially protected from inflation. Indexed government programs, like Social Security, can take credit for much of this inflation protection.

"The popular notion of the inflation vulnerability of the elderly is wrong," the economists conclude.

"The elderly do not live on fixed incomes derived from assets that depreciate when inflation increases. Rather, a substantial fraction of the elderly have an index of inflation vulnerability that is so low that inflation has no appreciable effect on their wealth."

However, what's true on average is not true individually, the studies note. Some of the elderly gained from the inflation of the 1970s; others lost significant portions of their wealth, the study shows. But, the indexing of Social Security and other government benefit programs prevented this variation in vulnerability to inflation from being greater, the study says.

The poor elderly, highly dependent on such government programs, are not usually greatly affected by inflation, the study notes, though they would be highly vulnerable to inflation without the government benefits.

The wealthy, more dependent on private pensions and bond holdings, do suffer from inflation, according to the study.

The study also dispels another myth by reporting that the survey participants, who are now between the ages of 72 and 77, got a bargain by participating in Social Security.

That age group, even considering those who did not live to collect any benefits, received an overall average 8% annual rate of real return on their contributions to the pension system.

"Relative to a market real rate of perhaps 3%, this means that this generation of elderly received a windfall gain of roughly $70,000 (each)," notes Mr. Shoven. "They have benefited from the fact that the program was relatively small during most of their working life, but is now large and mature during their retirement period."

> 'The popular notion of the inflation vulnerability of the elderly is wrong. Rather, a substantial fraction of the elderly have an. . .inflation vulnerability that is so low that inflation has no appreciable effect on their wealth,' the economists say.

However, these rates of return will not continue. In calculations made by the economists before the changes enacted by Congress last year in the Social Security Amendments Act, Messrs. Shoven and Hurd found that the rate of return on contributions would approach zero by 2030 and almost certainly be negative for many groups within today's younger population.

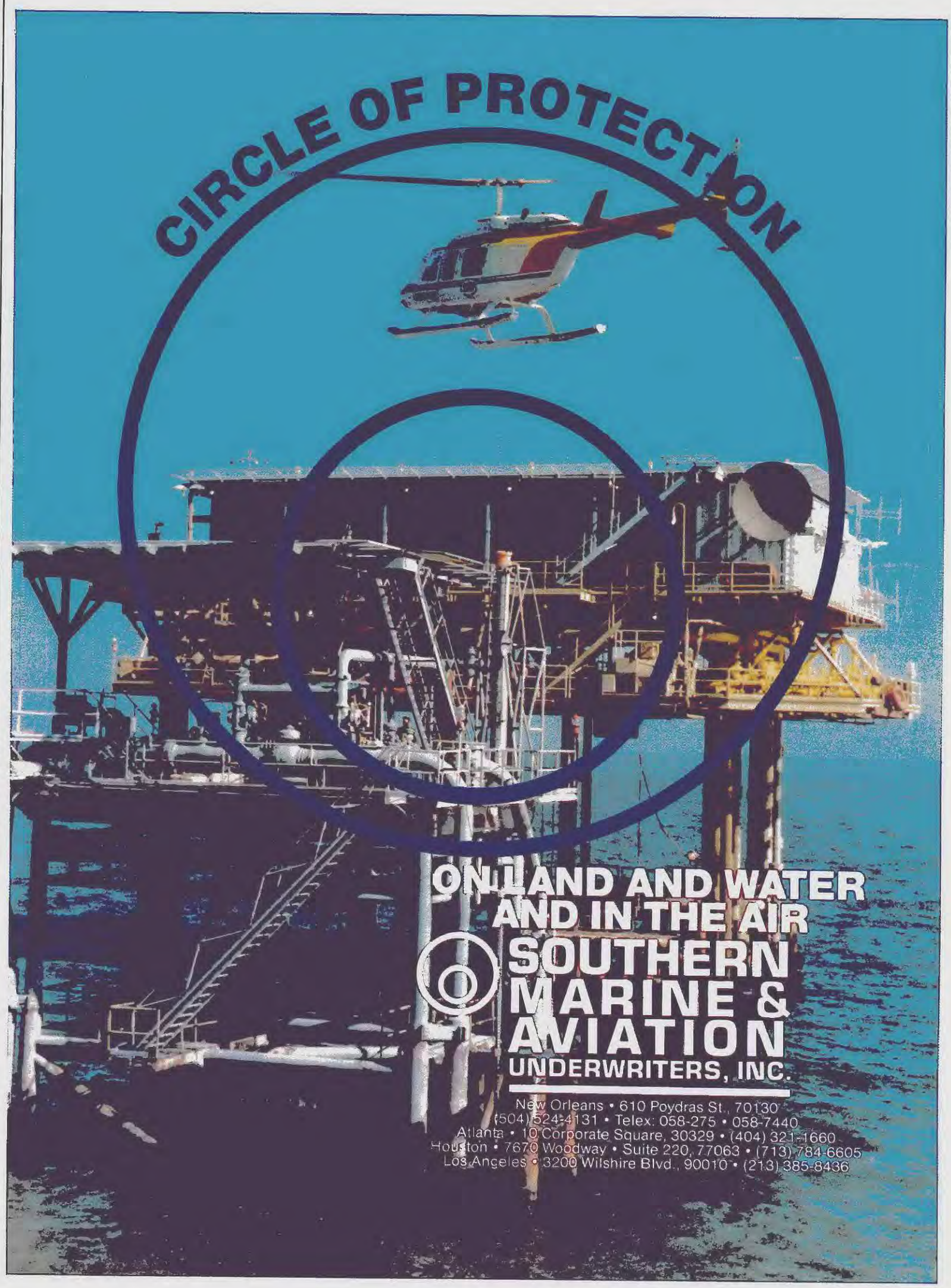
So, the current elderly are recipients of a substantial transfer of income from the working population, the report notes. Indeed, a typical senior citizen can expect to get back about 350% of the taxes paid by both employer and employee on his behalf.

Curiously, the well-to-do among the surveyed groups have probably received a larger windfall gain from Social Security than the poor. Those with higher earnings were allowed to participate in the program to a larger extent and received the above-market rate of return on that larger participation.

"Thus," says Mr. Shoven, "among the current elderly, Social Security does not redistribute lifetime income from rich to poor. . .quite the reverse."

This fact, he says, makes reasonable the section of last year's Social Security reform law that taxes a portion of the Social Security benefits of the elderly whose incomes exceed $25,000.

However, as the Social Security system matures, this redistribution reverses itself, with the rich realizing the lowest rates of return and, in effect, transferring some of their income to the poor. ■



Communities use grants to fight health costs

Continued from previous page

The per diem payment by Blue Cross of Greater New York to hospitals in the city ranges from $250 to $500, according to Dr. Warshaw.

"And the per visit cost for a nurse to care for a patient at home is less than $100," Dr. Warshaw noted.

Ten employers in New York have agreed to modify their benefit package as needed to encourage home care.

Currently, procedures that could be done on an ambulatory basis as safely as on an inpatient basis are being identified.

"We want to make sure we're not diminishing the quality of care and putting the patient at risk," said Dr. Warshaw.

Mecklenburg County, N.C.

The Mecklenburg County program, which encompasses the city of Charlotte and surrounding communities, is developing a pre-admission certification program for use by all employers and insurers in the country.

The goal is to reduce the number of admissions and average length of hospital stay.

"Our program is unique in that it was formed on the initiative of the Mecklenburg County Medical Society," said Wayne Godwin, chairman of the board of Celanese Fibers Corp., one of 21 employers sponsoring the pre-admission certification project.

Mecklenburg County employers have experienced health care cost increases of 20% to 50% in recent years, according to Mr. Godwin.

"Our county budget for 1983-84 shows $19 million for health care, compared with a total of $7.5 million spent in 1980-81," he explained.

Other projects to be tackled this year include the development of cost-effective health services alternatives for the elderly, reduction of the inappropriate use of hospital emergency rooms and cash incentives to employees to limit hospital stays.

Atlanta

The centerpiece of Atlanta's cost-containment project is development of a hospital utilization management plan.

"We have an excess of beds in the city's hospitals," said David Lieser, acting director of the Greater Atlanta Coalition on Health Care.

In the end, the city has 'too many people using too much care, probably unnecessarily," he says.

Health care costs are increasing 20% annually in the city while the national average increase was 9.2% in the middle of 1983, Mr. Lieser says.

The hospitals are making efforts to manage utilization, Mr. Lieser noted, and they are represented on the project's steering committee.

The utilization management project has four phases:

- Analysis of patterns of utilization and cost.
- Modifying benefit coverage and community education programs to promote alternatives to inpatient care.
- Pre-admission certification, in-hospital review and discharge planning.
- Analysis of the impact of the project on quality, physician behavior, changes in benefit plans and use of hospital services.

The Robert Wood Johnson Foundation anticipates funding several other community health care planning projects this year. Cosponsors with the foundation are the American Hospital Assn. and the Blue Cross & Blue Shield Assns.

The program is administered for the Foundation by the Hospital Research & Educational Trust of Chicago, directed by Robert M. Sigmond. ■

Most employers match deferrals to 401(k) plans

LINCOLNSHIRE, Ill.—The vast majority of employers offering 401(k) salary reduction plans match employee contributions, according to a recent survey.

And, the level of employee contributions is much greater in plans that include matching employer contributions, the survey notes.

The survey conducted by Hewitt Associates, a benefits consulting firm, is based on data from 246 primarily large industrial companies that operated 401(k) plans at the end of 1983.

Eighty-three percent of the companies surveyed said they matched employee contributions.

The most common employer contribution formula, cited by 31% of the company's providing matching funds, is to contribute 50 cents per every $1 of employee contributions.

Ten percent of the companies providing matching funds said they contributed less than 50 cents per $1 of employee contribution, while 23% said they contributed more than 50 cents for each dollar contributed by workers. Some 36% of the companies surveyed used some sort of variable matching formula, such as basing company contributions on profits or by the number of years a worker has been with the company.

Based on a separate survey of 55 companies that reported plan experience data, employees tended to contribute more to plans that included matching contributions from the employer. For instance, higher-paid employees at companies that matched worker contributions deferred an average of 5.2% of salary to a 401(k) plan, compared with an average of 3.4% of salary at companies that did not provide matching contributions.

Likewise, lower-paid employees at companies that matched contributions deferred 3.5% of salary, compared with a 1.9% deferral rate at companies that did not provide matching contributions.

At the companies that do provide matching contributions, 54% said they would only match employee contributions of up to 6% of annual pay. However, most allowed employees to contribute additional amounts to the plan, but without a company match. •

Copies of "Survey of 401(k) Salary Reduction Plans" are available for $25 each from Greg Martin, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000. The survey includes detailed plan experiences of 57 of the responding companies.

Cost-cutting begins at Bethlehem Steel

benefit beat

Benefit changes designed to trim $10 million annually from health care costs began this month at Bethlehem Steel Corp. in Bethlehem, Pa.

Approximately 15,000 salaried, non-union workers are affected by the changes that began Feb. 1. In addition, 19,000 retired workers will be affected by the changes April 1. Bethlehem totally self-funds its health benefits.

A shift from first-dollar coverage for basic hospitalization expenses to a comprehensive plan with additional cost sharing, plus a flexible spending account, will mean both short-term and long-term savings for the company, says Dave Kempken, Bethlehem's manager of employee benefits.

Prior to the establishment of the new plan, employees contributed nothing toward health insurance premiums for themselves or for their dependents. In addition, they received first-dollar hospitalization coverage and paid a $150 individual/$300 family deductible for major medical expenses.

The company continues to pay the entire premium for workers, but the workers now must pay $7 per month if a spouse is to be covered, plus $7 per month for dependent children.

The new comprehensive plan also includes several different deductibles that correspond to Medicare deductibles.

For health care expenses that fall under schedule A of Medicare (hospitalization expenses), workers must pay a $356 deductible per admission. For expenses incurred at non-hospital facilities, like a birthing center, workers must pay a $178 deductible per admission. And, workers must also pay a $50 deductible per emergency room visit.

For all other medical expenses, like surgery and office visits, workers must pay a $300 deductible.

After these deductibles are satisfied, workers are reimbursed at 80% of the remaining cost. Out-of-pocket expenses are capped at $1,000 annually. The deductibles and the stop-loss cap are the same for both individual and dependent coverage.

Bethlehem Steel built other cost-saving incentives into its new plan. For example, second-surgical opinions for elective surgery are mandatory; if a second opinion is not obtained, an employee who proceeds with the surgery must pay 30% of the surgeon's fees with no stop-loss cap.

Also, the company implemented a pre-certification requirement for hospital admissions. Once a physician recommends that an employee be admitted to the hospital, the physician must complete a form with the diagnosis and other information on the patient. This medical information is then forwarded to U.S. Administrators Inc. in Los Angeles, which determines whether the situation necessitates hospital admission and, if so, what the length of stay should be.

Bethlehem Steel then reimburses employees based on these findings. For instance, if U.S. Administrators determines that the employee should expect to be in the hospital for three days for a particular procedure, the employee will be reimbursed for up to three days. Unless there are complications or some emergency, any additional expenses will not be reimbursed.

Also, an employee who does not obtain pre-admission certification must pay an additional 30% in coinsurance—or 50% of the total bill—with no stop-loss cap.

"And the employee has an additional incentive for getting the pre-admission certification," Mr. Kempken said. "If the procedure is determined not to be medically necessary, he runs the risk of total denial of coverage.

"As you can see, we're going extremely strong on medical necessity."

The new plan also covers expenses at facilities previously not covered, like hospices and birthing centers

To make this additional cost-sharing more palatable to employees, Bethlehem Steel set up a flexible spending account. The company contributes $25 per month to each employee's account, and employees may contribute up to $400 per month or a total of $4,000 per year in pretax dollars.

Account funds may be used to pay for any non-covered medical expenses, like premiums for dependents, deductibles, coinsurance and non-insured expenses such as dental and vision care. Also, day-care expenses may be paid from the account.

At year-end, any unused funds are taken by employees as cash, which becomes taxable income.

"Our major reasons for change are to get a handle on health care costs, both short-term and long-term," Mr. Kempken said. "And, we want to provide employees with more control over where some of the benefit dollars will be expended. It provides them with a greater involvement in benefits, and more flexibility."

ESOP statistics

The average Employee Stock Ownership Plan owns 28.8% of the stock in its company, according to a new survey by the Employee Stock Ownership Assn. of America, a trade association that promotes participation in ESOPs.

In addition, 18% of the companies responding to the survey indicated that the ESOP owns more than half of the corporate stock

The median number of participants in an ESOP is 182, according to the association. About 15% of the ESOP participants nationwide are members of a labor union.

Fifty-six percent of the responding companies reported that they believed participation in the ESOP helped build both employee motivation and productivity, two principal reasons for a company to sponsor a stock plan, the association said.

Forty percent of the companies also reported that they contributed between 10% and 15% of their payoll to their ESOP in 1983. Company stock accounted for 87.7% of all ESOP holdings, the report says.

•

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Sallie J. Drury, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5282.

If a disaster hit Mor their policy be

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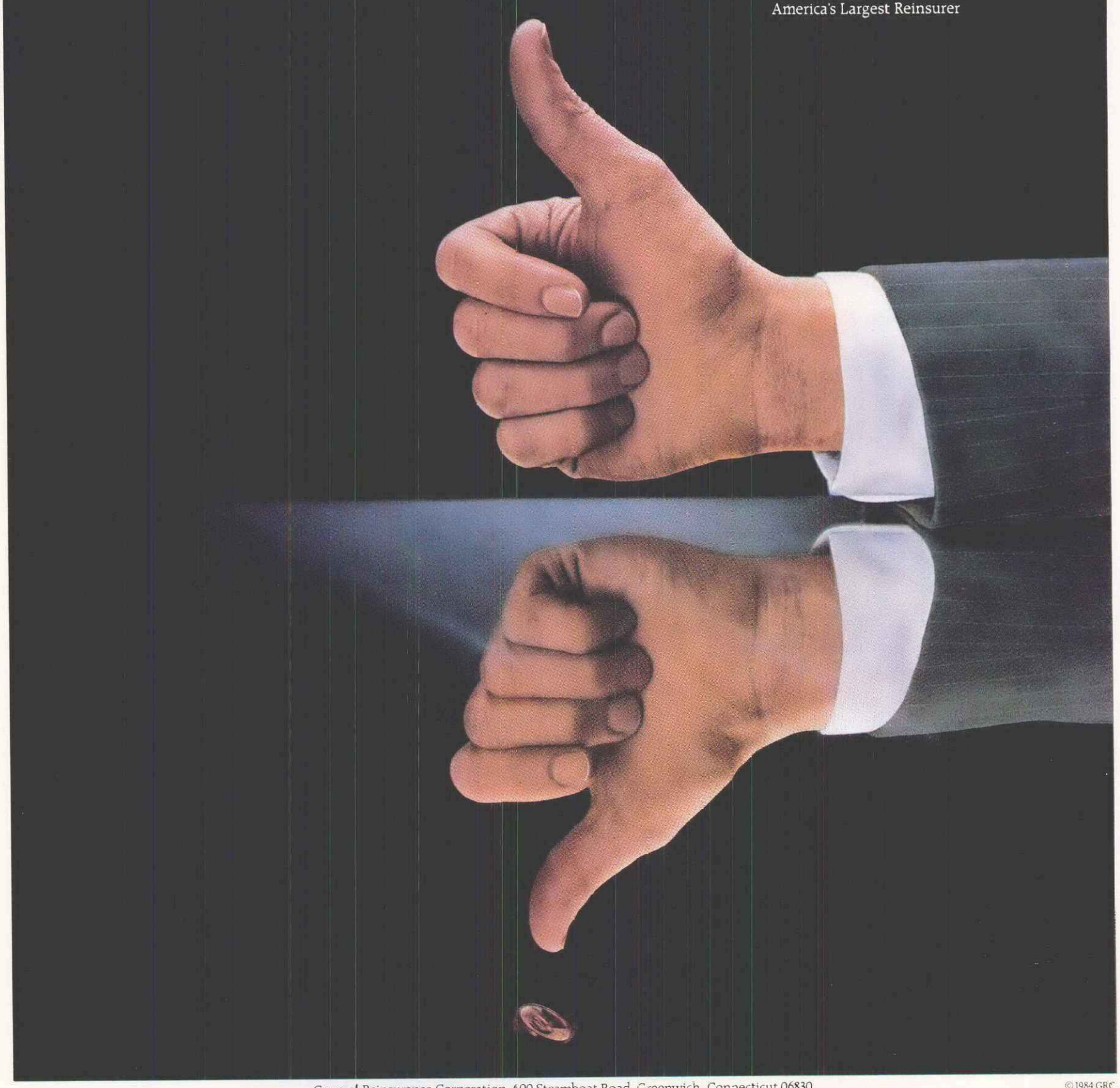

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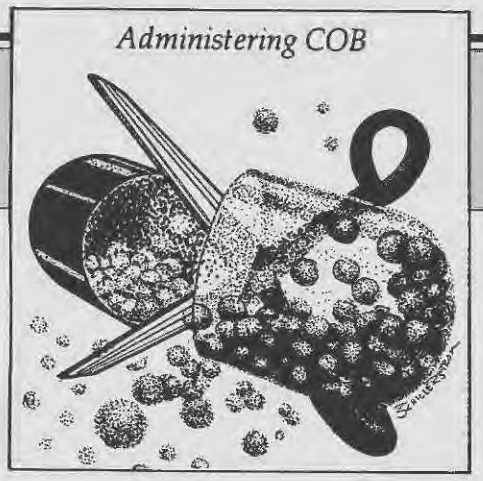
Administering COB



COST-CUTTING MEASURES

Coordination of benefits means the right plan pays

By Albert Cole Jr.

MOST employer-based group medical insurance programs have a dual-coverage provision. For the past 20 years, the industry standard has been to coordinate benefits.

There are established coordination of benefits (COB) procedures to determine the liability of each plan as a primary or secondary payer when an employee has group medical insurance through more than one plan.

Careful administration of COB should be an important cost-containment element.

The insurance company or claims administrator should use COB with the aim of first identifying all claims that suggest the existence of dual coverage. Then, these claims must be followed up to ensure that any other plan that should be the primary payer, in fact, does pay first.

The following case history illustrates the importance of careful COB administration.

During a recent claims audit performed for a large steel manufacturer, we reviewed a number of bills submitted for an employee's spouse.

Each claim submitted was for services rendered for seemingly non-emergency outpatient treatment (headache, upper respiratory infection, finger contusion, splinter, etc.) at a local hospital emergency room. Each bill reviewed was for less than $100. The employee did not answer the duplicate coverage inquiry questions on the corresponding claim forms.

Upon questioning the reimbursement of the claims, we learned that the administrator's procedures did not require pursuing duplicate coverage information when the COB questions were not answered or when the claim amount was $100 or less.

Further investigation revealed that the employee had been receiving benefits from the employer's group health plan as well as from the spouse's plan with *no* coordination. The administrator's lax claim procedures encouraged this employee to submit billings of $100 or less to avoid COB inquiries and profit from the dual coverage.

However, even with sound claims administration, the standard COB provision no longer may be accepted automatically as necessary or proper.

COB was initiated to prevent employees from being reimbursed for more than 100% of a covered expense. At the same time, for employees with dual coverage, it almost always guarantees reimbursement for a full 100% of covered expenses.

Current cost-containment efforts may have rendered the standard COB provision undesirable.

A recent Rand Corp. study, for example, showed the cost-containment value of out-of-pocket expenses, an element that may be lacking in plans with standard COB provisions, in controlling plan utilization.

Another reason COB provisions are not as effective as they once were is the increasing use of an array of medical plans from which employees may choose one that best fits their needs.

Often, but not always, the choice of different levels of medical insurance is part of a flexible benefits plan.

Employees who are covered as dependents under their employed spouses' plans may elect a low option at their place of employment and rely on the combined benefits from their own and their spouse's plan to provide 100% coverage.

This shifts costs from the employer offering the optional levels of benefits to the employer of the spouse.

Consequently, through the cost shifting resulting from standard COB, some employers are paying for other employers' cost-containment provisions.

COB compared with non-duplication

	COB	Non-duplication
Total covered charges	$4,100	$4,100
Paid by primary plan	3,000	3,000
Normal benefits of secondary plan ($4,100 − $100 × 80%)	3,200	3,200
Actual benefits of secondary plan	1,100	800*
Employee out-of-pocket expense	0	300

* Non-duplication extracts the $3,000 paid by the primary plan. This leaves $1,100 in covered charges against which the plan benefits are applied ($1,100 − $100 = $1,000 × 80% = $800).

Source: Buck Consultants Inc.

There are several options available to employers with self-insured plans that want to try to retain or initiate some out-of-pocket expense for employees with dual coverage or that want to protect themselves from the cost-shifting that occurs when other employers introduce optional plans.

Employers with insured plans most likely will have to work with their insurers to secure any necessary approval from the regulatory authorities before adopting one of these options. In any case, use of one of these options will have an impact on the administration of the plan. It will also require carefully planned communication efforts to ensure that employees understand the changes.

The options are:

- Include a non-duplication clause instead of a COB provision. This clause may provide that expenses paid by a primary plan are excluded in the calculation of benefits.

Take, for example, a $4,100 claim for which the primary plan pays $3,000 in benefits. The benefit plan of the secondary insurer has a $100 deductible and payment of 80% of expenses. Under non-duplication, the employee would have to pay a portion of the remaining $1,100 (see chart).

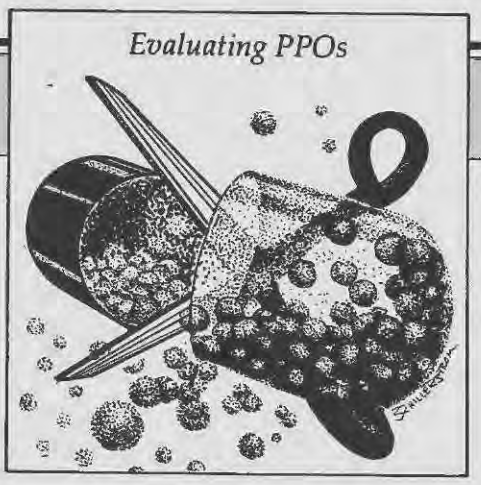
- Limit the total benefit to no more than the amount that would be paid if the secondary payer were primary. In the example in the chart, maximum benefits would be $3,200. If, as shown, the primary insurer paid $3,000, the secondary insurer would pay $200. The employee has a $900 out-of-pocket expense.

If the primary payer paid $3,200 or more, the secondary payer would pay nothing. The difference between the

Continued on page 44

Rating providers by case-mix adjustment

Evaluating PPOs



By Neil S. Fleming

AN EDITORIAL on preferred provider organizations, or PPOs, (*BI*, May 30, 1983) stated that when health care consumers examine this form of delivery, they "...must compare the discounted rates to rates charged by other health care providers. A 10% discount off rates that are 20% higher than those charged by the neighboring hospital...is no bargain."

Employers and employer coalitions do need to know if a group of hospitals forming a PPO will bill a higher or lower charge per hospitalization than another hospital. In fact, a coalition needs to know what the specific charges are before making contractual arrangements.

An employer or coalition should use what is called a case-mix adjustment method to compare more accurately what hospitals charge and how they should be reimbursed.

The method proposed here assumes that a data base exists for the employee exposure population of the coalition. The data base must minimally include hospital of admission, diagnosis-related grouping (based on discharge diagnosis, procedure, age and discharge status) and charges.

This data base must be reliable because it is essential to cost-containment activities and their evaluation. The collection of this type of information is a major thrust of current health care coalition activity.

This method provides a way to determine the average charge by a PPO and hospitals if the coalition's case mix in the PPO was identical to the coalition's case mix in total.

This means that hospitalizations occur within diagnosis groups with the same frequency in the PPO as they do in all hospitals treating employees of the coalition.

A hypothetical example of information from charges over a year's time that could be used to determine reimbursement rates for PPOs and other hospitals appears in the accompanying chart (see page 44). There are four hospitals and four diagnosis-related classifications, or DRCs.

Hospitals A and B have formed a PPO while hospitals C and D are separate. Hospital A charged $1,000 on average for hospitalizations due to DRC 1, a specific discharge diagnosis.

Hospital A's charges for other hospitalizations by DRC can be seen down column one, in each of the average charge rows.

The number or frequency of each DRC for hospital A can also be seen in column one in each of the frequency rows. For instance, hospital A had 500 hospitalizations occurring in DRC 1.

Looking at the total average charge and total frequency in column one, we see the average charge per admission in hospital A was $2,500 based on 2,000 discharges.

These 2,000 discharges in hospital A are used in the data base to determine the probability or percentage of each DRC in the total admissions.

For instance, 25% of admissions in hospital A occurred in DRC 1. This is computed as the ratio of 500 DRC 1 discharges to 2,000 total discharges, multiplied by 100%.

This percentage for each DRC can be seen for hospital A down column one in each of the case-mix percentage rows. These percentages represent the case mix of hospital A.

Hospital A has a uniform case mix because there are 500 discharges in each DRC, so each occurs 25% of the time. This can be seen for each of the hospitals.

In column three, the number

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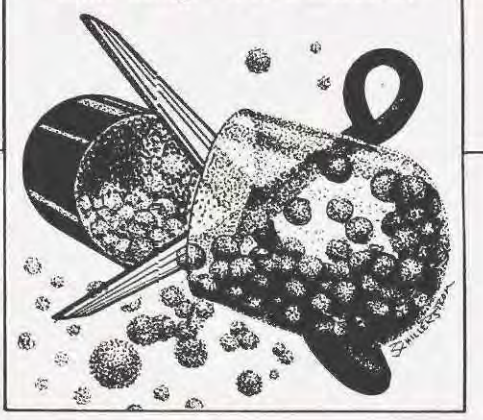
perspective

CALCULATING CHOICES

Combatting adverse selection



Working around adverse selection in flexible plans

By Lance D. Tane

WHENEVER flexible compensation is discussed in the insurance industry, there's an inevitable knee-jerk reaction: What about adverse selection and how do you keep it from driving up the cost of the plan?

Or, to take a familiar example, how do you keep all the employees with bad teeth from choosing dental coverage, while people with good teeth pass it up?

Let's face it—the very purpose of flexible compensation is to allow adverse selection. This may be heresy in insurance circles, but what the industry sees as adverse selection is intelligent selection from a worker's perspective. When employees are allowed to select the benefits they want, they tend to choose the ones they are most likely to use.

This simple truth lies beneath the appeal of flexible compensation to employees and the fear of this rapidly spreading trend among insurers. But peaceful coexistence is possible.

Plan sponsors are learning to control the potentially negative effects of adverse selection without killing the powerful attraction of flex plans for all types of employees.

Flexible benefits is a concept whose time has come. In an era of skyrocketing benefit costs, employers are wasting millions of precious dollars on traditional one-size-fits-all benefit packages.

These plans are structured for a "typical" employee who is no longer typical—the male breadwinner with a non-working wife and kids at home. At many large companies we have worked with, this vanishing breed represents less than 20% of the work force.

Instead of a single, rigid benefit package that doesn't really meet the needs of women, singles and working couples, flexible plans offer employees a choice of benefits as well as access to significant tax advantages. And just as flexible plans are being enthusiastically accepted by employees, they are proving cost-effective for employers.

Flexibility is clearly the wave of the future. With more than 100 flexible plans now in existence—some more comprehensive than others—the word has spread, and enormous interest has been kindled among large and small employers alike.

So what about adverse selection? Experience has shown that it can be predicted, managed and controlled with two basic tools—plan design and option price tags. But before we see how they can be used, we must first place the issues in perspective.

How did the concept of benefits evolve anyway? Before benefits, everyone was just paid in cold cash. You worked, you got paid for it. In general, the money you were paid represented the value of your work. That was it.

What happened when someone got sick or died? Generally, employees got together to pass the hat; frequently families underwent hardships.

So, an employer had the idea of setting up an insurance plan, a group plan that would benefit all employees, using some of the money that would have gone into cash compensation.

Thus, it wouldn't have to cost the employer more, and it was an efficient way to use those compensation dollars for the benefit of employees. It also introduced a new element into the workplace; compensation was no longer based simply on the value of an employee's work, but also on needs.

Eventually, a strange thing happened. Employees did not all perceive the change as equally attractive. A young employee who had no spouse complained that life insurance was useless to him, with no one to collect it.

An old fellow complained that he didn't need the dental coverage because he already had dentures. And so, with individuals losing cash compensation unfairly for useless "benefits," we had the first kind of adverse selection.

In other words, the whole problem of adverse selection arose when compensation dollars were no longer based solely on performance, but also on needs. With the introduction of benefits, the allocation function of compensation was changed.

Then, flexible compensation came along. With flexible plans, the problem can be approached from a fresh direction, giving employers a new tool to control the allocation of money. With flexible compensation, we're no longer tied to the past—we can have a choice about how much compensation we will allocate based on need. And we can also solve insurance issues involved in benefits (*BI*, June 7, 1982).

We know that true insurance—protection from excessive, unanticipated risks—has value for everyone. It makes sense to pool some compensation dollars to provide such protection. But to what extent should participation in an insurance arrangement be a voluntary decision of the employee, and to what extent a mandated decision of the employer?

So how do we provide appropriate insurance arrangements in the work place? The purpose of flexible compensation is to allow people to select benefits that meet their needs.

The real problem, however, is not adverse selection but how to anticipate and contain adverse selection so it doesn't drive up costs. This usually can be done.

And if, in some aspects of a flexible plan, the employer/insurer cannot anticipate the employee's needs as well as the individual can, then the flexible plan can be designed and priced to prevent employees from exploiting their inside knowledge to "beat the plan."

Yes, employees should be able to select benefits that meet their needs. But no, the plan need not give them a totally free ride to the dentist.

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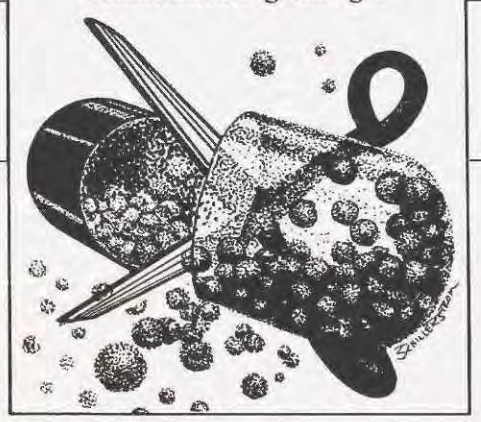
Communicating changes



DELIVERING THE MESSAGE

Worker opinion can help determine plan's reception

By Suzanne Kenney

IN AN EFFORT to hold the line on health care costs, many companies are asking employees to share a larger portion of the cost of their medical benefits. Announcing that message to employees can pose a significant challenge.

As a result, more companies are listening to employees before attempting to communicate the "bad news."

In numerous employee attitude surveys, we've uncovered some interesting patterns of responses that have helped employers maximize employee acceptance of plan changes.

The most surprising—and useful—insight of these studies may be that employees don't have the same understanding that employers do in this area. The employees are often not "on the same wavelength" as their employers.

Observations on typical employee reactions may be useful as decision makers go about planning the announcement of their own medical plan changes:

- Employees often react emotionally to the idea of medical cutbacks.

The medical benefit is the most sacred benefit to employees. According to our surveys, it is identified as the most important benefit by more than 65% of employees. Another 21% rate it second most important.

Whereas retirement will occur sometime in the future and disability benefits are used by relatively few employees, medical benefits are within everyone's realm of experience—even for those who claim never to have been sick a day in their lives.

Often lacking a detailed knowledge of plan stop-loss levels, employees fear that cutbacks will leave them vulnerable to devastating medical expenses.

As one employee anxiously explained: "A serious illness or accident can mean months of hospitalization or treatment, and thousands of dollars of expenses. I can't pay 20% of that. I'll be wiped out."

- Employees are aware that medical costs have risen, but they really don't sense the magnitude of the problem.

Only about half of the employees we've surveyed recognize that, proportionately, medical costs have far surpassed inflationary increases in other sectors of the economy.

The need for a cutback in benefits often comes as a surprise.

When inflation is seen as the "lone villian," employees typically expect more from the employers each year to keep their benefits compatible with rising costs.

Once acquainted with the big picture, though, employees at one company even chastized the company for not addressing the problem earlier.

"Why didn't the company say something to us sooner about this? We probably could have helped if only we had known."

"It's the generosity of the company's plan that has encouraged doctors to charge what the traffic will bear."

- Employees are surprised to learn they can affect health care costs.

The waste involved in health care costs is not clearly visible.

For example, the frequency of weekend hospital admissions, unnecessary hospitalization for ambulatory surgery and excessive medical treatment are not known. Doctors' orders are not questioned because "doctors know best."

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How, then, do we structure a flexible plan to contain unanticipated adverse selection? There are four proven strategies:

- Like insurance companies, we can underwrite the individual. Thus, if an employee wants to elect a high life insurance option or to make a significant change from one year to the next, we require proof of insurability.

For instance, in a plan that offers four life insurance choices ranging from half-pay to five times pay, the plan can hold year-to-year increases to one increment.

Applying underwriting standards, proof of insurability is required for increases of more than one increment. This helps the employer know as much as the employee about the probability of a claim without defeating the purpose of the flexible plan.

- We can place restrictions on optional coverage, so employees can't act on inside information as their conditions change.

In offering dental options, for example, some employers are providing 100% coverage for prophylactic care, 80% for ordinary dental procedures and 75% for more sophisticated treatment. Thus preventive care is encouraged, while foreknowledge of other dental needs cannot be exploited by the employee.

In some plans, after the initial year of implementation, once a person drops the dental care option and then selects it again, he or she can only get 25% of the benefit in the first year back. In succeeding years, the coverage goes up by increments of 25% until the employee again is covered completely.

- We can combine coverages where employee selection is predictable. For instance, if vision care is offered as a separate option, it will be selected only by people who are going to use it. Dental care also may be selected for the same reason.

Ultimately, the cost of such coverages must rise to the level of the experience itself, unless it is combined with overall medical care. In other words, vision and dental care can be offered only among the mix of medical plan items.

- The most valuable technique to anticipate and avert adverse selection is the reimbursement account.

Reimbursement accounts allow employers to give their employees meaningful tax breaks by enabling them to pay for a wide range of health care, dependent care and personal legal expenses that are not covered by company plans with pretax dollars.

Here the price tag is exactly equal to the experience. The advantage to the employee is the opportunity to save on many known expenses, including medical plan deductibles and copayments, vision and dental care and child care costs.

A major advantage to the employer is that more health care costs can be shifted to employees in an acceptable way. There also is a widespread expectation that reimbursement accounts will tend to reduce excess use of health services.

The validity of this relatively new benefit, which has its legal basis in Section 125 of the Internal Revenue Code, was attacked recently by the Internal Revenue Service (*BI*, Feb. 20). However, the IRS has thus far failed to distinguish clearly among reimbursement account structures that are solely tax-motivated and those that have economic substance and promote important social and public policy goals.

Retrospectively funded reimbursement accounts, in which an employee's salary is reduced only after he or she submits a claim, the so-called ZEBRAs (zero-balance reimbursement accounts), are not likely to stand up. But, employers have made it clear that they will litigate, if necessary, to defend prospectively funded reimbursement accounts, and consultants are confident that this structure will be upheld.

In addition to these plan design strategies that limit the potential for unanticipated adverse selection, an important yet frequently misunderstood technique is the use of option price tags. Some discussion of them is in order.

There are really two ways an employer finances a flexible compensation program. One way is to award benefit credits to individual employees, who then use the credits to buy the options they want.

The other way is the subsidy. Here, the employer assumes responsibility for the difference between total contributions for coverage and the actual plan experience.

Let's examine the subsidy approach. One's first reaction is that for the various options in a flexible plan, the total of the price tags should equal the experience under the plan. The issue, however, goes back to allocation.

For any individual in a group, the experience and contribution are not truly equal. An employer expects to allocate benefit credits to cover a certain amount of expenditures and to absorb other costs. In fact, in offering attractive options to a large number of people, it makes a lot of sense to use subsidies.

Consider the dental plan example. No matter how high we price dental coverage, we can't really beat adverse selection. When employees look at price tags, they make certain judgments.

If workers think their experience will be greater than the price, they elect the option; if not, they don't. If we price the option higher, the same judgment will be made.

So, if we want broad participation, we must charge less, subsidizing some of the experience, but making the option more attractive to more people. And because each person's expectations can't be based on absolute predictability, the larger base of participants will bring with it more predictability and help to cover our cost.

Price tags also can be used to motivate employee choice. That is, we use pricing to make certain options relatively more attractive than others. For instance, if a flexible plan offers two medical coverage options—a first-dollar option or comprehensive coverage with coinsurance—we can motivate employees, through pricing, to choose the option we consider better.

There is some evidence that when people choose lower coverage options, they become more careful health care consumers, because they have less to spend. If we think that assumption is valid, we should motivate employees to make the lower-coverage choice by pricing it invitingly.

Now an underwriter might be appalled by this approach and consider it adverse selection, because the total price tags paid by participants would be less than the experience under the coverage. If an employer, however, chooses to allocate compensation in ways that achieve a desired objective, a certain amount of adverse selection is perfectly acceptable.

In the real world of employee benefits, where employers make conscious choices about the allocation of compensation dollars, adverse selection is not a black-and-white issue.

It is clear that it has many ramifications, and more knowledge is needed so that it can be dealt with intelligently. Good research is called for in order to fully understand various group experiences under different forms of coverage.

One appropriate area of study is the predictability of various events relative to coverage cost. Another is the relative rationality of employee selections. Although the concept of adverse selection is predicated on the premise that employees, in making their choices, are perfectly rational, we know that people often act on emotion rather than reason.

With a growing number of flexible compensation plans now in existence for several years, we can begin to study the actual experience of different groups in a number of ways. It would be interesting to know how valid our premises have been.

Have we swung too far in the direction of allocating compensation based on need? Are some adjustments of the concept in order? Perhaps flexibility should be broadened to make insurance entirely optional for the employee.

Adverse selection is an important consideration in structuring flexible benefit plans, but it is certainly not the nemesis some think it is. ■

Lance D. Tane is manager of the flexible compensation team at The Wyatt Co. in Washington.

Continued from facing page

Employees need and want specific cases of how to use medical coverage wisely.

Many employees are receptive to doing their part, particularly lower-paid employees who are already concerned with inflation and waste in "the system."

"Hospitals charge *outrageous* prices for things—$8 for an aspirin. I told them I'd sell them a bottle-full!"

- Employees have been protected so well through the years that the real function of health care benefits has been lost.

"If you raise the deductible, I'll never get anything paid by the plan. My bills are never over $300 for the family."

Full payment for hospital costs has become an accepted way of life—and often taken for granted. For a mere stubbed toe, an employee can run to the emergency room and be covered 100% under the medical plan. Employees need to be reminded that the purpose of health insurance is to protect them from exactly what they fear most—unexpected catastrophic expenses.

- Some employees see no reason to care about rising health care costs. They believe that the insurer takes the risk involved in paying for medical expenses exceeding their contributions for coverage.

This even applies in companies that self-fund their health care, particularly if they have an insurance company administering the plan. Employees have no way of knowing that the company is footing the bill.

After all, the reimbursement check is signed by the insurance company. Once the concept of self-funding is introduced, employee support for cost control is boosted. Note two employee reactions:

"You mean it's *our* money directly paying for medical care? Now, I'm listening more. What we don't spend goes into our profit sharing."

"By calling it 'the Insurance Company plan,' everyone thinks it's some outsider paying for it. We're more likely to accept cost-containment efforts once we understand it's the company and us paying the bills."

- Employees are in awe of doctors and afraid to make waves in the medical community.

Physicians are traditionally respected, and somewhat held in awe, by members of the community. When one company suggested that specific questions should be asked of the doctor, a woman responded, "I'd be afraid to question my doctor. He might get mad and not want me as a patient."

But, employee behavior can change, particularly with preparation and encouragement. One company provided each employee, as well as local health care facilities, with a list of questions employees were "required" to ask the doctor and so removed the employee from the role of the "bad guy."

- Terminology common to benefit professionals can be interpreted quite differently by employees.

Some terms have strong connotations:

Clinic, for example, may mean a place for doctors to work when they can't get a job in a "real" hospital. This is a real deterrent to employees considering the new free-standing medical centers.

Reasonable and customary charges may mean the actual hospital costs, whatever they are, as long as that's what the hospital charges each patient.

Second opinion may mean looking for another doctor to say surgery cannot be performed even though the family doctor suggested it.

Coverage can mean the employee will incur no costs above premium payments.

For example, one employee noted: "You said the company would still pay the full cost of employee coverage. That's not true. There's a deductible, the 15% copayment and any charges over the reasonable and customary."

When an employer attempted to change employee behavior by encouraging use of outpatient clinics by paying only hospital charges within the reasonable and customary range and by requiring second opinions, these suggestions clearly can fall on ears that hear a different message.

Often, to an employer's surprise, some employees are quite receptive to cost-containment efforts: "The old plan was nice while it lasted, but it sounds like it was too nice."

On the other hand, cost containment can be reacted to very negatively by employees for reasons ranging from not recognizing or believing that there is a need to control costs to straightforward concern over reduced benefits.

Employee listening, to determine which of these patterns of opinions exists, can help the employee feel more comfortable about implementing cost controls. It also can give the confidence to implement even more significant cost controls than might otherwise be introduced.

By anticipating employee reactions and recognizing concerns, changes in the structure of health care benefits can be made with positive employee reaction. ■

Suzanne Kenney is head of employee listening services for Hewitt Associates, an employee benefit consultant based in Lincolnshire, Ill.

datebook

MARCH 27-30. 1984 Risk Management and Insurance conference in Cambridge, England, sponsored by the Assn. of Insurance & Risk Managers in Industry & Commerce; $492 plus value-added tax; discounts for AIRMIC, AEAI and RIMS members and for more than one registant from the same organization. AIRMIC, Plantation House, 31/35 Fenchurch St., London EC3M 7DX.

MARCH 28. One-Day Health Care Cost Containment seminar in Portland, Ore., sponsored by the International Foundation of Employee Benefit Plans; $140 for members; $165 for non-members. Also **March 29** in Los Angeles; **June 6** in St. Paul, Minn.; **June 7** in Rosemont, Ill.; **Sept. 6** in Boston; **Sept. 7** in Tarrytown, N.Y.; **Sept. 17** in Dearborn, Mich.; **Sept. 18** in Cleveland; and **Sept. 19** in St. Louis. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 28-30. Sixth Annual Energy Security conference in Denver, sponsored by the American Society for Industrial Security; $330 for members; $395 for non-members. Lewis Schneider, American Society for Industrial Security, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

MARCH 29-30. Introduction to Communications Safety seminar in New York, sponsored by the Computer Security Institute; $545 for members; $575 for non-members; group discounts available. Also **June 21-22** in Atlanta. Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

MARCH 30. Right to Know: Illinois Toxic Substances Disclosure Act of 1983 conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $80 for members; $120 for non-members. Also **April 10** in Chicago, **April 11** in Springfield, Ill. Illinois State Chamber of Commerce, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

APRIL 1-6. Workers' Compensation college in Tempe, Ariz., sponsored by the International Assn. of Industrial Accident & Insurance Boards & Commissions; $300 for members; $390 for non-members. J.T. Noblin, International Assn. of Industrial Accident & Insurance Boards & Commissions, P.O. Box 79109, Jackson, Miss. 39236; 601-366-4582.

APRIL 1-6. 22nd Annual Risk & Insurance Management Society conference in New York; $520 for members; $620 for non-members. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

APRIL 2-3. Industrial Hygiene and Safety Applications of Microcomputers course in Los Angeles, sponsored by the University of Southern California; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

APRIL 3. Surety Claims '84, Contract Bond Claims—"The Options" conference in Chicago, sponsored by CMA Consulting Group; $295. Arlene D. Brower, CMA Consulting Group, 170 E. Hanover Ave., Box 2287R, Morristown, N.J. 07960; 201-267-7171.

APRIL 5-6. 14th Annual Employee Benefits institute in New York, sponsored by the Practising Law Institute; $350. Nancy B. Hinman, Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

APRIL 5-7. Insurance Consultants Society Spring Educational conference in New York; $75. Barron S. Wall, P.O. Box 2326, South Hackensack, N.J. 07606; 201-343-8833.

APRIL 6. New Approaches to Increasing the Profitability of Your Offshore Insurance Company conference in New York, sponsored by Executive Enterprises; $495. Executive Enterprises, 33 W. 60th St., New York, N.Y. 10023; 212-489-2680.

APRIL 9. Professional Liability workshop in Philadelphia, sponsored by the Philadelphia Chapter of the Society of Chartered Property & Casualty Underwriters; $110 for members; $120 for non-members. Also **May 8** in St. Louis. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2735.

APRIL 9-11. Planning an EDP Disaster Recovery Program seminar in Chicago, sponsored by the Computer Security Institute; $750 for members; $795 for non-members; group discounts available. Also **June 18-20** in Atlanta. Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

April 9-12. Inspector Training seminar in Houston, sponsored by the International Safety Academy; $490. International Safety Academy, 1600 Arch St., P.O. Box 8527, Philadelphia, Pa 9101; 1-800-231-3147 or 215-241-5800.

APRIL 9-12. Seventh Annual Conference on Prevention, Behavior, Cleanup of Spills and Waste Sites sponsored by the Bureau of Explosives, Chemical Manufacturers Assn., U.S. Coast Guard and U.S. Environmental Protection Agency; $200 $150 for early registration 1984 Hazardous Material Spills Conference, 1629 K St. N.W., Suite 700, Washington, D.C. 20006; 202-887-1209.

APRIL 9-13. Advanced Instruction in Retirement Plans for Bank Trust Personnel seminar in Winston-Salem, N.C., sponsored by Booke & Co.; $775. Also **Sept. 24-28** in Winston-Salem. Booke & Co., P.O. Box 66, Winston-Salem N.C. 27102; 919-748-1120.

APRIL 9-13. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; $625. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001; 404-466-6001.

APRIL 10. Public Employees workshop in St. Paul, Minn., sponsored by the International Foundation of Employee Benefit Plans; $140 for members; $165 for non-members. Jordan Fox, IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

APRIL 12-13. 1984 National Workers Compensation seminar in Atlantic City, N.J., sponsored by Workers' Compensation Monthly; $195. Workers' Compensation Monthly, Box 829, East Falmouth, Mass. 02536.

APRIL 12-14. 1984 Employee Benefits Communications institute in Miami, sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

APRIL 16-17. 10th Annual Public Utilities workshop in Rosemont, Ill., sponsored by the American Society for Industrial Security; $270 for members; $360 for non-members. Lewis C. Schneider, ASIS, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

APRIL 18-20. End Crisis Management: Designing and Managing an In-House Retirement Planning Program workshop in St. Louis, sponsored by Retirement Advisors; $425. Discounts available for early registration. Also **May 16-18** in New York; **June 20-22** in Chicago; **Oct. 17-19** in Ft. Lauderdale, Fla.; **Nov. 28-30** in Dallas. Miriam Nacmanie, Retirement Advisors, 919 Third Ave., New York, N.Y. 10022; 212-421-2400.

APRIL 23-24. Captives: Making Optimum Use of the International Risk Management Tool seminar in New York, sponsored by the World Trade Institute; $570; discounts for subsequent registrants. World Trade Institute, One World Trade Center, 55W, New York, N.Y. 10048; 212-466-3162.

APRIL 24. Environmental Impairment Liability workshop in Rockford, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters and the Rock Valley Chapter of the Society of CPCU, $60 for members; $70 for non-members. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2735.

APRIL 24-25. 54th Annual Michigan Safety conference in Lansing, Mich., sponsored by the Michigan Safety Conference; $11 for one day; $16 for both days before April 14; $13 for one day, $18 for both days thereafter. John Sweeney, Michigan Safety Conference Headquarters, 3338 Christine Drive, Lansing, Mich. 48910; 517-882-3225.

APRIL 24-25. Managing Risks in the Electronic Data Processing Environment conference in New York, sponsored by the Institute for International Research; $750; group discounts available. Institute for International Research, 310 Madison Ave., Suite 1105, New York, N.Y. 10017; 212-883-1770.

APRIL 25-26. Physical Security: Technology and Practice seminar in New York, sponsored by the American Society for Industrial Security; $295 for members; $385 for non-members. Lewis Schneider, ASIS, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

APRIL 29-30. Public Employees conference in San Francisco, sponsored by the International Foundation of Employee Benefit Plans; $400 for members; $495 for non-members. IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

APRIL 29-MAY 2. Third Annual Employee Benefits symposium in Hershey, Pa., sponsored by the International Society of Certified Employee Benefit Specialists; $450 for members; $525 for persons holding CEBS designation. International Society of Certified Employee Benefit Specialists, P.O. Box 209, Brookfield, Wis. 53005; 414-786-8771.

APRIL 30. Using the NIOSH Guide to Manual Lifting seminar in Philadelphia, sponsored by the International Safety Academy; $145. International Safety Academy, 1600 Arch St., P.O. Box 8527, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

APRIL 30-MAY 4. Assets Protection II—Practical Applications course in Boston, sponsored by the American Society for Industrial Security; $650 for members; $695 for non-members. Susan Melnicove, American Society for Industrial Security, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

MAY 1-4. Risk Financing conference in Dallas, sponsored by International Risk Management Institute; $575 for three days; $450 for two days; $195 for one day. International Risk Management Institute, 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231; 214-363-9656.

MAY 2. Action on Health Care Cost Management seminar in Philadelphia, sponsored by Martin E. Segal Co.; free. Mary L. Feldman, Martin E. Segal Co., 730 Fifth Ave., New York, N.Y. 10019.

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MAY 3-4. EDP Physical Security seminar in New York, sponsored by the Computer Security Institute; $545 for members; $575 for non-members; group discounts available. Computer Security Institute Educational Resource Center, Department EERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

MAY 3-4. Legal Aspects of Occupational Safety and Health course in Los Angeles, sponsored by the University of Southern California; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

MAY 3-5. Radiation Safety Officers' workshop and refresher course in Banff, Alberta, for graduates of five-day RSO training program, sponsored by Applied Health Physics; $550. Also **May 10-12** in Washington; **Sept. 24-26** in Ottawa; **Oct. 16-18** in Pittsburgh. Robert Gallaghar, Applied Health Physics, 2986 Industrial Blvd., Box 197, Bethel Park, Pa. 15102; 412-563-2242.

MAY 6-9. Aviation Insurance Assn. annual convention in Nashville, Tenn.; $75 for members; $250 for non-members. John Leigh, Aviation Insurance Assn., Airport 17, Penthouse, 377 Route 17, Hasbrouck Heights, N.J. 07604; 201-353-1400.

MAY 6-9. The Employee Benefits Institute: Executive Program for Human Resources Managers in Waltham, Mass., sponsored by Brandeis University; $650. Nan Adams, Heller Graduate School, Brandeis University, Waltham, Mass. 02254; 617-647-2925.

MAY 7-11. Recognition of Occupational Health Hazards course in Los Angeles, sponsored by the University of Southern California; $650. University of Southern California, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, Los Angeles, Calif. 90089; 213-743-6523/6524.

MAY 9. Corporate One-Day Health Cost Containment seminar in Birmingham, Ala., sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MAY 9-11. Fundamentals of Insurance course in Boise, Idaho, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Also **June 4-6** in New York. Claudia Shnider, Administrator, Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MAY 13-19. Fourth Third World Insurance Congress in Casablanca, Morocco, sponsored by the Assn. of Insurers of Developing Countries; $274 for members or delegates; $550 for others. John D. Thomas, John David Thomas Inc., 401 E. 80th St., Suite 10F, New York, N.Y. 10021; 212-570-2338.

MAY 14-16. International Foundation of Employee Benefit Plans 1984 Trustees and Administrators institute in Las Vegas, Nev.; $420. Also **July 23-25** in Monterey, Calif.; **Aug. 13-15** in McAfee, N.J. Public Relations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MAY 14-18. Hazardous Materials: Handling and Disposal course in Los Angeles, sponsored by the University of Southern California; $650. University of Southern California, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, Los Angeles, Calif. 90089; 213-743-6523/6524.

MAY 16-18. Techniques of Loss Control seminar in Atlanta, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Also **Oct. 1-3** in New York. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MAY 21-23. Employee Benefits—Advanced course in Washington, sponsored by American Management Assns.; $695 for members; $800 for non-members. Also **June 25-27** in New York. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-0065.

MAY 21-25. American Industrial Hygiene conference in Detroit, sponsored by the American Industrial Hygiene Assn.; $65 for members, $90 for non-members before May 7; add $15 for registration after May 7. Stephanie Beidler, American Industrial Hygiene Assn., 475 Wolf Ledges Parkway, Akron, Ohio 44311; 216-762-7294.

MAY 22-23. "Your Western Frontier for Safety, Health, Fire and Security" exposition in Anaheim, Calif., sponsored by the Los Angeles Chapter of the National Safety Council; $25. Greater Los Angeles Chapter, National Safety Council, 616 S. Westmoreland Ave., Los Angeles, Calif. 90005; 213-385-6461.

MAY 24-25. Labor/Management workshop in Chicago, sponsored by Health Research Institute; $195. Also **June 14-15** in New York; **July 19-20** San Francisco; **Aug. 9-10** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 6-8. Techniques of Risk Management course in New York, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Claudia Shnider, Administrator, Continuing Education Program, RIMS, 205 E. 42nd St., New York, NY 10017.

JUNE 6-9. International Conference on Disability Compensation for Occupational Disease in New York, sponsored by the New York State Workers' Compensation Board and the Collegium Ramazzini; $300. New York State Workers' Compensation Board, Office of Communication, Information & Education, Room 4099, 2 World Trade Center, New York, N.Y. 10047; 212-488-3100.

JUNE 11-13. Techniques of Finance and Accounting course in Denver, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Also **Sept. 17-19** in Atlanta. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 13-15. Risk Management Information Systems course in San Francisco, sponsored by the Risk & Insurance Management Society; $545 for members; $645 for non-members. Claudia Shnider, Administrator, Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 18-20. 1984 Food Industry Institute Employee Benefits program in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

JUNE 18-22. Industrial Ventilation Fundamentals course in San Diego, sponsored by the University of Southern California; $650. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089.

JUNE 19-21. Risk Management in Environmental Health and Protection summer institute in New York, sponsored by New York University's Graduate School of Public Administration; $525. Charles Nicolson, Summer Institute in Risk Management in Environmental Health and Protection, Graduate School of Public Administration, New York University, 4 Washington Square N., New York, N.Y. 10003; 212-598-3133.

JUNE 19-22. 1984 Insurance Company Education Directors Society national conference in San Diego; $160 for members; $200 for non-members. Barry Shiller, California State Automobile Assn., Training Development Department, 150 Van Ness Ave., San Francisco, Calif. 94104-1860.

JUNE 20-22. Reinsurance Concepts course in New York, sponsored by Risk & Insurance Management Society; $495 for members; $595 for non-members. Also **Oct. 1-3** in San Francisco. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 17-19. Fundamentals of Industrial Exhaust Ventilation course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $400; group discounts available. John Garis, National Loss Control Service Corp., Long Grove, Ill 60049; 312-540-2026.

SEPT. 24-26. Highly Protected Risk Valuation seminar in Long Grove, Ill., sponsored by Kemper Group; $300. W.P. Thomas Jr., Manager of Engineering Reasearch and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

OCT. 21-24. Fourth International Benefits seminar in Chicago, sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

OCT. 22-26. Social Responsibilities of the Insurance Industry program in Bangkok, Thailand, sponsored by the East Asian Insurance Congress; $200 for members; $400 for associate members; $600 for non-members. M.C. Douglas, Thai Reinsurance Co. Ltd., General Insurance Assn. Building., 3rd Floor, 223 Soi Ruamrudee, Wireless Road, Bangkok 10500; 2514811, 2514826-9.

OCT. 29-NOV. 2. Advanced Property Conservation course in Long Grove, Ill., sponsored by Kemper Group; $400. W.P. Thomas Jr., Manager of Engineering Reasearch and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

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The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Canadian inflation outstrips pensions

TORONTO—Canadian pensions for retired employees have increased an average 4% per year during the last 10 years, a survey of 12 major Canadian employers reveals.

During the same 10-year period, the Canadian Consumer Price Index increased by an annual rate of 9.5%.

"A surprising result of our survey is that five of the large companies pay the post-retirement pension increases from the company's revenue, instead of from the pension fund," noted the survey, done by William M. Mercer Ltd., a compensation and benefits consulting firm.

"Employers paying supplements from revenue believe that this method provides more flexibility, involves less of a commitment for the future, is less likely to be challenged as being discriminatory and involves less government red tape."

The survey also indicates that all of the companies granted increases to their pensioners in the past 10 years. ■

Fireman's Fund decentralizes group underwriting

Fireman's Fund Insurance Cos. is decentralizing the underwriting of commercial group programs marketed by its FAMEX network of independent agents.

The reorganization, which began Feb. 27 and is expected to be completed by June 30, is intended to streamline the insurer's group insurance activities, said William M. McCormick, Fireman's Fund's chairman and chief executive officer.

FAMEX markets property/casualty and employee benefit products to members of 30 trade associations, dealer groups and franchise operations nationwide.

The underwriting of these programs, which had been managed by the insurer's commercial group headquarters in San Rafael, Calif., will now be handled by Fireman's Fund branch offices.

About 75 group programs are already underwritten through the branch offices.

markets

Intermediary formed

Summit Intermediaries Inc., a new reinsurance intermediary, has been formed by C. Rowbotham & Sons (Insurance) Ltd., a Lloyd's of London broker.

The new intermediary will specialize in the reinsurance of programs and association business.

The principals of the new company were all formerly associated with Wilcox Inc., a New York intermediary. The president of the new company is Robert C. Lonsdale, while Richard C. Standing, Richard D. Stary, Joseph R. Curcio and James C. Cerreta have been named vps.

Summit Intermediaries Inc. is located at 354 Eisenhower Parkway, Livingston, N.J. 07039; 201-740-1700.

HMO expands

Group Health Services of Michigan Inc., a health maintenance organization based in Saginaw, Mich., plans to expand both its service area and its range of services.

The HMO, a subsidiary of Blue Cross & Blue Shield of Michigan, will expand from the three counties it currently serves to a 12-county area in east and central Michigan.

The HMO also plans to offer a "mixed model" of prepaid medical, dental and vision services. The program will allow members to continue to be patients of private practice physicians, dentists and optometrists while belonging to the HMO.

The target date for the expansion is June of this year.

Agency franchises

Eighteen Pennsylvania agencies have joined ISU/InsurersGroup, a franchise network of independent agencies.

The agencies joining the group are:

- ISU/Albert L. Allen Co. of Harrisburg.
- ISU/Baugher Insurance Agency of Hanover.
- ISU/Chamberlin-Bovard Inc. of Scranton.
- ISU/The Dillsburg Agency Inc. of Dillsburg.
- ISU/Engle-Hambright & Davies Inc. of Lancaster.
- ISU/Friedman Insurance Agency of Harrisburg.
- ISU/Charles S. Gardner Associates Inc. of Blue Ridge Summit.
- ISU/Paul N. Garrett Agency Inc. of Camp Hill.
- ISU/Hazelton Insurance Center Inc. of Hazelton.
- ISU/Hockley & O'Donnell Insurance Agency of Gettysburg.
- ISU/Insurance Brokers of York in York.
- ISU/Huber Agency Inc. of Millersville.
- ISU/A.W. Lawrence & Co. Inc. in Harrisburg.
- ISU/McDowell Insurance Inc., with offices in Chambersburg, Greencastle, Waynesboro, Mercersburg and Carlisle.
- ISU/Owen Inc. in York.
- ISU/F.E. Parkhurst Inc. in Wilkes-Barre.
- ISU/Purdy Insurance Agency Inc. in Sunbury.
- ISU/C.A. Weber Agency Inc. in Hanover.

With the new additions, ISU now has 36 members in Pennsylvania and more than 500 franchises nationwide.

NYIE additions

The New York Insurance Exchange has added two new underwriting members and two new broker members.

MONY-RE Group Inc., a wholly owned subsidiary of MONY Reinsurance Corp., has been capitalized at $4 million and will write treaty and facultative reinsurance. The syndicate will be managed by MONY-RE Management Inc.

MML Syndicate Inc., a subsidiary of Massachusetts Mutual Life Insurance Co., has been capitalized at $5 million and will write both direct property/casualty insurance and reinsurance. Johnson & Higgins Willis Faber (USA) Inc. will manage the syndicate.

The new brokers are Inre International (New York) Ltd. and First Reinsurance Intermediaries Corp.

The number of underwriting members on the exchange now totals 44, and the number of brokers has reached 95.

Separately, the Exchange announced refunds totaling $600,000 to participating syndicates and brokers. The refunds, which represent 18.5% of the participants' 1983 assessments, resulted from higher-than-expected membership and premium volume.

PPO established

Metropolitan Life Insurance Co. has opened a preferred provider organization in Miami to offer health care services to its group insurance clients.

The new PPO, known as Met-Elect, has signed contracts with five Dade County hospitals to provide a broad variety of low-cost medical services. The Dade County School Board, with 28,500 employees, was the PPO's first participating employer.

Acquisitions

Conning & Co., a financial analysis and consulting company in Hartford, Conn., has acquired **International Insurance Financial Service** of Stamford, Conn., a source of financial information on non-U.S. domiciled property/casualty insurers. ■

comings & goings: buyers

Ameritech names Malone to benefit planning post

Harry A. Malone, 34, is now manager of benefit planning, a new position at Ameritech Corp. in Chicago. Mr. Malone had been manager of employee benefits at Continental Illinois National Bank & Trust Co. of Chicago. He joined Continental in 1975. Mr. Malone received a bachelor of science degree in personnel management and a master of business administration degree at Northern Illinois University in DeKalb. Mr. Malone reports to Roy Leet, director of benefits at Ameritech, the newly formed company that includes Illinois Bell, Indiana Bell, Michigan Bell and Ohio Bell.

* * *

Terrence A. Reiff is now director of the corporate risk and insurance department at Mead Corp. in Dayton, Ohio. He had been the manager of the department. Mr. Reiff is responsible for analyzing risk exposures, placing insurance coverage and designing protective systems for Mead and its affiliates. Before joining Mead in 1980, Mr. Reiff had been an assistant insurance manager for NCR Corp., also headquartered in Dayton. He earned his bachelor of arts degree in business administration from Michigan State University in East Lansing in 1966. Mr. Reiff also has earned a Chartered Property & Casualty Underwriter designation. Mr. Reiff reports to Robert E. Miller, Mead's treasurer.


Mr. Reiff

* * *

Douglas W. Payne was promoted to manager of corporate insurance, a new position, at American Electric Power Service Corp. in Columbus, Ohio. He is responsible for the property/casualty insurance programs of AEP and its subsidiary companies. Mr. Payne had been the supervisor of corporate insurance at AEP, which he joined in 1981. He earned his bachelor of science degree in physics in 1977 at Purdue University in West Lafayette, Ind. He received his master of business administration degree from the University of Dayton in 1983. Mr. Payne reports to Leonard G. Zawodniak, AEP's director of risk management.


Mr. Payne

* * *

Carmen Velez has been hired as the administrative assistant to the director of safety and risk management for the city of Corpus Christi, Texas. In this new position, Ms. Velez will assist the safety and risk management director in administering the city's property/casualty, liability and workers compensation insurance programs and in implementing safety programs. She previously worked part-time as a risk analyst for the San Antonio, Texas, school district. Ms. Velez earned her bachelor of business administration degree in insurance and risk management from St. Mary's University in San Antonio in 1983. She reports to Allen F. Hyman, director of safety and risk management for the city of Corpus Christi.


Ms. Velez

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Business Insurance would like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Claudette Dampier, Assistant Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5282. Please send a photograph, too.

State legislators oppose tort reform bill

By JERRY GEISEL

washington

WASHINGTON—Congress should not pass legislation that would establish a uniform federal product liability law, the National Conference of State Legislatures says.

"We ask that the federal government recognize instances where the state interest in jurisdiction outweighs the federal interest," Jeffrey Teitz, vice chairman of NCSL's law and judiciary committee, testified before the Senate Commerce Committee last week. "Products liability is one such instance."

Speaking on behalf of the NCSL, the offical representative of the country's 7,438 state lawmakers, Mr. Teitz said a provision in the federal product liability legislation, S. 44, proposed by Sen. Robert Kasten, R-Wis., would have the effect of denying citizens access to courts.

That provision, known as a statute of repose, would bar plaintiffs from filing suits against manufacturers of capital goods, like printing presses, if the goods are more than 25 years old.

Mr. Teitz, who also is a Rhode Island state representative and a practicing attorney, said the legislation's supporters have failed to produce significant statistical evidence that the lack of a uniform product liability law has increased the cost of products for consumers or forced companies out of business.

At the same March 5 hearing, several employer-supported groups, like the Product Liability Alliance and the Coalition for Uniform Product Liability law, testified in favor of the bill.

Official sentenced

The former president of a International Longshoremen's and Warehousemen's Union local has been given a prison term for fraudulently using funds from the union and a related employee benefit plan.

A U.S. District Court in Seattle sentenced Constantine Baruso to three years in prison. The court also barred him from serving as a union officer, employee or fiduciary of any employee benefit plan for five years and ordered h m to pay $5,000 to the ILWU Local 37 Cannery Trust.

Mr. Baruso was convictec last December by a Seattle jury on 16 counts of mail fraud and for embezzling more than $5,000 from Local 37 and the trust, the Labor Department said.

At the time of the acts Mr. Baruso was a delegate to the ILWU All-Alaska Council, president and business agent of Local 37 and a trustee of the Local 37 Cannery Trust, the Labor Department said.

The criminal conviction of Mr. Baruso resulted from a joint investigation by the Labor Department's Office of Pension and Welfare Benefit Programs and the Labor-Management Standards Enforcement office in Seattle.

Sanitation standard

The Occupational Safety and Health Administration wants agricultural employers to provide better sanitary facilities for farm workers.

In a proposed rule, OSHA says employers should be required to provide toilets, handwashing facilities and drinking water at field worksites.

Under the proposal, which would affect about 67,000 farms and 765,000 workers, employers would have to provide at least one toilet and handwashing facility for every 20 employees within a quarter mile of each employee's worksite.

Drinkable water also must be "readily accessible" to all employees, according to the proposal.

The new standard, which was published in the March 1 issue of the Federal Register, would cost farmers between $15.5 million and $22.5 million annually, or between 53 cents and 77 cents per worker per day, according to OSHA.

The proposal, however, exempts employers with less than 11 workers and those that employ only immediate family members.

In addition, the standard does not apply to agricultural workers inside permanent structures, like canneries, and does not require toilets and handwashing facilities for employees who work in fields for less than three hours a day, including travel time.

Comments on the proposal should be sent to OSHA Docket Officer, Docket No. H-308, Room S-6212, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. The deadline for comments is April 16.

Drilling accidents

Most fatal accidents in the oil and gas drilling industry occur when workers are struck by equipment or other objects falling, rotating or whipping around the rig area, the Occupational Safety and Health Administration says.

According to an OSHA study of 459 fatalities between 1977 and 1981 in the oil and gas well drilling:

- Some 27% of fatalities occurred when workers were struck by falling or rotating objects or equipment around the rig and surrounding areas.
- Falls from rig structures—like platforms, ladders, girders, tubing racks and other elevated work surfaces—caused 18% of the deaths.
- Some 17% of the fatalities occurred when workers were caught in, under or between rig components and equipment.
- Fires and explosions caused 14% of the deaths.

Copies of the report, "Selected Occupational Fatalities Related to Oil/Gas Well Drilling and Servicing," are available from the National Technical Information Service, Port Royal Road, Springfield, Va. 22161; 703-487-4650. The cost is $26.50 per printed copy or $4.50 for the microfiche version.

VDT dangers?

Women who work with video display terminals are more likely to experience an abnormally high rate of pregnancy problems, an office workers' union says.

Representatives of District 925 of the Service Employees International Union told a House subcommittee that their study of 300 airline telephone sales representatives found that half of the 48 pregnancies over a four-year period resulted in miscarriages, still-births, premature births and other problems. ■

Institute to study work comp problems

By CAROL CAIN

WALTHAM, Mass.—The Workers Compensation Research Institute, a new independent long-term research organization of employers and insurers, is picking which of the many objectives it will tackle first.

Slated for study by the information-gathering organization are:

- Occupational disease and cumulative injury.
- The relationship of workers compensation to other benefit systems.
- The factors influencing litigation and legal costs.
- Controlling health care costs.
- The relationship between the workers compensation and tort systems.

"We're still narrowing it down. . . .Over the next four to five years we will be doing (everything) on that list," said Richard B. Victor, executive director of the WCRI.

"The institute will engage in practical, empirical research on major public policy issues affecting the participants in the workers compensation system," Mr. Victor said. "We will be rigorous and objective in our approach, present our findings in understandable language and disseminate those findings widely."

Mr. Victor came to his new post after six years at The Rand Corp., serving in both its Santa Monica, Calif., and Washington, D.C., offices.

Mr. Victor, who has a doctorate in economics as well as a law degree, directed workers compensation research at Rand's Institute for Civil Justice.

"Our work will be very much like Rand—closely linked with current policy (both federal and state) concerns. We'll have policymakers and business executives as our primary audience," Mr. Victor said.

High expectations for the new institute, which began operations in November, were already being expressed last summer at the annual National Symposium on Workers' Compensation in Orono, Maine.

"The institute will have to carefully define its role in monitoring and analyzing the operation of the system," said Donald H. McComber at the Maine symposium. He is senior executive vp of Crum & Forster Corp. in Morristown, N.J., which is one of the insurer members of the new institute.

"In order for the institute to succeed, it must broaden its base of support. It must also spawn research that will become one of the tools for structuring change in the workers compensation system," Mr. McComber said.

"If it fails to realize either of these objectives, its usefulness will be somewhere between extremely limited and nil," he said.

"The WCRI's scope of research should be the middle ground between the global issues researched by the Institute for Civil Justice and the direct price-related research being undertaken by the National Council on Compensation Insurance.

"This middle-ground research should be of tremendous probative value not only to insurers, but also to self-insured employers, state funds and state industrial accident commissioners," Mr. McComber said.

The WCRI expects to parallel studies done by Rand and the California Workers' Compensation Institute in San Francisco, Mr. Victor said. It will be national in scope but won't become involved with pricing, like the NCCI's research, he added.

Operating on a $500,000 first-year budget, with funds from its employer and insurer members, the WCRI will supply the broad-based, non-partisan and interdisciplinary research required to produce the needed information to improve and preserve the current workers compensation system, Mr. Victor said.

'We will be rigorous and objective in our approach, present our findings in understandable language and disseminate those findings widely,' Mr. Victor says.

"We want to preserve what's good about the workers compensation system and through research bring about an orderly change in what should be improved," said John Eavenson, chairman of the institute's board of directors and vice chairman of Liberty Mutual Insurance Co. in Boston, Mass.

The institute will not take positions, but it is hoped it will provide forums for employers and insurers through conferences, seminars and papers.

The institute also is expected to serve as a clearinghouse for other work comp research, he said.

"Our feeling is this is one instance where the carrier and client can get together, analyze the system and get it to work better," said Albert Pearsall, insurance manager for Texaco Inc. in White Plains, N.Y., one of the three founding employer members.

"Over time, during the past five to 10 years, like everything else in the world, costs have gone through the roof," Mr. Pearsall said in giving reasons Texaco is putting its money behind the WCRI.

Other founding employer members include McDermott Inc., an energy services company in New Orleans, and Turner Construction in New York.

The institute has not made a concerted, systematic effort to solicit new members yet, but expects that the number of employers will outnumber insurers by the end of the year, Mr. Victor said. There are about 25 insurer members and six employer members now.

The membership drive will begin within the next couple of months, after the institute moves into its permanent offices in Cambridge, Mass. In the meantime, Mr. Victor is interviewing candidates for its research staff of four, to be supplemented by assistants and consultants.

Membership is open to all employers, insurers and other associations having a substantial interest in workers compensation.

Information about the institute is available from its temporary offices: P.O. Box 1609, Waltham, Mass. 02254; 617-647-9377. ■

Fidelity & Deposit names Joseph Eanes as new CEO

Joseph C. Eanes Jr. will become chief executive officer of Fidelity & Deposit Co. of Maryland in Baltimore May 3. He will succeed **H. Coe Culbertson** who plans to take early retirement, though he will retain his post as chairman of the board.

Mr. Eanes, who is now president of the corporate surety bond specialist, joined Fidelity & Deposit in 1958.

In addition, **Bernard J. Dorsch**, currently an executive vp, will become chief operating officer. Mr. Dorsch managed Fidelity & Deposit's Detroit and Milwaukee branch offices before being named executive vp.

Other insurer changes:

Dwight K. Bartlett elected president of Mutual of America, previously National Health & Welfare Mutual Life Insurance Assn., in New York. He had been the chief actuary of the company. Before joining Mutual, he was the chief actuary of the U.S. Social Security Administration.

Union Mutual Life Insurance Co. in Portland, Maine, promoted **Carl J. Sardegna** to executive vp for insurance operations. Mr. Sardegna, who had been senior vp of the employee benefits division, joined Unionmutual in 1975. In addition, **Richard B. Dalbeck** named first senior vp. He had been senior vp-corporate staff.

William R. Brick Jr. promoted to vp at Chubb & Son Inc. in Warren, N.J. Mr. Brick is national casualty claims manager, responsible for technical handling of all third-party claims. He has been with the company since 1965.

Richard J. Beidleman named vp-home office underwriting for Utica National Insurance Group in New Hartford, N.Y. He had been director of casualty underwriting.

comings & goings: industry

Agents/brokers

Mark R. Sheehan named chairman and chief executive officer of Twin City Group, a group of agencies based in Minneapolis. He had been president of the company. **Edward D. Bates** succeeds Mr. Sheehan as president. Mr. Bates had been the president of Twin City Administrators Inc., a third-party administrator and subsidiary of Twin City Group.

Albert G. Christensen named vp of Marsh & McLennan Inc. in Seattle. Mr. Christensen had been assistant vp in the Seattle office.

Excess/surplus

Scott L. Carey promoted to senior vp-claims administration at L.W. Biegler Inc., a Chicago-based managing general agency. He had been a vp at Biegler. Mr. Carey joined the company in 1978.


Mr Carey

Kenneth G. Cuprisin joined W.W. Vincent Co. in Chicago as vp and manager of the agency's new excess/surplus lines and special risk department. Mr. Cuprisin previously was with Illinois R.B. Jones Co. W.W. Vincent Co. is a subsidiary of Chicago Title & Trust Co.

J.H. Blades & Co. Inc. in Houston named **Albert J. Lusk** and **John C. Vint** vps. Mr. Lusk, who is vp-commercial property, is responsible for all underwriting and brokering for that Blades division. Mr. Vint is vp-petroleum/petrochemical properties division.

Other suppliers

John B. Gardiner joined Buck Pension Fund Services Inc. in New York as director of consulting services. Mr. Gardiner had been senior vp of the A.G. Becker Funds Evaluation Service.

Richard B. Hall appointed managing vp of Anistics' New York office. He was previously deputy managing vp at the firm. Anistics is the risk management consulting unit of Alexander & Alexander Inc.

Dale A. Comer is now president and vp-claims of Northland Adjusting Service Inc. in Kansas City, Mo. In addition, **George V. Ahrens** has named vp of operations. Northland is a claims adjusting firm. ■

TPF&C founder dies at age 89

Arthur U. Crosby, 89, founder and retired president of consultant Towers, Perrin, Forster & Crosby, died Feb. 17 in Philadelphia.

In 1934, Mr. Crosby joined forces with John A. Towers, Charles C. Perrin and H. Walter Forster to form TPF&C.

Mr. Crosby was born in Newton, Mass., and graduated from Yale University. He served with the French army in World War I and was awarded the Croix de Guerre.

NATLSCO offers hearing test analysis

Computerized analyses of hearing tests conducted by large companies are offered by National Loss Control Service Corp., a Kemper Group affiliate.

HEARS, an acronym for the Hearing Evaluation & Record Keeping Service, provides data management, analysis and review of audiometric tests conducted by employers.

Included in NATLSCO analysis are:

- An index and summary of the current hearing status of all tested employees.
- The hearing test results in chart and graph form.
- Employee notification letters.
- A quality assurance summary.
- A management summary, in charts and graphs, of employee test results.

Results are compared with previous hearing tests and existing Occupational Safety and Health Administration criteria. This helps employers spot workers who show a tendency for noise-induced hearing loss.

The analysis costs $2 per hearing test.

For more information, contact George Krafcisin, Vp-Health Services, National Loss Control Service Corp., K-3, Long Grove, Ill. 60049; 312-540-2022 or 800-323-9585.

Commercial package

The Atlantic Cos. is now marketing a commercial package policy that has the capacity to combine essential property, liability, auto, crime and umbrella coverages into a single policy.

Atlantic's Commercial Package Policy, designed for various types of policyholders, features expanded property/liability coverage, automatic extensions and fewer exclusions.

In most cases, limits are written to policyholder specifications.

The CPP contains a broad personal property coverage, including the property of others while in the insured's care, control or custody, with no legal liability requirement.

Automatic coverages include 60-day coverage on newly acquired property, with limits of $250,000 on buildings and $50,000 on personal property; valuable papers and records; extra expenses; and fire department service calls.

Consequential loss caused by temperature and humidity changes are covered, too, subject to contents' limit liability.

The broad-form comprehensive general liability coverage contained in the package includes protection of precious metals in the policyholder's manufacturing process; coverage for loss caused by backed-up sewers, drains or seepage and surface water; transit coverage; and theft from an unlocked vehicle.

Additional coverages that can be purchased include:

- Boiler and machinery coverage, with varying limits.
- Crime coverages, with up to a $2 million primary limit.
- Commercial auto and garage coverage, with limits reaching to $3 million.
- Commercial umbrella coverages, with a $20 million limit.
- Printers' errors and omissions designed for large printers or quick-print shops.
- Updated standard manufacturers' output policy, an alternative to standard property policies. It insures buildings, contents, production and products in transit, at a warehouse or at a seller's premises.
- Electronic data processing coverage, with varying limits.

For further information, contact John Gubernat, Product Manager, Commercial Lines, The Atlantic Cos., 45 Wall St., New York, N.Y. 10005; 212-943-1800.

products & services

Funding alternatives

A new monograph on alternative methods of risk funding is being offered by the Society of Chartered Property & Casualty Underwriters.

"Risk Retention: Alternate Funding Methods" contains six articles on topics like self-insured workers compensation self-insurance taxation, risk retention groups for hazardous waste facilities and captives.

The articles are written by industry executives and insurance educators.

The volume was edited by Numan A. Williams, professor of finance and insurance at Ball State University and editor of the CPCU Journal.

The monograph costs $22.95, including postage and handling charges.

To order, write the Society of Chartered Property & Casualty Underwriters, Kahler Hall, Providence Road, Malvern, Pa. 19355.

Health awareness

A two-step program of health education and risk assessment is offered to employee groups covered by State Mutual Life Assurance Co. of America.

The first component of the Wellcare program is health education. Employees receive a quarterly Wellcare newsletter containing health tips. Posters on different illness- and accident-prevention methods accompany the newsletter.

A booklet listing local health programs available to employees is also sent to workers.

The program's second component is health analysis. A confidential questionnaire on personal and family health is given to employees. Employees complete and return their forms to General Health Inc., a health analysis and wellness program organization in Washington.

General Health then sends the employee a personalized computer report with details on his or her risks of heart attack, stroke, auto accidents, cancer and other illnesses or injuries.

The health risk analysis costs $5 per employee. If 50 or more employees participate in the risk analysis, the employer receives a free group profile report.

After two years, State Mutual offers employers a follow-up health risk analysis program in which employee profiles cost half the price of the original profiles.

For more information on the Wellcare program, contact Hank Giles, Public Information Coordinator, State Mutual Life Assurance Co. of America, 440 Lincoln St., Worcester, Mass. 01605; 617-852-1000, extension 3099. ■

Asbestos compensation inadequate, study says

By STEPHEN TARNOFF

A recent study on the compensation of survivors of asbestos disease victims shows that current compensation methods are "grossly inadequate" when it comes to replacing lost wages.

The study, one of the first on occupational disease compensation, reports that overall only about 36% of the average net losses of survivors receiving compensation was replaced.

The study details how state workers compensation systems fail to adequately compensate asbestos disease victims.

It also notes that Social Security and private pensions, the only sources of income for the majority of widows of asbestos victims, also are inadequate.

Only tort awards to survivors are adequate compensation, the study notes. However, few widows were compensated by such awards in 1979, though the study does not take into account those plaintiffs who sued and were unsuccessful or cases where the proceeds from tort awards ran out before 1979.

The study included interviews with 792 survivors of victims of asbestos-related diseases concerning income they received in 1979. It was conducted by William G. Johnson, professor of economics at Syracuse University, and Edward Heler, assistant professor in the School of Public and Environmental Affairs at Indiana University Northwest in Gary.

The authors conclude that those who benefited from asbestos production—including asbestos producers—are, in effect, being subsidized by asbestos workers and their survivors.

"They (the results) demonstrate that those who benefit from the production and use of commodities, like those using asbestos, have not paid the full cost of their production," the authors say.

"They have, in effect, been subsidized by the workers who have died and by their survivors.

"Whether one wishes to measure social goals in terms of economic efficiency, morality or some common-sense definition of what is just, compensation that fails to pay even the net loss to the survivors of dead workers is grossly inadequate."

The study focuses on the adequacy and equity of benefit payments in 1979 for 249 widows whose husbands would have been working that year had they not died from asbestos diseases.

To measure how the widows' losses were compensated, the study uses a "replacement ratio," which is the ratio of compensation benefits to the survivors' net losses.

Average net losses in 1979 were 47% of gross wages, the study found, while the various compensation methods paid only 36% of the losses of the widows receiving compensation.

The study found that the 249 widows lost a total of $3.4 million during 1979, while only 124 of them received any benefits to reimburse them for their losses.

Benefit sources included workers compensation, tort awards, social insurance and private pensions.

The study found that workers compensation replaced only 36.2% of the losses of widows for whom it was the only source of income in 1979.

Those who also received other sources of income received from 44.7% to 58.4% of their net losses from workers compensation.

These figures are far below the normal standard that workers compensation benefits should equal 66⅔% of the worker's wages prior to death, the study says.

"...Workers compensation payments are not adequate," it says. "The conclusion is reinforced by the fact that our results include only the widows who received such payments.

"If the losses of the widows who did not receive workers compensation are included, the replacement ratios are substantially lower."

Tort awards were a much more successful way for widows to recover income, the study found. Losses were totally replaced for 11 of 12 widows who recieved income

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from tort awards during 1979.

But, the study shows that only eight of 11 widows would have received enough income from tort awards to replace their 1980 losses; the other three would have exhausted their award that year.

Most widows during 1979 received social insurance and private pensions as their only sources of income, the study shows. However, these benefits were even less than the amounts received through tort awards and workers compensation.

Benefits from social insurance and private pensions typically amounted to less than 30% of the widows' losses, and only those who combined these benefits with other sources were able to exceed their losses, the study found.

"The fact that these plans are the only source of income for most of the widows of workers killed by asbestos is further evidence of the failure of workers compensation plans and the common law," the study adds.

Overall, the study noted that about 55% of those receiving some form of benefits had less than 40% of their losses replaced. The figure would be much lower, however, if the 125 widows receiving no compensation were included.

Moreover, the study says that a large proportion of cases where the widows received above-average amounts are instances where their losses were low.

None of the 249 widows received public assistance, the study notes.

Those widows who did not receive benefits through workers compensation, tort suits, pensions or social insurance presumably received income from such sources as life insurance, their own wages, savings and assistance from relatives, the report adds.

The authors note that the results of the study show that the replacement for workers compensation is comparable with the results of a study on occupational illness done in the 1950s.

> 'Whether one wishes to measure social goals in terms of economic efficiency, morality or some common-sense definition of what is just, compensation. . . to the survivors of dead workers is grossly inadequate,' the study says.

"One would expect to find many changes in the structure of benefits and in benefit adequacy between the 1950s and 1979," the study says. The only important difference is in tort awards, which currently replace wages in significantly greater amounts than during the earlier study.

The study also examined the effect a bill in Congress introduced by Rep. George Miller, D-Calif., would have on the compensation of survivors. The bill would provide no-fault coverage for asbestos disease victims, but would take away the right to sue.

The study found that the bill would "substantially increase" the adequacy of compensation relative to workers compensation and suing in tort, but that it would also discriminate against survivors with relatively large losses.

"Had the Miller bill benefits been paid to the 560 survivors (of the 792 originally surveyed), 80.5% of the losses of 560 survivors would have been reimbursed," the study says.

"This is more adequate than our estimates for the small number of widows who received payments in 1979. The most important improvement, however, is the payment of benefits to widows who would not be paid under the current system."

Professor Heler notes that the Miller bill provides reasonable compensation for widows whose period of loss is between three and seven years. For those survivors of injured workers who lost more than seven years of work because of exposure to asbestos, the compensation is too little.

However, the bill "totally overcompensates" those who lose less than three years of wages, the study says.

Thus, for the younger workers who die in their 40s or early 50s, the Miller bill would not provide enough compensation. "It doesn't really cover young workers who become ill and die," Professor Heler says. "It (the compensation) very quickly deteriorates."

Professor Johnson added the study's estimates of losses and benefits are conservative, and that the replacement ratios cited are biased upward, if anything.

He said also that it was uncertain how the results of the study compare with the experiences of workers and survivors in 1983.

While more persons are aware of asbestos disease and more claims might be filed now, the replacement ratio might be less today because compensation programs have not kept pace with inflation, Professor Heler noted.

The study will be published soon in the Industrial and Labor Relations Review, a scholarly journal published by Cornell University. ■

london line

Court rules Lloyd's can punish members

By STACY SHAPIRO

LONDON—Lloyd's of London has the power to discipline its members for misdeeds they committed prior to the date when the Lloyd's Act of 1982 was enacted, the British High Court ruled last week.

Late last month, Lloyd's asked the court for a declaratory judgment on whether the new Lloyd's Act allowed the Council of Lloyd's to use its new disciplinary powers for alleged offenses that occurred before January 1983, while the old Lloyd's Act of 1871 was still in effect, or whether those members would receive what would amount to amnesty.

Peter Scott, an attorney for Lloyd's, argued that amnesty would have "very serious consequences, both for Lloyd's and for the members of Lloyd's."

"It means that the misconduct would go unpunished while the members remained in the society," he stated.

Two Lloyd's members, Thomas Raymond Brooks and Terence John Dooley, directors of Brooks & Dooley (Underwriting) Ltd., argued against Lloyd's during a two-day hearing last month, claiming that Lloyd's did not have the power under the new act to discipline members for offenses committed before 1983.

The two underwriters have been suspended by the Lloyd's Council while it investigates their syndicates' reinsurance arrangements.

The court ruled last week that the intention of the new Lloyd's Act was to update disciplinary procedures for offenses committed before 1983, not to ignore them.

"As I see the matter, it was the plain intention of Parliament to introduce a new method because of certain weaknesses of the old. I can find nothing, either in the 1982 act itself or in the general law, to prevent the new method and the new machinery from being applied to past events," the court stated in the opinion.

Messrs. Brooks and Dooley were ordered to pay the costs of the trial. They have 14 days in which to appeal the case.

The high court decision will affect three other investigations at Lloyd's, Mr. Scott pointed out. All three involve incidents that took place prior to the effective date of the new Lloyd's Act:

- The investigation into allegations of missing syndicates funds at Alexander Howden (Underwriting) Ltd. and Posgate & Denby (Agencies) Ltd.
- An investigation into similar allegations at syndicates managed by P.C.W. Underwriting Agencies Ltd.
- An investigaton of Multi-Guarantee Ltd., which administered and managed extended warranty policies that Lloyd's says were altered.

British benefits

The growth of employee benefits in Britain is adversely affecting the economy, concludes a major research project by Leverhulme Trust Co.

The researchers concluded that:

- Benefits usually are given to the already highly-paid employees who do not need the perks. A typical management official earning 25,000 pounds annually will receive another 12,500 pounds in benefits, including five to six weeks vacation, full sick pay, a large pension, a company car and subsidized housing.

In contrast, the lowest-paid British workers receive benefits worth only 3% of their salaries, the researchers say.

- Workers in industries where wages are the highest receive the best benefits.

In the insurance and banking industries, for example, the average employee receives one-third of his or her compensation in the form of benefits.

- Many of these benefits are given to employees to reduce the taxes they must pay on their total compensation.

"We conclude that the distribution of fringe benefits is unfair and unjust and that certain measures ought to be introduced by legislation," says the report.

"For example, tax (benefits) on occupational pension schemes is worth 5.1 billion pounds ($7.14 billion).

"(Benefits) represent an ineffective form of work incentive and they have channeled enormous subsidies into the pensions industry and the car industry, not only at the expense of other interests but also at the expense of democratic planning," says the report.

U.S. business

British insurance companies write just a small portion of U.S. risks, according to a new study.

The report, issued by Kluwer Publishing Ltd., says that British insurers, not including Lloyd's of London syndicates, collected only 3.9% of the total premiums written in the United States in 1982.

And, the report adds, most of these premiums were written by just six insurance companies: Commercial Union Assurance Co. P.L.C.; Royal Insurance P.L.C.; General Accident Fire & Life Assurance Corp. P.L.C.; Sun Alliance & London Insurance P.L.C.; Phoenix Assurance P.L.C.; and Guardian Royal Exchange Assurance P.L.C.

Although small, the British insurers' stake in the U.S. market in 1982 increased from their 1981 share of just 3.2%, the study notes.

British storms

Blizzards and windstorms in Britain could cost insurers more than 70 million pounds (about $99.4 million), the British Insurance Assn. announced.

Of this, Commercial Union Assurance Co. P.L.C. will be hit by claims as high as 10 million pounds ($14.1 million), says a CU spokesman.

However, few, if any, of the winter storm claims will come from the London area, where only a few snowflakes have been seen all winter. The claims primarily originate in Scotland and the northern regions of England.

These losses are considerably less than the losses of 1982 when snowstorms that paralyzed London produced claims of 250 million pounds ($352.5 million). ■

Honeywell plan features FSAs and PPOs

By MARGARET LeROUX

CLEARWATER, Fla.—The 10,000 employees and dependents at Honeywell Inc.'s Clearwater plant are sharing some of the costs and some of the savings from a new benefit plan.

And, if the new program proves to be successful, elements of the medical plan, dubbed HealthShare, most likely will be adopted by other Honeywell facilities throughout the United States, noted Larry Schenk, corporate manger of health care.

Although Honeywell's decentralized form of management means that "corporate headquarters doesn't dictate what individual plants offer as benefits," Mr. Schenk noted that "the HealthShare program is the most complete (of any other of the company's plans), having most of the elements we'd recommend."

One of the main features of the HealthShare program, which went into effect Jan. 1, is a flexible spending account, funded by Honeywell, that employees can use to pay non-covered health care and other benefit expenses.

In addition, the program gives employees the option of joining either health maintenance organizations or a new preferred provider organization.

The redesign of the Clearwater plant's benefit program was necessary because health care costs at the facility had been rising at an average annual rate of 21% compounded over the past five years, according to Charles Peters, the facility's manager of compensation and benefits.

The new program has the goal of "keeping employees and their dependents out of the hospital," Mr. Peters said. "And if they are in the hospital, our goal is to get them out as quickly as possible."

About the only extra cost to be borne by employees is a hike in their premium contributions to $22 per month for family coverage from $11 per month, no matter which option they choose. The contribution for those opting for individual coverage is now $15 per month.

The three coverage options employees can pick from are:

- A self-insured fee-for-service plan administered by the Travelers Insurance Co.
- A preferred provider organization called the Av-Med Health Plan. The PPO includes 23 area hospitals and emergency centers and more than 250 physicians and specialists.
- Three health maintenance organizations.

Under the traditional plan, employees must pay a $100 deductible for individual coverage and a maximum $300 deductible for family coverage. The plan then generally pays 80% of covered charges until an out-of-pocket limit is reached.

Employees selecting the PPO option, however, receive additional benefits.

For instance, deductibles do not apply when employees receive care from a preferred provider. If they do not, the fee-for-service plan deductibles apply.

In addition, employees receiving inpatient care at a PPO-member hospital pay only a 10% coinsurance charge, instead of the normal 20%.

Also, workers do not have to pay any coinsurance for physician charges in PPO-member hospitals, and office visits to a PPO physician are fully covered after a $5 per-visit charge.

"For employees who are willing to do some shopping, there are considerable savings available through the PPO plan," Mr. Peters said.

He used his own family as an example. "My wife has been seeing the same doctor for 20 years and she's not about to change even if he's not one of the contract providers, so we'll pay the 20% for her visits. But I'm willing to be more flexible and find a doctor who is a contract provider and get 90% of the charges paid.

"What's appealing about the PPO plan," he continued, "is that the level of benefits is determined at the time the service is utilized, not at enrollment."

In addition, Mr. Peters notes that some cost-containment features apply to both the PPO and the fee-for-service plans. For instance, any applicable deductibles are waived for pre-admission testing and for surgery performed the same day the patient is discharged. If a second surgical opinion is obtained, the 20% copayment for hospital inpatient charges is waived, even if members of the PPO plan do not use a member hospital.

Finally, the stop-loss limits in both the fee-for-service and the PPO plan have been lowered to $1,500 for individual coverage and $3,000 for family coverage. Formerly, the stop-loss limit was $3,000 per covered individual, so a family of five could have paid up to $15,000 a year in medical expenses.

Employees who choose the fee-for-service or PPO plans qualify for the HealthShare spending account; it is not available to employees enrolled in any of the HMOs.

The company contributes $15 per month to the accounts for an individual, $30 for a family. The account can be used to offset any non-taxable benefit expenses, including health plan deductibles and coinsurance (*BI*, Jan. 9).

Any amount left over in the HealthShare account at the end of year is paid to the employees in cash, although employees must pay income and Social Security taxes on the amount they receive.

Although the IRS challenged the legality of many types of flexible spending accounts in a Feb. 10 press release, Mr. Peters said there are no plans to alter the HealthShare program (*BI*, Feb. 20, March 5).

Currently, the Clearwater plant is the only Honeywell facility to offer a flexible spending account.

The PPO plan has been well-received by Honeywell employees at the Clearwater plant. According to the benefit manager, 30% of them shifted to the PPO plan at the beginning of this year, he said, adding that he expects the PPO plan to attract 50% by next year.

Prior to introduction of the HealthShare program, Honeywell studied approaches to health benefits for more than a year.

"We interviewed more than 400 employees about what they wanted and how they used their medical benefits," Mr. Peters said. "Our aim was to do what's fair and at the same time contain our costs."

New health benefit programs are expected to save the Clearwater Honeywell facility more than $30 million within the next decade. In 1982 alone, the company reports, the cost of medical expenses for employees at the Clearwater plant totaled more than $7 million.

Honeywell introduced the HealthShare program with a health promotion campaign that included free health screening for 30 different appraisals including hearing, blood pressure and lung capacity. "It was close to a free complete physical," Mr. Peters said.

A multicolor brochure announced the HealthShare program; it was mailed to employees at home "so that the spouses and dependents would be aware of the changes in the program and what their options would be," he said.

The program was further described to employees at hour-long meetings at the plant, where speakers and videotape presentations described the levels of benefits under the new program for six different types of employees, from a young single person to an employee nearing retirement.

All communications materials for the program were prepared in-house.

During the enrollment period, a hot line was established to answer employees' questions. It was manned by Mr. Peters and his staff who answered inquiries 24 hours a day for six days a week. ■

Medical program cuts could cost airlines

Continued from previous page

TWA lost 399 pilots to disability over the 18-year period, while ALPA—extrapolating from its 12-year age-adjusted rate—would have lost 546.

The assumed gain of 147 pilots saved TWA $44.5 million in disability insurance payments and $29.4 million in costs for training replacement pilots, a total savings of $73.9 million, the study concludes.

TWA spent about $12 million over the same period to maintain the preventive medicine program, giving it a 6-to-1 return on its investment.

The study also compares TWA's disability experience directly with ALPA's over the four-year period from 1976 to 1979. Here, TWA lost 99 pilots to ALPA's 151. That difference of 52 pilots translated to savings of $15.8 million in disability payments and $10.4 million in retraining expenses, a total savings of $26.2 million, the study concludes.

While the assumed savings of $6.5 million per year over the four years wouldn't have made the difference between profit and loss for the airline, it would have been significant: TWA's pretax net income moved from $24.2 million in 1976 to a loss of $27.2 million in 1979.

FAA statistics for the years 1978-1980 also indicate that airlines with their own medical facilities or cooperative agreements with outside facilities had lower pilot disability rates than those without.

Pilot certification denial rates for airlines with medical facilities averaged 2.8 pilots per 1,000 and ranged from a low of 1.4 per 1,000 for Northwest to a high of 4.8 per 1,000 for Pan Am.

Denial rates for airlines with no medical facilties averaged 8.3 per 1,000 and ranged from a low of 2.4 per 1,000 for St. Louis-based Ozark Air Lines Inc. to a high of 35.1 per 1,000 for New York-based Seaboard World Airlines Inc.

Some experts quibble with the reliability of all these numbers.

The FAA statistics, again, don't include many disabled pilots who know they won't be recertified and don't bother taking the exam.

ALPA's Dr. Masters also complains that the TWA study is "biased" because the 18-year span it examined represents a more recent period than the ALPA data it used for comparison, and that pilots' health is generally believed to have improved throughout the industry since 1955.

But Dr. Anderson points out the the head-to-head comparison between 1976 and 1979 still shows a savings, and Dr. Masters doesn't disagree with the study's conclusion that a preventive medicine program is a cost-saver.

Others, however, dispute the effectiveness of health maintenance programs, whatever the data may show.

"Preventive medicine programs are entirely dependent on the willingness of people to participate," said Eastern's Dr. Hutsor. "If a guy's got that kind of bent—that he wants to do something about his health—he's going to do it anyway.

"Pilots don't want airline medical services," he added.

Another area of disagreement is whether the absence of a pilot health maintenance program threatens safety.

Most aeromedical experts say that the FAA certification exam is enough to ensure that poor pilot health won't cause accidents.

"Flight safety is not an issue and if you look at the record, it's pretty darned good," said Dr. Gullett, a former TWA medical director who is now medical director and president of Harvey W. Watt & Co., a pilot loss-of-license insurance agency based in Atlanta.

Dr. Stanley R. Mohler, director of aerospace medicine at the Wright State University School of Medicine in Dayton, Ohio, found that at one unidentified airline, only one in-flight pilot incapacitation occurred for every 192,308 departures between 1960 and 1981. None of those incapacitations—caused mainly by acute intestinal problems—resulted in passenger injuries or deaths.

Others hedge on the question, though, and allow that medical department cutbacks might have some safety implications.

Dr. Anderson worries that outside doctors may be more interested in treating their pilot patients—particularly in cases of alcoholism or behavioral disorders—than in assessing their fitness to fly.

"That's my biggest concern about the changes that have taken place," he said.

It's also possible—though difficult to prove—that pilot medical problems are contributing to accidents officially attributed to "pilot error" by the National Transportation Safety Board, he said.

"There are no illustrative disasters—in that sense (airlines) can't be charged with being unsafe," Dr. Mohler said.

But the FAA certification exam by itself may not be enough to ensure safety and should probably be "augmented," he added.

"The bottom line in the airline industry is a crash," Dr. Mohler observed. "They can get away with anything until there's a crash. Then all hell breaks loose." ■

Cover denied to Nigeria, Brazil

LONDON—The British government agency that insures the credit risks of exporters is refusing to cover certain risks in the financially troubled countries of Brazil and Nigeria.

The Export Credits Guarantee Department has announced that it will no longer insure most British export business to Nigeria until negotiations to refinance Nigeria's trade payments are settled.

But the ECGD will continue to honor the credit insurance it already has underwritten covering British exports to Nigeria totaling between 600 million pounds and 800 million pounds, a spokesman said. And the agency may consider covering some long-term projects in the central African nation.

The ECGD is also scaling back its coverage for Brazilian credit risks.

The spokesman said the agency will not insure new Brazilian risks unless they are short-term projects lasting fewer than six months. But, he added, the ECGD is already committed to covering more than 500 million pounds of British export risks to the country.

The credit agency's move may have been spurred by its own financial difficulties. The ECGD suffered a $223.5 million underwriting loss in 1982 (*BI*, Oct. 10, 1983). But, last week, the agency assured Parliament that it will be able to fund its claims, though it may have to borrow from government funds. ■

Review of insurer statistics shows effects of soft market

By DIANE KASTIEL

A compilation of 1982 statistics for the property/casualty insurance industry paints a gloomy picture, reflecting trends that continued into 1983 and may persist in 1984.

The data contained in the 1983-84 edition of "Insurance Facts," a reference book published by the Insurance Information Institute, show a rapidly narrowing gap between investment income and underwriting losses, lagging premium growth and decreased insurance company earnings.

In 1982, the property/casualty insurance business suffered a record underwriting loss of $10.29 billion, up 63.5% from $6.29 billion in 1981. For every $100 earned in premiums in 1982, the industry incurred $110.09 in losses and expenses.

Faced with fierce competition, insurers' after tax earnings dropped 22.8% in 1982 from almost $7 billion in 1981 to $5.33 billion, according to the III.

Policyholders' surplus of $60.39 billion in 1982 represented a 12% increase over 1981 surplus. Although this is a healthier increase than the 3.1% reported in 1981, insurers added 20% and 23% to their surplus in 1979 and 1980, respectively, the publication notes.

Although net premiums written in 1982 by property/casualty insurers totaled almost $104 billion, a 4.7% jump from 1981, this increase was well below the 1982 overall inflation rate of 6.1%.

To further darken the property/casualty business' financial horizon, the gap between investment income and underwriting deficits narrowed in 1982. Although investment income reached a record high of $14.91 billion, this figure was only 1½ times the insurers' underwriting losses.

In 1981, the industry's investment income was almost double its underwriting losses.

Commercial insurance purchases made up $49.56 billion of total net written premiums. Workers compensation, commercial automobile, comprehensive general liability and commercial multiperil coverages made up the bulk.

Insurers reported underwriting red ink in all of these areas during 1982, except workers compensation.

The combined ratio in the workers compensation line was 94.0% in 1982, according to the III statistics. The commercial auto combined ratio was 110.1%; the ratio for general liability lines was 128.6%; and the commercial multiperil combined ratio stood at 115.6%.

Other commercial lines also reported combined ratios exceeding 100%. For instance, the medical malpractice combined ratio was a whopping 149.3% in 1982. Fidelity bonds posted a combined ratio of 113.5%, reflecting a decline in premium volume in this line for the first time since 1975.

The combined ratio for boiler and machinery insurance was 100.3%; the combined ratio for glass insurance was 105.2%; the inland marine combined ratio was 102.1%; and the ocean marine combined ratio stood at 112.9.%

However, a few lines reported combined ratios of less than the 100% benchmark. The fire insurance combined ratio was 97.4%; the surety bond combined ratio stood at 89.4%; and the burglary and theft insurance combined ratio was 94.5.%

In 1982, property/casualty companies paid out $5.9 billion in fire damage claims, $9.4 for crime losses and $1.5 billion for insured catastrophe damage, the III reported.

Employment in the property/casualty sector of the insurance industry increased by only 0.5% during 1982, according to "Insurance Facts," compared with a 4% increase in employment in the insurance industry in general.

However, these employment figures, compiled by the Department of Labor, do not include an estimated 270,000 independent agents and agency staff employees working in the industry in 1982.

Data compiled from the Equal Employment Opportunity Commission show that the number of women and minorities employed in the insurance industry continues to grow, and more women are becoming managers.

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Copies of the 1983-84 edition of "Insurance Facts," are available for $6.00 from the Insurance Information Institute, 110 William St., New York, NY 10038; 212-669-9200.

Judge tells Dalkon Shield producer to 'confess'

By STEPHEN TARNOFF

MINNEAPOLIS—Like a Puritan preacher calling down the wrath of heaven, a U.S. District Court judge has severely castigated the conduct of officials at A.H. Robins Co., the maker of the controversial Dalkon Shield.

In open court on Feb. 29, Judge Miles W. Lord accused the company's president, general counsel and director of research and development of engaging in callous and disreputable practices to the detriment of thousands of women.

He charged the men and the company with a systematic effort of delay and obfuscation, all for the purpose of protecting the company's bottom line at the expense of the health of women.

"The only conceivable reasons you have not recalled this product are that it would hurt your balance sheet and alert women, who already have been harmed, that you may be liable for their injuries," the judge said.

"You have taken the bottom line as your guiding beacon and the low road as your route. This is corporate irresponsibility at its meanest.

"You are the people with the power to recall, you are the corporate conscience," he added. "Please, in the name of humanity, lift your eyes above the bottom line."

Judge Lord's comments came at a hearing in which he approved the settlement of seven cases for a reported $4.6 million.

The Dalkon Shield, an intrauterine device used to prevent conception, was taken off the market in 1974. Claimants have alleged the device has caused infections of the uterus, in some cases causing the need for hysterectomies, and spontaneous abortions in pregnant women.

Robins has been self-insured for Dalkon Shield losses since March 1977. Although it has not discussed the limits of its previous insurance coverage, one plaintiffs' attorney has estimated that Robins has more than $325 million in coverage for the years between 1970 and 1977 (*BI*, Feb. 22, 1982).

After the hearing, Robins, based in Richmond, Va., vigorously denied the charges, saying that Judge Lord had "abandoned his role as an impartial arbiter" and that his comments were based on a "selective review" of the evidence.

The company also maintained that it has acted responsibly in the litigation.

Judge Lord urged Robins and its officials to confess to alleged misdeeds, inform victims of problems connected with the Dalkon Shield and recall the product.

"Confession is good for the soul, gentlemen," he said. "Face up to your misdeeds. Acknowledge the responsibility that you have for the activities of those who work under you.

"Rectify this evil situation. Warn the potential future victims and recompense those who have already been harmed."

Judge Lord said that if an individual—rather than a company—had without consent inflicted damage on one woman, he would be jailed for much of the rest of his life.

"And yet your company, without warning to women, invaded their bodies by the millions and caused them injuries by the thousands," he said.

"And when the time came for these women to make their claims against your company, you attacked their characters, you inquired into their sexual practices and into the identity of their sex partners.

"You exposed these women and ruined families and reputations and careers in order to intimidate those who would raise their voices against you.

"You introduced issues that had no relationship whatsoever to the fact that you planted in the bodies of these women instruments of death, mutilation and of disease."

Judge Lord said that he came to his conclusions only after months of reflection, study, cogitation and "no small amount of prayer."

He urged the Robins officials "to seek new horizons in corporate consciousness and a new sense of personal responsibility" for those working under them.

"It is not enough to say 'I did not know, it was not me, look elsewhere.'" he said.

In particular, Judge Lord assailed the legal practices of the company in its desire to avoid liability. Among the practices he disproved of were, "delay and obfuscation" in the litigation in courts across the country.

As an example, he cited a discovery matter in which Robins' personnel passed responsibility for answering "the hard questions."

In response to a question, according to the judge, the company's project manager said the question should have been addressed to the medical department, the medical department said it should be asked of the quality control department and that department said the question should be posed to the project manager.

The company also has sought to "segment and fragment" litigation of the cases, the judge added.

"The sheer number of claims and the dilatory tactics used by your company's attorneys clog court calendars and consume vast amounts of judicial and jury time," he said.

"Your company settles those cases in which it finds itself in an uncomfortable position, a handy device for avoiding any proceeding which would give continuity or cohesiveness to this nationwide problem."

As a result, no one plaintiff or group of plaintiffs can assert a sustained assault on the company's misconduct, he added.

Judge Lord said Robins has demanded that, as a price for settling claims, plaintiffs' lawyers must agree to never again take a Dalkon Shield case or help less experienced lawyers with cases against the company.

Judge Lord also contended that the company has persisted in asking that cases be transferred to other jurisdictions and to judges unfamiliar with the cases, so they will wait at the bottom of the calendar for months before they are heard.

The company has also attempted, through various "callous legal tactics," to force poor women not to file claims, he added. "Your target, your worst tactics were reserved for the meek and the poor.

"Despite your company's protestations, it is evident that these thousands of cases cannot be viewed in isolation, and that is one of the main reasons why I feel free to make this statement here today," he added.

"If every judge is terminated as soon as he catches on to what's going on, if you settle the case and flee the jurisdiction, that leaves no one to follow up to make any cohesivenss to this."

Judge Lord likened Robins' efforts to avoid punitive damages to the "poor and downtrodden" who commit crimes and then plead that they are crimes of survival and should be excused.

"But no court would heed this plea when the individual denies the wrongful nature of his deed and gives no indication that he will mend his ways," the court said.

"Your company in the face of overwhelming evidence denies its guilt and continues its monstrous mischief."

He added that until Robins changes its approach, an attempt to find a congressional solution to reduce punitive damages should not prevail.

"Until such time as your company indicates that it is willing to cease and desist this deception and seek out and advise victims, your remonstrances to Congress and to the courts of this country are indeed hollow and cynical."

The parties singled out by Judge Lord were E.C. Robins Jr., the company's president; William Forrest, its general counsel; and Dr. Carl Lunsford, Robins' director of research and development.

He accused Dr. Lunsford of hav-

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ing violated "every ethical precept" that every doctor must pledge when he takes the Hippocratic oath, and he told Mr. Forrest that he had "not brought honor" to the legal profession.

During the hearing, Judge Lord admitted to being biased in favor of the plaintiffs and acting as an advocate for their position.

"At the end of this case, after reviewing thousands of documents, looking at the briefs, reading the depositions and studying the depositions, I have concluded that the plaintiffs are right and that the things I say are based. . .on the record.

"You don't have to argue that I am prejudiced at this point," he responded to a Robins attorney. "I am."

In a prepared response, Robins vigorously objected to the judge's comments.

"Judge Lord's comments are not surprising in view of his previously expressed dislike of corporate America," the statement said.

"What is surprising and distressing is the fact that a federal judge has abandoned his role as an impartial arbiter and, acknowledging from the bench his prejudice against the company, became an open advocate for one side.

". . .The judge's comments, based on a selective review of only a part of the evidence that would have been presented had the cases been tried, constituted a gross abuse of judicial discretion and power.

"Contrary to the judge's accusation, the company believes it has acted responsibly in the handling of the Dalkon Shield. The court chose to overlook the fact that, in September 1980, Robins mailed a letter—recommending the removal of the Dalkon Shield from any women still using the device—to approximately 200,000 physicians, clinics and government agencies.

"At the same time, a news release was distributed to major wire services and newspapers in order to make the general public aware of the recommendation. The company believes this action was an adequate means of informing both the medical profession and any remaining users of the device of the desirability of removal.

"It should be noted," the company added, "that the (federal Food and Drug Administration) utilized essentially the same channels of dissemination nearly three years later when it issued a recommendation for removal of the device from remaining users."

According to Judge Lord, there are more than 3,000 Dalkon Shield cases pending across the country involving more than 9,000 women. ■

Florida city increases deductibles

APOPKA, Fla.—Employees of the central Florida city of Apopka will have to pay more for health care benefits as a result of plan revisions introduced late last year.

Deductibles were raised from $100 to $200 per individual and from $300 to $400 per family for the group medical insurance, underwritten by the Florida Municipal Health Trust Fund, an insurance program provided through the Florida League of Cities.

Once the deductible is reached, the plan pays 80% of annual costs up to $5,000, when full coverage begins. These coinsurance levels are the same as they had been under the old plan.

The city continues to pay employees' individual premiums at a cost of $64.12 per month per employee, up from $61.46 last year. Employees must pay the additional $99.88 charge for family coverage, which covers an unlimited number of dependents. That's up from $96.02 per month.

The new benefit plan also provides health maintenance organization coverage for the first time.

The HMO option, which went into effect March 1, is underwritten by CIGNA Healthplan Inc. Of the city's 130 eligible full-time employees, 99 joined the plan, city accountant Cheryl A. Martin said.

Premiums for employees who join the HMO cost the city $62.31 per month per employee. Dependent insurance costs employees $97.80 a month.

The HMO has no annual deductible, Ms. Martin said, but employees and dependents must pay $5 per approved doctor's office visit and $3 per prescription.

The HMO also covers dental services for the restoration of natural teeth and pays a portion of the cost of eyeglass lenses and frames. ■

Nevada closes Baptist church for not buying comp coverage

SPARKS, Nev.—The state of Nevada shows no favorites and grants no exceptions when it comes to enforcing its workers compensation law.

A Baptist church and its day school were closed by the Department of Industrial Relations last month because the pastor refused to purchase workers compensation insurance for the church's lone employee—himself—from the State Industrial Insurance System, Nevada's state work comp fund.

Nevada is one of six states that operate monopolistic state funds, though employers that qualify have been allowed to self-insure their workers compensation risks since 1972.

The church vs. state dispute began after the Rev. James Hollingsworth took over as pastor of the 20-member Grace Baptist Church in Sparks in June 1982. When the next quarterly workers compensation premium came due in October 1982, he didn't pay it.

After several attempts to collect the premium, the State Industrial Insurance System turned the matter over to the Department of Industrial Relations in August 1983. The department has jurisdiction over both the state fund and the self-insurers program in Nevada.

"We made several attempts to collect the money, but the pastor declined to pay the premium," said James Barnes, director of the department, who said the church's premium would be about $13 monthly.

A final notice was issued Feb. 13, and on Feb. 23 sheriff's deputies from Washoe County physically removed the Rev. Hollingsworth, who was teaching school at the time, and closed the building, which the church rents.

The school has been in existence since 1973 and the church since 1975, the Rev. Hollingsworth said.

Both sides were in Washoe County District Court on March 2 seeking injunctions. The state asked that the church's facility remain closed until the premium is paid.

The Rev. Hollingsworth, who argued for separation between church and state, asked that his facilities be kept open until the court makes a final ruling.

The pastor is representing himself in court. "I have a good lawyer in heaven," he noted.

Both motions were taken under advisement by Judge Peter Breen and a ruling on the injunctions is expected this month.

According to Nevada law, an employer with even one employee must purchase workers compensation coverage from the state fund.

"We've made no exceptions of any churches," said Laury M. Lewis, general manager of the fund, admitting that there are probably some churches, as well as other businesses not covered because they have gone undetected.

In fact, five churches that saw local stories about the Grace Baptist Church incident wrote letters to the state fund saying they didn't know about the law and wanted to purchase coverage, Mr. Lewis said.

Since the church was closed, the congregation has been losing members, the Rev. Hollingsworth said, and those left are "meeting secretly." The 20 children who attended the church's day school—a kindergarten through 12th grade program—at first met in homes, but they have since enrolled in other Christian schools in the area, he said. ■

British mining accidents decline in '83

LONDON—British mining accidents are decreasing, says the British Health and Safety Executive.

But, more care and attention to safety and the training of supervisors could reduce the accident rate even more, it notes.

Last year, 38 persons were killed and 865 injured in mining accidents in Britain. Most of the injuries were sustained underground in two separate explosions.

The Health and Safety Executive, however, expressed concern that too many miners suffered eye injuries last year. ■

Florida conditionally approves 10.1% workers comp rate hike

TALLAHASSEE, Fla.—A 10.1% average increase in workers compensation rates will take effect in Florida April 2 if the National Council on Compensation Insurance amends its rate request.

The ratemaking organization originally filed for an average 17.7% increase, but Insurance Commissioner Bill Gunter reduced the proposed increase "because the NCCI did not adequately take insurance company investment income into account and some of the data submitted was questionable."

The 17.7% increase would have resulted in an estimated $142 million rate hike, Mr. Gunter says. The 10.1% increase will result in an estimated $81 million rate hike.

The filing was conditionally approved March 1 but only if the NCCI makes changes so that the overall rate level will not exceed 10.1% and no increase for an individual rate classification exceeds 15%, said Dan Sumner, an attorney with the Florida Insurance Department.

Investment income of insurers also must be reflected in the profit contingency factor, which must be held to a minus 3%, he said.

The NCCI has until April 2 to make the changes. It also may ask for an administrative review of Commissioner Gunter's decision, but will probably go along with the order, according to R.E. Ferguson, director of government, consumer and industry affairs for the Florida NCCI office in Jacksonville.

The last change in Florida rates was an average 10% increase in December 1982. A 10% average rate hike was denied last September.

Admissions decline

MINNEAPOLIS—Some health care cost-containment measures being used by employers in the Minneapolis-St. Paul area are being cited as a key reason why annual admissions to area hospitals have declined by more than 14,000 between 1977 and 1982.

In addition, the average stay for the typical patient dropped by one-half day between 1980 and 1982 to 7.2 days, according to information compiled by the Council of Community Hospitals in Minneapolis.

The admissions and length-of-stay trends combined to cause a net decrease of 200,000 hospital patient days, said David Aquilina, vp of the council.

around the states

"The bottom line is clear—utilization is declining," Mr. Aquilina said, adding that preliminary data indicates that the downward trend has continued through 1983 and into 1984.

The increasing growth of non-hospital alternatives is partly responsible for the declining demand for inpatient services, he said.

Health maintenance organizations and other alternative forms of care—like freestanding emergency clinics, ambulatory surgery centers, community-based chemical dependency treatment facilities and home health care—all substitute outpatient care for inpatient care, eroding the market for traditional hospital services, Mr. Aquilina said.

"As demand declines, Minneapolis-St. Paul hospitals must also contend with public and private payers that are determined to contain their health care expenditures," he said.

PPO legislation

LANSING, Mich.—The state Senate Commerce Committee is studying legislation that would permit health insurers to offer plans identical to preferred provider organizations.

H.B. 5069—the "Prudent Purchaser Act"—would establish "prudent purchaser arrangements" that are similar to PPOs in other states.

These arrangements would provide coverage for services rendered by approved sources and pay providers on a fee-for-service basis, said Mary Anne Ford, administrative aide to the state House Insurance Committee.

Providers would be approved by each plan's insurer, said Robert C. Van Ravensway, a House Republican caucus research analyst.

Patients would be able to go to non-approved providers, but there would be some additional charge, like a copayment or deductible, Ms. Ford said.

"The provider and insurer are distinct," Ms. Ford said. "If an insurer thinks a provider is submitting excessive bills, it can take the provider off its approved list in the future."

The legislation was recommended last July by a state House ad hoc committee on health care cost containment, approved by the House in December and is now in the Senate Commerce Committee, where action is expected soon.

Hospital freeze

COLUMBUS, Ohio—Hospital construction and expansion in Ohio has been frozen until July 1 as a result of legislation signed by Gov. Richard F. Celeste.

During the moratorium, in which the state will not approve certificates of need for building by hospitals, 14 task forces will review the state's criteria for granting these certificates.

The recommendations of these panels will be designed to promote health care cost containment, a state Health Department spokesman said.

Also covered under the legislation will be proposals for construction of "urgent care centers," which are stand-alone for-profit facilities that perform the same services as hospital emergency rooms.

Emergency construction will not be prohibited during the moratorium period. ■

Bermuda pledges crackdown on violators of insurance law

By ROGER SCOTTON

HAMILTON, Bermuda—Finance Minister David Gibbons is promising an unprecedented crackdown on insurance companies that fail to comply with Bermuda's insurance law.

In a no-nonsense speech to the Bermuda Insurance Brokers Assn., Mr. Gibbons indicated that the government is fed up with hearing excuses from companies that have not filed annual financial reports, which are required under the country's 1978 Insurance Act.

The finance minister told the brokers that he had previously "deliberately avoided a sweeping, heavy-handed approach," and that insurers had been given "every opportunity to explain the cause for their delay and to rectify it."

In many cases, Mr. Gibbons said, there were "good reasons for the delay," but he added that the "government's patience is very nearly exhausted.

"And let me now put on notice those companies that have still not submitted their returns. In the future, reporting requirements will be strictly enforced," he told the brokers.

Mr. Gibbons warned that several courses of action for dealing with "delinquent companies" are open to the government, and he said he would "not hesitate to use the sanctions available, including the cancellation of an insurer's registration and winding up" the insurer.

The tough new policy follows several complaints from the industry, which has long argued that the credibility of the Bermuda insurance market has been eroded by the government's soft approach to regulatory enforcement.

But Mr. Gibbons did not restrict his strong talk to domestic issues.

Referring to the recent spate of insurance scandals at Lloyd's of London and what he called "abuses by members of your profession," the finance minister said that a number of these scandals have included a Bermuda connection, which had "tainted" the whole market.

"I, therefore, welcome the steps that the Lloyd's authorities are now taking to put their own house in order, even if it means that—in the short run, at any rate—the growth of Bermuda's insurance industry will suffer," he said.

He recommended that efforts to police activities in the London market "should be welcomed by all honest members of the profession," but he added there was little that the authorities in Bermuda can do to aid Lloyd's and British government authorities.

"Our responsibility," he told the brokers, "does not extend beyond insuring that insurance companies registered in Bermuda comply with all the requirements of the 1978 act. It must be obvious to all that our very status as an offshore center prevents us from exercising control over the flow of the funds into and out of Bermuda.

"If Lloyd's members have been illegally transferring funds here, then that is a matter for the U.K. authorities. For my part, I shall endeavor to ensure that the regulatory control I possess is exercised to the fullest possible extent."

While publicly washing his hands of responsibility for what he termed "the industry's external" problems, Mr. Gibbons said he regretted that each additional disclosure "casts another cloud over Bermuda and encourages those in the United States and the U.K. who would wish to curtail our developments as an offshore center."

Mr. Gibbons pledged the government's full assistance in helping the industry restore its image.

"If that means enforcing rigidly our own regulatory procedures, then so be it," he added. ■

Occurrence ruling

Continued from page 1

written by five insurers, was $28 million per occurrence and $28 million aggregate. Michigan Chemical has been indemnified to the limits of its policy for 1973.

Travelers Indemnity Co. of Hartford, Conn., provided $1 million in primary coverage to Michigan Chemical. Excess insurers included Lloyd's of London, $2 million excess of $1 million, and American Home Assurance Co. of New York, $15 million excess of $3 million.

A final $10 million excess of $18 million is shared equally by Aetna Casualty & Surety Co. and Insurance Co. of North America, part of CIGNA Corp.

However, the lawsuit names as defendants only American Home, Aetna and INA, plus a reinsurer.

Travelers and Lloyd's are not named in the coverage suit. To be dismissed from it, Travelers paid the chemical firm an additional $1 million and Lloyd's paid an additional $2 million, bringing to $31 million the amount of insurance recovered by Michigan Chemical.

The reinsurer named in the suit is Midland Insurance Co., which reinsured some of American Home's liability.

However, American Mutual Reinsurance Co. (Amreco), which reinsured Midland, intervened in the suit on the side of Michigan Chemical. Its reinsurance obligations expired in 1973 and so it is hoping for a coverage ruling in which the majority of damages fall in the 1974 policy year.

The American Home and Aetna policies followed the terms and conditions of the Lloyd's policies while INA followed the Travelers' policy. However, both the Lloyd's and Travelers' policies essentially define occurrence the same, the appeals court said.

The Travelers policy, for example, says, "'Occurrence' means as respects property damage 1) an accident or 2) continuous or repeated exposure to conditions which results in injury to or destruction of tangible property, including consequential loss resulting therefrom, while this agreement is in effect. All damages arising out of such exposure to substantially the same general conditions shall be considered as arising out of one occurrence."

Michigan Chemical argued that under this definition and prior case law, each claim filed against it was an occurrence. It contended there could be no occurrence until injury took place since an indemnifiable event arises only when damage is suffered and not at the time of the insured's abstract act of negligence.

The insurers argued, however, that the occurrence was the accidental shipment of the PBB and that the number of occurrences was governed by the cause of the accident rather than its effects.

The appellate court agreed with the insurers, holding that occurrence is based on the cause of damage and not the number of injuries or claims.

It based its decision on the "vast majority" of prior court decisions and the language of the policies. The court said there was only one reasonable interpretation of the policy and, thus, it was not ambiguous and should not be construed against the insurers.

"The vast majority of courts have concluded that although injury must be suffered before an insured can be held liable, the number of occurrences for purposes of applying coverage limitations is determined by referring to the cause or causes of the damage and not to the number of injuries or claims," the court said.

In rejecting Michigan Chemical's arguments, the court also said it made no difference that there was a gap of several months between the shipment of the PBB and the subsequent damages for determining the number of occurrences.

There was a vigorous dissent by Judge Damon Keith, who contended that occurrence took place at the time the damage resulted and not at the time of shipment.

He contended that the language of the policy and prior cases supported such a ruling.

"It is well established that liability does not result until harm occurs," he said. ". .An indemnifiable event does not arise at the time of some abstract act of negligence, but rather at the time it results in injury or harm."

Judge Keith said the other judges erred because they relied on employment discrimination cases as precedent rather than product liability cases. He said the decision did not recognize the principle that an insurance policy must be interpreted in a way to make sense of it as a whole.

"An examination of the definition of products liability in the instant policy makes it apparent that the majority's interpretation of occurrence runs contrary to this principle," he said.

"Indeed, the majority's interpretation deprives the policy's products liability section of any reasonable meaning."

Quoting the definition of product liability in the Lloyd's policy, Judge Keith said product liability coverage applies only to occurrences away from the insured's premises and after the goods have been transferred.

"Yet, if occurrence means the misshipment or cause of injury, then there could not be liability (on the insurers' part) in this case because neither occurred away from the plant," he said.

"At most, an examination of the policy language and consideration of arguments as to its intended merits lead to a conclusion that occurrence should be construed as taking place at the time injury results. At the very least, one must find the terms ambiguous."

Noting the dissent by Judge Keith, Robert Finke, an attorney for Michigan Chemical with the Chicago firm of Mayer Brown & Platt, said that he will ask the three-judge appellate panel to rehear the case and then ask for a hearing with the full appellate court.

He said also said it is possible more than one misshipment of PBB occurred, which would entitle the firm to more coverage.

Attorneys for the defendant insurers were pleased with the decision because they say it goes against the trend of courts' efforts to maximize coverage by finding that an insurance policy is ambiguous.

"We're very, very pleased with the result. It is significant decision in insurance law," noted Michael J. Walter, an attorney representing American Home with the Detroit law firm of Tyler Reynolds Kenny & Thayer.

Mr. Walter said that "one of the interesting things" about the case is that it specifically rejected the district court's finding of ambiguity in the language of the policies.

Mr. Walter added that the decision is not a setback for policyholders. "In the long run the effect won't be to restrict coverages or stick policyholders," he added, but it does add to the certainty of the meaning of the terms contained within the policy.

James Ferrini, an attorney for INA with the Chicago firm of Clausen Miller Gorman Caffrey & Witous, said the decision "means an awful lot as to coverage. It has national implications."

Several of the insurer attorneys also said that there appeared to be only one shipment of PBB and, thus under the decision, only one occurrence.

Mr. Finke, representing Michigan Chemical, said more than 1,300 claims involving several hundred lawsuits have been disposed of by Michigan Chemical and the Farm Bureau Services.

About 50 lawsuits remain. However, the defendants have won the four cases that have gone to trial, Mr. Finke added. ■

NAIC ratemaking report criticized

Continued from page 2

surer profits and already takes insurer investment income into account. Since competition affects rates differently for each insurer, it also holds down excesses in a more practical and specific way than can be accomplished with any type of rating model, they say.

"In the insurance marketplace of today, competition exists," explains Michael J. Velotta, counsel for Allstate Insurance Group, a subsidiary of Sears, Roebuck & Co. "This has been demonstrated by many independent studies of the property/casualty market and displaces the need to prevent excessive profits by (rate of) return regulation.

"The NAIC has previously explored the issue of the efficacy of competition as a regulator of rates and has embraced the concept of competition as an effective measure of regulting rates and...in turn, the return on property/casualty insurance," he says.

"Allowing the competitive forces to operate fully does assure that income from all sources is considered in determining equitable prices," added R.L. Jewell Jr., vp of the National Assn. of Independent Insurers. "Competition has worked and should be permitted to continue working to hold down prices and profits in the insurance industry."

Moreover, market competition is a better measure of rate adequacy than a financial ratemaking model because of financial variations among individual insurers, according to Kim Brunner, government relations officer for Nationwide Insurance Cos.

The NAIC recommendation, he says, errs by treating the insurance industry as a monolith rather than a collection of individuals.

"This approach seriously limits its potential utility to the majority of insurance regulators whose duty it is to evaluate the rate filings of hundreds of insurers to numerous lines of insurance. Thus, the report does not provide guidance on how the regulator should respond to the differences from insurance company to insurance company, which are substantial."

Other speakers also attacked assumptions behind the NAIC recommendations.

For instance, economist Irving H. Plotkin, testifying for several of the trade groups, attacked the NAIC assumption that the insurance industry has a lower level of financial risk than other types of business.

"The report is internally inconsistent and contradictory," Mr. Plotkin said.

Phillip Schwartz, vp-accounting and financial reporting for the American Insurance Assn., urged the NAIC also drop its suggestion that ratemakers be compelled to use Generally Accepted Accounting Principles (GAAP).

Although GAAP accounting is designed to allow companies in all industries to report to shareholders uniformly, it is not an appropriate technique for a general ratemaking model, he says.

GAAP reporting, he explained, is historical in its purpose and influenced by nationwide financial factors that should not affect ratemaking.

"It is better suited for individual company reporting than for industry reporting," he says.

Rodger S. Lawson, vp and director of research for the Alliance of American Insurers, added another complaint: the draft report's failure to consider mutal and other nonshareholder-owned insurance companies.

"This might be viewed as a simple oversight if it were confined to just one section of the report. However, a close reading showed that nowhere in the exposure draft are the special problems of non-stock companies addressed," he says. ■

Study tracks cost of back injuries

NEW YORK—Lower-back pain injuries account for 25% of all lost-time workers compensation claims and are expensive to treat, reports a recent survey.

But the average lost-time and medical cost of a disc injury is almost five times that of the average cost for all other back injuries, the study shows.

"Disc claims are more serious and, accordingly, cost more to treat," said David Appel, assistant vp with the National Council on Compensation Insurance, the ratemaking organization that compiled the study.

The study's findings are based on the results of the NCCI's "Call for Detailed Claim Information," instituted in 1979. Information from more than 300,000 claims from 13 states were gathered and put into the NCCI's data base, Mr. Appel said.

The average cost of a disc claim was $23,250, more than four times the average cost of lower-back sprains ($5,515) and five times the average cost of lower-back strains ($4,203).

A disc injury is five times as likely to be a permanent total disability than a back sprain or strain, and 6.5 times as likely to be a permanent total disability.

More than 50% of disc injury claimants receive permanent disability benefits, compared with about 10% of claimants with back sprains and strains, according to the report. The duration of the average disc injury is a little more than six times that of the average back sprain or strain.

Because disc injury claimants tend to be somewhat older than strain or sprain claimants, costs are higher, the report notes. This is because older workers, whose wages tend to be higher than younger workers', also tend to recover from injuries more slowly.

Also, claimants with disc injuries are three times as likely to be represented by an attorney than claimants with back sprains and strains, the report says.

"The likelihood of attorney representation increases with the severity of the claimant's injury," Mr. Appel said. ■

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Associations	1,133
Government, Unions, Educational Institutions	799
Commercial Consumers Sub-total	**24,376**
Insurance Agents & Brokers	9,655
Insurance Cos.	5,461
Financial Institutions	441
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,977
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*Source: Business/Occupational breakdown of qualified circulation, November 7, 1983 issue, as submitted to BPA for December 1983, BPA Publisher's Statement.

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Notice is hereby given that the Southern California Rapid Transit District will receive proposals for Design and Administration of an Owner-Controlled Insurance Program for the Metro Rail Project, per requirements on file at the Office of Contracts Procurement and Materiel, 124 West 4th Street, Los Angeles, California 90013

All proposals must be submitted according to the format furnished by the Southern California Rapid Transit District, and must be submitted to the Office of Contracts Procurement and Materiel on or before 4:00 P.M., April 6, 1984. Each proposal must be sealed and marked "RFP #048406".

This RFP is for the same services described in the District's RFP #118330 issued on November 1, 1983. On February 23, 1984, the District Board of Directors rejected all responses to RFP #118330, and ordered issuance of a new RFP for those services. No proposals submitted in response to RFP #118330 shall be considered valid as responses to RFP #048406.

The District reserves the right to reject any and all proposals, and to waive any informality in the RFP process. All proposal submitters will be required to comply with all applicable equal opportunity laws and regulations. The resulting contract will be subject to a financial assistance agreement between the District and the U.S. Department of Transportation.

All proposers will be required to certify that they are not on the Comptroller-General's list of ineligible contractors.

The District hereby notifies all proposers that it will take affirmative action to insure that Disadvantaged and Women Business Enterprises will be afforded full opportunity to participate in any contract which may result from this RFP. Proposers will not be discriminated against on the grounds of race, color, national origin, religion, age or physical handicap in consideration of contract award.

For further information contact Don Heida at (213) 972-6147.

Maynard Z. Walters
Director, Office of Contracts,
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Panels OK ban on comp reserve deductions

Continued from page 2

Under the proposed economic performance test, a tax deduction wouldn't be allowed until an employer's liability is actually discharged by payment from a reserve fund.

The proposed rule would apply not only to workers compensation self-insurers, but to any taxpayers that establish reserves to meet future liabilities. These might include mining companies that must pay future land reclamation costs, or utilities that must meet future nuclear power plant decommissioning costs.

Although structured settlements aren't specifically singled out, experts believe these also would be affected by the proposed rule.

Currently, companies in some situations may take a tax deduction for the entire cost of a structured settlement in the year the agreement in reached (*BI*, Feb. 20).

The proposed rule would eliminate "unwarranted tax benefits" to employers that might overstate the amount of their future liabilities, said Ronald A. Pearlman, deputy assistant treasury secretary for tax policy, in testimony before a Ways and Means subcommittee.

The overstatement could come from a failure to recognize the "time value of money." Investment income earned on reserves before payout occurs may boost the value of those reserves far beyond the actual cost of the liability, Mr. Pearlman testified.

Self-insurers and their representatives have argued against the economic performance test, however.

"The Treasury is perpetuating an unfair and discriminatory practice" in barring deductions for self-insurers while allowing commercial insurers to deduct reserves, said Douglas S. Stevenson, executive director of the National Council of Self-Insurers and an attorney with the Chicago firm of Rooks, Pitts, Fullagar & Poust.

Mr. Stevenson and others say that the Treasury Department, which intends to increase revenue with the proposed rule, will actually lose funds by driving self-insurers to the commercial marketplace. Employers then would be able to deduct their premium payments, while insurers would boost their reserve deductions.

Opponents suggested alternatives to the economic performance test. For instance, they suggested that reserve deductions be permitted for workers compensation payments to be made within five years.

Another alternative would be to allow a deduction for the discounted present value of future liabilities, Mr. Stevenson said.

The Treasury Department considered allowing deductions for such discounted future expenses, but concluded that it would result in "unmanageable uncertainty and undesirable complexity," Mr. Pearlman testified.

The discounting alternative would require a complex set of rules for the recalculation of overstated and understated deductions in cases in which actual payments differed from what was projected, he explained.

The economic performance test would avoid the "administrative burdens" imposed by discounting, he said.

Mr. Pearlman's testimony dealt only with discounting of companies' accruals of future expenses, and didn't directly address the question of reserve discounting for property/casualty insurance companies.

The General Accounting Office recently concluded that insurers are getting an unwarranted tax break in their ability to deduct the full amount of their reserves based on estimates of future claim payments (*BI*, Feb. 13).

The GAO draft report, now circulating among trade associations for comment, recommends that insurers be required to discount loss reserves to reflect investment income they will earn on the reserve funds in the future.

A Treasury Department spokesman said that Mr. Pearlman's testimony doesn't necessarily reflect the department's position on discounting property/casualty reserves.

The Treasury Department is now looking at the possibility of discounting property/casualty reserves in response to the GAO report but has not yet reached any conclusions. ■

Agency rules on Morrow's death

LOS ANGELES—The National Transportation Safety Board has ruled that debris from a special-effects explosion caused the helicopter crash that killed Vic Morrow and two others actors during the filming of the movie "The Twilight Zone."

The report also says that poor communication between director John Landis and pilot Dorcey Wingo contributed to the July 23, 1982, crash.

The decision is regarded as a boost to two pending civil suits filed on behalf of the child actors killed in the accident. The family of Renee Shinn Chen is seeking $100 million in compensatory damages and $100 million in punitive damages. The family of My-Ca Dinh Lee is seeking an unspecified amount.

In July 1983, a grand jury indicted Mr. Landis and Mr. Wingo on voluntary manslaughter charges, along with Dan Allingham, the film's production manager; George Folsey Jr., its associate producer; and Paul Stewart, the production's chief of special effects.

A judge is expected to decide next month if there is sufficient evidence for a criminal trial. ■

Malpractice insurer to be liquidated

Continued from page 2

surance was designed to provide coverage for retiring attorneys or attorneys quitting their practice."

Since underwriters assumed that the purchasers of tail insurance would be primarily retirees who had been curtailing their practice for some time, the special coverage was inexpensively priced.

However, attorneys who switched their current liability insurance also began to buy the low-priced tail insurance to fill in coverage gaps, increasing the insurer's liabilities without adding significantly to its premium base, according to Mr. Threadgill.

"LPLIC officers told us that they had poured nearly $11 million into the company and it still wasn't enough. Liquidation was the only answer," he says. ■

Attack on benefits

Continued from page 1

trust each year could be received by the highest-paid 10% of the workforce.

A 501(c)(9) trust, named for the section of the Internal Revenue Code authorizing it, allows employers to receive tax deductions for contributions to the trust. In turn, the trust's assets and interest earned are not taxed.

The trusts pay for a wide variety of employee benefits, especially health care and long-term disability coverages.

• Extend a freeze on maximum pension benefits and contributions for two additional years.

This proposal would extend—until 1988—a cap on how much an employer may contribute to a defined contribution plan and how large a benefit may be paid by a defined benefit plan.

Employer contributions to pension plans are tax-deductible.

The current maximum annual contribution an employer may make to a defined contribution plan, like a profit-sharing plan, is $30,000. The maximum annual benefit that a defined benefit plan may provide to an employee is currently $90,000.

The Tax Equity and Fiscal Responsibility Act of 1982 froze these limits until 1986, after which the caps were supposed to be raised to match annual increases in the Consumer Price Index.

• Establishing permanent rules on taxing benefits, like employer-provided parking spaces, that are not covered by a specific section of the tax code.

Those rules, identical to those included in a much smaller deficit reduction bill approved last year by the Ways and Means Committee, also would prevent cafeteria benefit plans from offering taxable benefits, with the exception of group term life insurance exceeding $50,000 and extra vacation days (*BI*, Oct. 10, 1983; Aug. 1, 1983).

Currently, some cafeteria plans offer a choice of taxable benefits like financial counseling and group auto and homeowners insurance.

• Barring employer-sponsored retirement plans that are funded solely by employee contributions.

Since contributions to these plans are made with aftertax dollars, the employee is not taxed again when he withdraws the contributions.

However, the contributions to these plans also accumulate interest tax-free until the funds are withdrawn, giving employees significant tax advantages.

It is not known how many of these plans exist.

This proposal, though, would not affect individual retirement programs, like Individual Retirement Accounts and Keogh plans.

While the benefit proposals approved by the Ways and Means Committee last week would have profound effects on many employers if they are enacted, a suggestion by one member of the Senate Finance Committee would have even more severe repercussions.

Sen. John Danforth, R-Mo., suggested to the Finance Committee last week that Section 125 of the tax code be repealed.

Section 125, which was added to the tax code in 1978 by Congress, popularized cafeteria benefit plans by allowing employees to choose among cash, taxable benefits and non-taxable benefits. It also governs flexible spending accounts, currently coming under attack by the Internal Revenue Service.

Although the Finance Committee had not acted on Sen. Danforth's proposal as of last week, the proposal would, if enacted, eliminate hundreds of cafeteria plans and other forms of flexible compensation that provide benefits to millions of employees.

Benefit lobbyists last week were trying to convince Sen. Danforth to withdraw or modify his proposal.

While benefit experts believe an outright repeal of Section 125 is unlikely, the actions in the both the tax-writing committees illustrate how vulnerable benefit plans are in light of Congress' attempt to find ways to increase tax revenues.

Not a single member of the Finance Committee spoke in defense of employer-provided benefit plans when Sen. Danforth last week said: "My own view is that too many benefits are being provided."

And benefit lobbyists are finding it hard in some cases to get out their message in defense of benefit plans.

For example, the Ways and Means Committee approved its $50 billion deficit reduction bill in closed sessions. That made it difficult for employer groups and consultants to lobby because committee members were not under public scrutiny when they voted on the bill's provisions.

The Finance Committee sessions were open, although benefit lobbyists found it tough to talk to committee staff members at length because these staffers had to grapple with dozens of different tax provisions in a short time.

Still, employers did score some victories.

The Ways and Means committee did not consider a proposal by the Joint Committee on Taxation, an influential advisory panel, that would have barred employees from withdrawing contributions from 401(k) salary reductions for such purposes as paying for a new home or financing a child's college education (*BI*, March 5).

In addition, the Joint Committee's proposal to change the rules governing pre-retirement withdrawals from pension and other retirement programs that require employee contributions was not considered.

Currently, an employee participating in a contributory plan is allowed to first withdraw his own contributions. Since these contributions are made with the employee's aftertax dollars, the employee is not taxed when he withdraws his funds.

Under the Joint Committee's proposal, an employee would have to first withdraw any employer contributions, on which he is taxed. Only then would he be able to withdraw his own contributions.

Although the two committees have not yet acted on these proposals, there's still a possibility that they could be included in legislation when the full House and Senate discuss the measures.

But, the House committee also did not act on pleas by employers and their trade associations to force the Internal Revenue Service to withdraw a Feb. 10 news release that implied that most types of flexible spending accounts are invalid (*BI*, Feb. 27; Feb. 20). The committee report is absolutely silent on the subject of FSAs.

The committee's reluctance to tackle the FSA issue became obvious at a Feb. 28 hearing on tax shelters when a employer and consultant-led campaign to convince committee members that the accounts are valuable health care cost-containment tools fizzled.

Committee members, like Rep. J.J. Pickle, D-Texas, said the plans had been promoted as a means to avoid Social Security and income taxes, rather than for cost-containment purposes (*BI*, March 5).

Employers were having a bit more lobbying success at the Senate Finance Committee hearings last week.

For example, the committee at first seemed ready to approve funding and benefit limitations for 501(c)(9) trusts similar to those cleared by the House committee.

But as Finance Committee Chairman Robert Dole, R-Kan., was prepared to call for a vote on the 501(c)(9) restrictions, Sen. Robert Packwood, R-Ore., read before the packed hearing room a hand-delivered letter from Ed Davey, executive director of the Assn. of Private Pension & Welfare Plans, a benefits lobbying group.

The APPWP letter warned that if the Senate accepted the funding restrictions approved by the Ways and Means Committee, the trusts could not fund benefits, like health care and long-term disability coverages, on an actuarially sound basis.

With lobbyists, committee staffers and reporters straining to hear Sen. Packwood, whose microphone went dead, the Oregon Republican criticized the attempt to vote on a provision that never was discussed at Senate committee hearings.

"We are starting on a road that we are unfamiliar with," Sen. Packwood said.

Sen. Dole then delayed the vote to give Sen. Packwood and Treasury Department officials time to draft new language on the proposal affecting the trusts.

Benefit lobbyists interviewed last week outside the Finance Committee hearing room said limiting 501(c)(9) trust reserves to 75% of the average paid out over a two-year period could weaken the trusts' financial stability.

For example, if trust participants incurred a significant number of incurred-but-unpaid claims at the end of a year, the benefits paid by the trust during that year might not be an accurate barometer to determine how much in future liabilities must be paid, said the APPWP's Mr. Davey.

The Ways and Means Committee proposal does give the secretary of the treasury authority to issue regulations that would allow employers to establish larger reserves if they are hit with a large number of incurred-but-unpaid claims.

This scenario could possibly occur if a high number of employees were disabled near the end of the year and became eligible for LTD benefits.

But employers might have to wait a long time for supplementary 501(c)(9) trust regulations from the Treasury Department. For instance, it took the Internal Revenue Service more than two decades before it published final regulations on 501(c)(9) trusts in 1981.

And, employers have been waiting for almost six years for the IRS to publish rules on Section 125 of the tax code.

The Senate Finance Committee also heard criticism of the Ways and Means Committee decision to extend until 1988 the cap on maximum pension plan benefits and contributions.

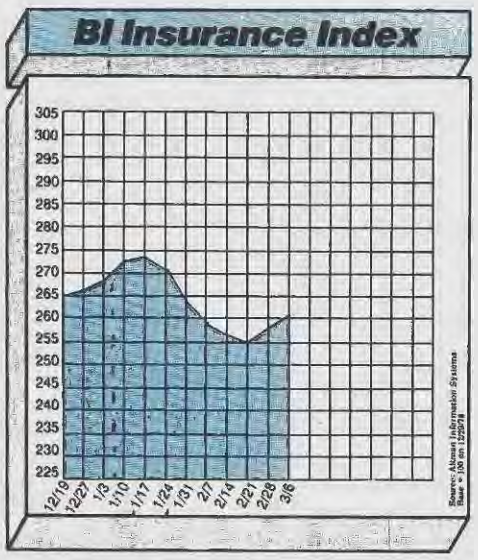
These limitations would be unfair since similar caps have not been imposed on public retirement plans such as Social Security and federal Civil Service plans, said Robert Peters, manager of compensation and benefits at Mobil Oil Corp. in New York, in testimony submitted to the Senate committee.

Late last week, the Senate committee tentatively approved two proposals that would block changes in the tax status of some other benefits.

It tentatively approved a proposal that would extend through 1985 the tax-free status of employer-provided educational benefits. The current law governing these benefits expired last Dec. 31.

The panel also gave tentative approval to a proposal that would extend through 1985 a moratorium barring the Treasury Department from issuing regulations concerning the taxation of benefits not covered by a specific section of the tax code, like employer-provided parking spaces. The earlier moratorium also expired Dec. 31.

The House committee had earlier voted to establish permanent rules regarding the taxation of these benefits. ■



The *Business Insurance* stock index continues to rebound as the index of insurance industry stocks advanced 2.5 points to 260.7 from 258.2 for the trading period ending March 6. The index also gained during the previous period after six consecutive weeks of decline. During this latest trading period, 29 stocks gained, 13 issues were unchanged and 19 closed lower. The largest gains were reported by Statesman Group Inc., 29.7%; Corroon & Black Corp., 12.0%; Frank B. Hall & Co. Inc., 8.5%; American National Insurance Co., 8.4%; and Reed Stenhouse Cos. Ltd., 8.3%. The largest losses were posted by Optimum Holding Corp., 15.0%; American International Group Inc., 7.9%; Integrated Resources Inc., 5.5%; Poe & Associates Inc., 4.8%; and Avemco Corp., 4.7%. The *Business Insurance* index outperformed other market indicators, posting a 1.0% increase, compared with a 0.2% decrease in the New York Stock Exchange composite.

British Issues

6 Mar Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	179	N/A	16.86	9.4	179—	171
Genl Accident	486	13.1	27.14	5.6	486—	460
Gdn Royal Exch	526	13.5	30.71	5.8	526—	516
Phoenix	448	19.5	26.00	5.8	448—	460
Royal	553	13.2	40.72	7.4	553—	502
Sun Alliance	1413	16.2	78.57	5.6	1425—	1413
Brokers						
CE Heath	325	8.1	22.86	7.0	325—	317
Hogg Robinson	181	13.9	9.43	5.2	181—	167
JH Minet	144	11.1	7.57	5.3	144—	137
Sedg Grp	218	10.9	11.43	5.2	218—	210
Stew Wrightson	310	10.3	22.57	7.3	310—	303
Willis Faber	668	13.9	30.00	4.5	668—	660

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Rate increase could revive brokers' positive leverage

By LEONARD M. WILSON

Special to Business Insurance

TALK OF AN IMPROVING premium rate environment for commercial lines comes as a tonic for dispirited brokers awaiting a lift in their operating results. There are now enough signs of an early change in the competitive climate to justify a degree of guarded optimism.

Mr. Wilson

And why not? The publicly owned insurance brokers have experienced negative operating leverage for three years in a row. Profitability has undergone a major contraction. Any material easing in rate competition might allow operating leverage to go in the other direction.

Operating leverage, simplistically, refers to the tendency of profits to experience a large percentage change on a relatively small change in revenues. Leverage occurs because a sizable portion of brokerage costs do not vary with unit volume. In addition, increases or decreases in dollar realizations per unit of volume have, in the short run, almost a dollar-for-dollar impact on the bottom line.

For example, a 10% advance in commission might generate a 20% increase in profits. That's positive leverage. A 2% increase in commission, correspondingly, could actually result in a decline in net income. That's negative leverage.

The four largest public brokers—Marsh & McLennan Cos. Inc., Alexander & Alexander Services Inc., Frank B. Hall & Co. Inc. and Corroon & Black Corp.—have all experienced some degree of negative operating leverage in the current cycle of rate competition. Revenues have increased narrowly, while profits have fallen—or, at best—advanced much more slowly than revenues.

We can gauge the extent of negative operating leverage by using these four publicly held brokers as a composite. From 1980 to 1983, aggregate revenues for the four brokers have risen about 25%, while net income has dropped 15%. After-tax profit margins have slipped to 8.8% in 1983 from 13% in 1980.

(In these calculations, we have excluded the estimated impact of the purchase of Alexander Howden Group P.L.C. on Alexander & Alexander's year-to-year comparisons.)

The adverse leverage is still more dramatic when Marsh & McLennan is removed from the composite. The increase in revenues from 1980 to 1983 for the three remaining brokers in our sample amounts to 11%. But, the net income of the group declined a whopping 54%. Moreover, after-tax profit margins fell to 5.1% in 1983 from 12.2% in 1980. This is the reality of soft premium rates.

The corollary of negative leverage is the potential for a rebound in profitability as price competition eases. However, this upside leverage won't necessarily occur willy-nilly. Expenses, too, must be managed even as the velocity of the revenue stream accelerates.

What kind of earnings potential is inherent in a more hospitable phase of commercial lines pricing?

Taking a hypothetical broker, Risk-Adverse Associates, as a model, let's say earnings stood at $2 a share in 1983. In 1984, Risk-Adverse's budget calls for an 8% to 9% increase in revenues and a 6% to 7% jump in expenses. Those numbers translate into earnings for the broker in 1984 of $2.40 to $2.50 per share, a gain of 20% to 25% on a much less dramatic growth in revenues.

In 1985, assuming modest commercial rate increases, revenues and expenses could advance 12% to 13% and 7% to 8%, respectively. That would permit earnings to reach $3.40 or even $3.60 per share, a rise of about 50%.

Finally, postulating the potential for 1986, revenues might conceivably expand 13% to 14%, while expenses would increase by 11%, by now reflecting the greater buoyancy of the business. This would produce earnings of $4.60 to $4.80 per share.

Risk-Adverse, it appears, could experience a 150% gain in earnings in the short span of three years. This recovery in profit margins would almost retrace the lost ground from 1980 to 1983.

This positive leverage is impressive. But, to happen, it will require a moderate, substantial firming in rates and a willingness by the public brokers to restrain costs for the first year or two of the upswing. Close attention to productivity will be key to cost containment.

Since the easing in rate competition is still in its earliest stages, it is a little premature to take our scenario as much more than an illustration of what could possibly happen. The public brokers may yet have a few quarters of less-than-stellar results before the outlook brightens decisively. ■

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

BI Industry Stock Report

MAR. 6, 1984 2/29/84 THRU 3/6/84

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	35.25	1.4	11.5	2.64	7.5	35.25	34.13	600.7
American Bankers Ins Group	OTC	13.38	-1.8	9.4	0.50	3.7	13.75	13.38	74.9
American General Corp	NYSE	20.88	2.5	6.3	0.90	4.3	21.00	20.50	869.6
American Indty Finl Corp	OTC	21.63	3.0	12.8	1.12	5.2	21.63	21.00	3.4
American Intl Group Inc	OTC	52.50	-7.9	9.1	0.44	0.8	57.00	52.50*	1,516.3
American Natl Ins Co	OTC	24.25	8.4	7.5	0.96	4.0	24.25	22.75	241.1
Aneco Reins Ltd	OTC	3.00	0.0	21.4	0.00	0.0	3.00	3.00	5.9
Avemco Corp	AMEX	17.63	-4.7	11.4	0.58	3.3	18.50	17.63	6.3
Banks Iowa Inc	OTC	51.00	1.0	19.0	1.52	3.0	51.00	50.50	0.3
Bitco Corp	OTC	17.75	4.4	0.0	1.33	7.5	17.75	17.00	2.7
Carolina Cas Ins Co	OTC	4.75	5.6	0.0	0.00	0.0	4.75	4.50	5.8
Chubb Corp	OTC	68.00	0.7	9.9	3.12	4.6	69.00	68.00	387.9
Combined Intl Corp	NYSE	33.25	1.5	8.6	2.00	6.0	33.38	32.50	264.0
Continental Corp	NYSE	26.50	-2.8	139.5	2.60	9.8	27.13	26.50	276.6
Crawford & Co	OTC	15.25	-1.6	10.8	0.66	4.3	15.25	15.25	3.7
Crown Life Ins Co	OTC	120.00	-0.4	7.8	3.20	2.7	120.13	120.00	98.2
Employers Cas Co	OTC	32.00	0.0	7.2	1.20	3.8	32.00	32.00	9.5
Equifax Inc	NYSE	26.00	-1.4	10.3	1.60	6.2	26.63	26.00	30.8
Farmers Group Inc	OTC	40.38	0.0	10.0	1.52	3.8	40.75	40.38	154.2
Foremost Corp Amer	OTC	24.25	1.0	11.2	0.96	4.0	24.50	24.25	64.2
Fremont Gen Corp	OTC	14.13	3.7	0.0	0.48	3.4	14.50	13.88	332.8
Great West Life Assurn Co	OTC	300.00	-3.2	10.8	12.00	4.0	310.00	300.00	0.4
Hanover Ins Co	OTC	50.50	0.5	6.5	0.88	1.7	50.50	50.00	4.2
Hartford Steam Boiler Insptn	OTC	51.50	3.0	8.8	3.00	5.8	51.50	50.00	5.0
Jefferson Natl Life Ins Co	OTC	41.00	5.1	18.1	0.76	1.9	41.50	41.00	18.8
Kemper Corp	OTC	38.13	0.3	8.1	1.80	4.7	38.13	37.88	72.8
Lincoln Natl Corp Ind	NYSE	30.25	-0.8	8.7	1.68	5.6	30.63	30.13	223.3
Mission Ins Group Inc	NYSE	21.25	2.4	0.0	0.50	2.4	21.38	20.75	181.9
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT	TRADE
Northwestern Natl Life Ins	OTC	37.75	0.0	9.4	1.50	4.0	38.25	37.75	64.4
Ohio Cas Corp	OTC	44.50	0.0	9.2	2.68	6.0	44.75	44.50	38.5
Old Rep Intl Corp	OTC	33.38	-0.7	7.2	0.90	2.7	33.63	33.38	70.4
Orion Cap Corp	NYSE	24.88	-2.9	12.0	0.76	3.1	25.63	24.75	32.7
Preferred Risk Life Ins Co	OTC	20.00	0.0	7.6	0.67	3.3	20.00	20.00	3.4
Provident Life & Acc Ins Co	OTC	69.50	0.0	7.3	2.60	3.7	70.00	69.50	28.3
St Paul Cos Inc	OTC	58.00	-1.3	9.0	3.00	5.2	58.88	58.00	243.8
SAFECO Corp	OTC	59.38	0.2	8.3	2.60	4.4	59.75	59.25	194.3
Sri Corp	OTC	17.13	2.2	8.5	0.68	4.0	17.13	16.75	139.5
Seibels Bruce Group Inc	OTC	18.50	-2.0	12.0	0.80	4.3	18.88	18.50	16.6
Statesman Group Inc	OTC	10.38	29.7	9.0	0.15	1.4	10.50	8.13	253.9
Tokio Marine & Fire Ins Co	OTC	119.50	6.5	24.1	0.96	0.8	119.75	113.25	8.0
Travelers Corp	NYSE	32.75	0.4	8.0	1.92	5.9	32.75	32.38	568.1
United Fire & Cas Co	OTC	29.50	0.0	10.5	1.60	5.4	29.50	29.25	0.0
United States Fid & Gty Co	NYSE	57.75	1.8	9.6	3.84	6.6	58.50	57.00	378.4
United Svcs Life Ins Co	OTC	25.38	1.5	7.2	1.00	3.9	25.38	25.00	12.1
Ustife Corp	NYSE	25.75	4.6	7.0	0.96	3.7	26.00	25.25	129.7
Washington Natl Corp	NYSE	22.25	-2.2	11.8	1.08	4.9	22.88	22.25	45.5
Zenith Natl Ins Corp	OTC	13.25	1.9	9.0	0.60	4.5	13.25	13.25	14.2
INSURANCE COMPANIES	AVERAGE			10.5		3.9			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	19.75	-4.8	0.0	1.00	5.1	20.75	19.75	634.1
Baldwin & Lyons Inc	OTC	37.00	0.0	15.4	0.80	2.2	37.00	37.00	0.5
Corroon & Black Corp	NYSE	25.75	12.0	16.1	1.00	3.9	25.75	23.50	151.6
Cruma E H Cos Inc	OTC	10.75	0.0	14.3	0.40	3.7	10.75	10.75	12.4
Emett & Chandler Cos Inc	OTC	10.00	0.0	27.0	0.00	0.0	10.00	9.75	0.0
Hall Frank B & Co Inc	NYSE	22.38	8.5	23.6	1.35	6.0	22.38	20.75	258.4
Integrated Res Inc	AMEX	23.75	-5.5	7.7	0.00	0.0	25.25	23.75	95.2
Marsh & Mclennan Cos Inc	NYSE	44.63	1.1	12.8	2.20	4.9	45.00	43.50	285.6
Poe & Assoc Inc	OTC	5.00	-4.8	0.0	0.00	0.0	5.25	5.00	10.3
Reed Stenhouse Cos Ltd	OTC	13.00	8.3	17.0	0.60	4.6	13.00	12.25	39.8
AGENTS/BROKERS	AVERAGE			16.5		3.5			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	28.75	-2.1	11.4	1.28	4.5	30.00	28.75	2,488.9
Anderson Clayton(Ranger/PanAm)	NYSE	31.25	2.9	35.1	1.32	4.2	32.00	31.25	18.4
Armco Inc	NYSE	19.00	2.0	0.0	0.40	2.1	19.13	18.50	445.8
Baldwin Utd Corp	NYSE	2.25	0.0	0.0	0.00	0.0	2.38	2.25	160.9
CIGNA Corp	NYSE	39.50	-4.2	7.5	2.60	6.6	41.25	39.50	2,087.9
City Investing Co. (Home Ins.)	NYSE	32.38	-7.2	8.0	1.80	5.6	35.00	32.38	399.1
CNA Finl Corp (CNA)	NYSE	24.25	-1.5	8.6	0.00	0.0	24.38	23.75	103.9
Control Data (Comml. Credit)	NYSE	35.38	-3.7	8.4	0.66	1.9	37.13	35.38	673.2
General Re Corp	NYSE	59.75	3.7	14.0	1.44	2.4	60.00	58.88	376.8
ITT (Hartford Group)	NYSE	39.25	-2.5	8.8	2.76	7.0	41.00	39.25	790.7
Optimum Hldg Corp	OTC	4.25	-15.0	32.7	0.00	0.0	5.00	4.25*	4.3
Sears Roebuck & Co. (Allstate)	NYSE	34.00	-0.7	8.9	1.76	5.2	35.25	34.00	1,896.1
Teledyne Inc (Argonaut)	NYSE	163.75	1.2	11.0	0.00	0.0	166.88	163.75	650.9
Transamerica Corp (Occidental & Fred S. James)	NYSE	22.88	-1.1	8.3	1.56	6.8	23.75	22.88	552.3
CONGLOMERATES/HOLDING COS.	AVERAGE			14.0		2.9			

*Record high/low since Jan. 1, 1983

System design: Altman Information Systems

Financial briefs

Frank B. Hall

Providence International Ltd. of Bermuda and two subsidiary insurance companies, Capitol Life Insurance Co. of Denver and Providence Washington Insurance Co. of Providence, R.I., have purchased 5.1% of the outstanding common stock of brokerage Frank B. Hall & Co. Inc., according to a recent filing with the Securities and Exchange Commission.

Providence International, which owns several other subsidiary property/casualty and life insurers around the country, noted that subsidiary insurers have purchased a total of about 612,000 shares of Hall common stock for $16.3 million. About two-thirds of stock purchases were made during a 60-day period ending Feb. 23.

In its 13-D filing with the SEC, Providence International officers said the purchase was intended to be an equity investment and that the insurers had no intention to attempt to influence current Hall management on issues other than those normally submitted for shareholder approval.

Providence International, formerly called Providence Capitol Ltd., also owns approximately 5.6% of the outstanding shares of broker Alexander & Alexander Services Inc. The company purchased the A&A stock last October, also as an equity investment, according to SEC filings made at the time (*BI*, Oct. 3, 1983).

Equitable

Equitable Life Assurance Society of the United States says that it added $300 million to its reserves at the end of 1983 to cover lower-than-expected investment returns on guaranteed-interest contracts it sold.

Guaranteed-interest contracts are financial instruments offered by insurers primarily to pension funds and corporate savings plans. The insurer promises to pay a set interest rate and then attempts to earn an even higher rate on the funds it receives for the contract.

Mission Insurance Group

Moody's Investors Service Inc. has lowered its rating on the senior debt of Los Angeles-based Mission Insurance Group Inc. to Baa-3 from A-3.

The rating downgrade affects $75 million of outstanding Mission senior debt, most of which was issued on Jan. 20, 1983.

The rating reduction "indicates our expectation that operating results may not return to a more acceptable level in a reasonable period of time," Moody's says. However, the rating service notes that Mission maintains "a high-quality investment portfolio."

GEICO Corp.

GEICO Corp. reported a 133% increase in net income in 1983 to $113.8 million from $48.8 million. The Washington-based insurer's 1983 results include realized gains of $18.9 million from securities transactions, while 1982's included realized losses of $28.6 million, sustained mostly to offset the taxable gain on the sale of a subsidiary.

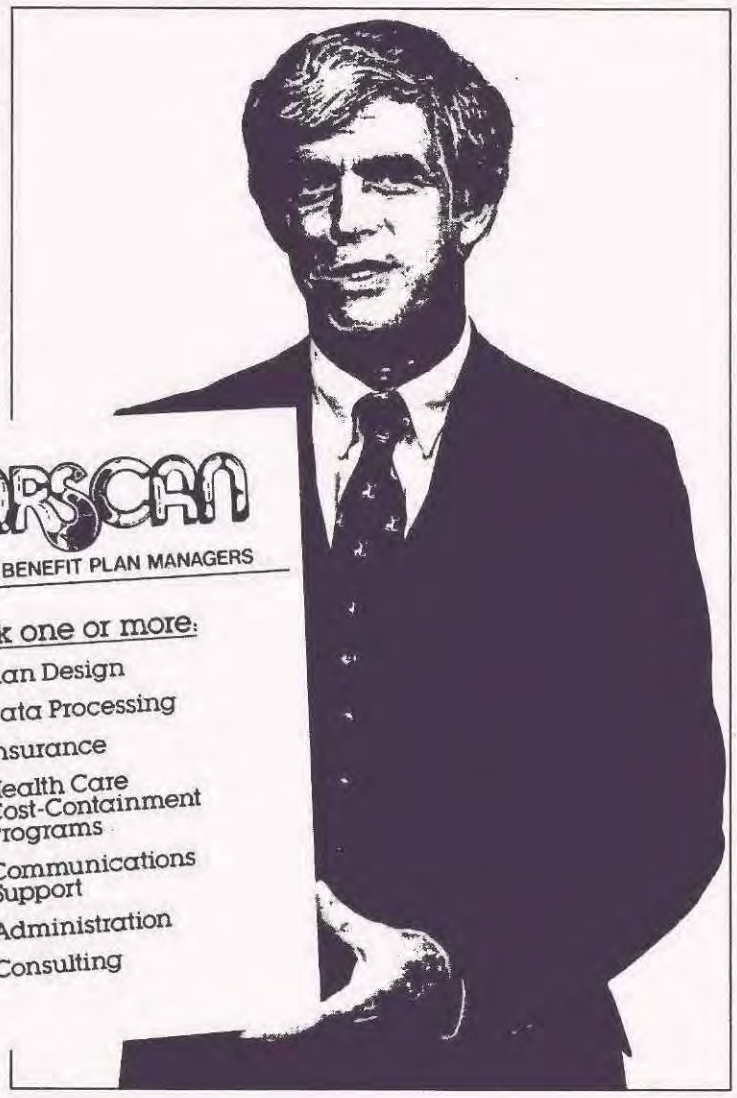
Aftertax 1983 operating earnings of $94.8 million showed a 22.3% gain from the $77.5 million reported in 1982.

In addition, the firm has announced a 22% increase in the quarterly dividend on common shares to 22 cents per share from 18 cents. The dividend will be payable March 30 to shareholders of record March 14. ■

The Hartford introduces Starscan.℠

"Now you can get all the advantages of flexible benefits– without the drawbacks."

Ray Drury, Vice President, Special Markets Department, tells Benefit Plan Managers how The Hartford's Starscan serves the interests of employee and employer alike.



Q. What advantages does the Starscan approach have over traditional group benefit plans?
A. Starscan provides the flexibility needed to meet the more complex and varied insurance needs of employees today. It gives employees an important say in benefit programs by letting them select which benefits they prefer among traditional coverages such as life, medical, dental, disability, and pensions. But the Starscan approach can also incorporate emerging, non-traditional coverage choices as well. And it lets employees—within limits—select levels of coverage.

Other advantages include more effective and efficient use of employer contributions, the opportunity to contain escalating benefit costs, greater employee appreciation of benefits, reduced pressure for across-the-board increases in benefits, and a progressive employer image. Not least, Starscan helps employers recruit and retain employees.

Q. How does the Starscan flexible benefit approach work?
A. In the way best suited to meet the needs of you and your employees. For example, existing benefits might be kept as they are, or reduced to a standard core for all employees. In either case, employees would be given credits to purchase additional benefits to fit their needs. Benefits beyond those the credits would buy could be purchased through payroll deductions.

Or, set benefits might be offered with different levels of coverage. By choosing a higher level of one benefit and a lower level of another, employees could match benefits more closely to their needs.

Q. What support services does The Hartford offer?
A. Working closely with your agent, broker, consultant, or third party administrator, we'll provide whatever services you require.

Depending on your needs, we offer consulting services for feasibility studies and plan design, alternative data processing services, complete communications support, and a variety of health care cost-containment programs. And, of course, we can provide a full range of coverage and funding options, along with pension and actuarial expertise.

Q. What about cost?
A. Obviously, changing a traditional benefit program to a tailored flexible plan involves initial costs. But selecting only those items you need from the Starscan menu can make those costs much lower than you might expect. And the kind of synergy involved in this approach has a real impact on bottom-line results, and can lead to significant cost savings over traditional group benefit plans.

Q. How can I get a brochure describing Starscan?
A. Just write to Starscan, Special Markets Department B, 8 Griffin Road North, Griffin Office Center, Windsor, CT 06095. Or call David Washburn, Director of New Procucts, at (203) 683-8435.

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