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MARCH 14, 1983

business insurance®

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update

Polaroid agrees to settle suit from former worker

CAMBRIDGE, Mass.—Polaroid Corp. has agreed to a $1.9 million settlement of a suit brought by a former employee who claims the company was negligent in treating his depression that later caused him to attack his family with an ice pick, his attorney says.

Lawrence L. Okerblom Jr., 58, a former Polaroid engineer, filed suit in Massachusetts Superior Court in 1974,

Continued on next page

Tax would curb appeal of flexible benefits

By JERRY GEISEL

WASHINGTON—Congress' proposal to impose Social Security taxes on flexible benefit plans will diminish the appeal of the fast-growing plans and cost employers more, benefit experts say.

The House of Representatives last week approved Social Security bailout legislation that imposes FICA payroll taxes on cafeteria-style benefit plans that give employees a choice of tax-free benefits and cash.

Under the legislation, H.R. 1900, which is now pending in the Senate, cafeteria plans would be subject to Social Security taxes if the menu of benefits from which employees can choose includes cash or any other taxable benefits.

For example, if a cafeteria plan offered an employee a choice of family health insurance coverage or $500, the employee's taxable wage base would be increased by $500—even if the employee selected the health insurance benefit.

By contrast, under current tax law, employees enrolled in cafeteria plans only pay taxes if they select a taxable benefit.

While the proposed legislation states that any cash or other taxable benefit offered in a flexible benefit plan would be subject to the FICA taxes, other taxable benefits besides cash are seldom included. If they were, the amount the company spent on those benefits also would be figured into the taxable income.

The proposed taxation of cafeteria benefit plans would diminish the appeal of the fast-growing cafeteria plans, experts say.

For employers, the cost of the plans would increase, too. Companies would have to pay Social Security taxes on the taxable benefits, which could cost large employers hundreds of thousands of dollars.

For example, if the average employee's taxable wage base were increased by $200 because of taxable flexible benefit plan options, a 10,000-employee company would find its Social Security costs rising by $140,000, assuming the FICA tax next year rises to 7% of payroll from the current 6.7%.

At the same time, employees' take-home pay would be reduced since they would pay more Social Security taxes.

"This will increase the cost of employee benefits," said Sylvester Schieber, director of research at the Employee Benefit Research Institute, a Washington-based benefits think tank.

Employers, though, could avoid the in-

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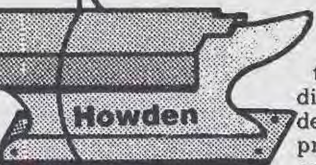
Industry seeing red

Howden's burden too much for A&A

By LEN STRAZEWSKI

NEW YORK—Alexander & Alexander Services Inc.'s continuing efforts to float the underwriting divisions of its Alexander Howden Group P.L.C. subsidiary have sunk the parent company to new financial depths.



Graphic: Jim Bakesetas

Reporting year-end red ink for the first time since going public in 1971, A&A suffered a net loss of $25 million in 1982. Almost the entire loss was due to problems uncovered after it merged with Howden early last year, A&A announced at a special press conference last week.

"We are obviously disappointed by these results, which cap the most difficult year in A&A's history. We were hurt by the problems we discovered at Howden, a generally depressed worldwide economy, the relentless pressure of the soft insurance market and poor underwriting results of the Howden underwriting facilities," A&A Chairman John A. Bogardus explained.

"Though we can't say that there won't be any more surprises, we believe the worst is behind us," he added. "Through the years, A&A has generally produced the best track record of any of the brokers. We think we will now be able to return to that kind of record again."

Howden was clearly the culprit that pushed A&A off its track. The Howden acquisition, which originally cost A&A $300 million, has produced a series of additional expenses for the U.S. company since a fair-value audit last summer turned up several questionable reinsurance agreements with companies allegedly owned by former Howden officials.

These former officers, according to lawsuits filed by A&A in London courts, used the reinsurance agreements to divert assets from Howden underwriting subsidiaries to a Swiss bank they secretly owned.

After efforts to recover the estimated $55 million in missing assets led to the return of only about $15 million, A&A was forced by the Securities and Exchange Commission to take a $40 million extraordinary charge against third-quarter earnings to account for a reduction in Howden's tangible value (*BI*, Nov. 15, 1982).

In September, A&A also added $10 million to the capital of Sphere Drake Insurance Co., a Bermuda-based Howden underwriting subisidiary, to allow it to continue operating.

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Worst probably not yet over for insurers

By BILL DENSMORE

U.S. property/casualty insurers are hoping 1982 will be remembered as the worst underwriting year in the industry's history, but that dream isn't likely to come true.

The major insurers, as a group, saw their operating income tumble 9.6% during 1982, while underwriting losses zoomed to a record $4.57 billion.

Some insurers, though, made it through 1982 in relatively good shape. For example, American General Corp., without including results from its merger partner, NLT Corp., reported nearly a 20% rise in operating income and a combined ratio well below the industry aggregate.

Perennial top-performer American International Group Inc. remained one of the few insurers to show an underwriting profit and increased its earnings 19.5%. And, General Re Corp. and The St. Paul Cos. Inc. also posted double-digit gains in operating income.

But most large insurers fared dismally last year, and observers say the worst is probably not yet over: 1983 results could deteriorate even further (see chart, page 65).

Most of the insurers blamed their poor 1982 performances on the usual culprit: unabated price competition in commercial lines—especially general liability and medical malpractice. They also pointed to the economy-pinched workers compensation market.

"The results stank in just about all quarters," says B.P. Russell, chairman of Crum & Forster, the large property/casualty insurer acquired by Xerox Corp. Crum & Forster has yet to report year-end results through Xerox.

Mr. Russell says he thinks rates may begin to firm in most areas during this

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Top performers in '82

	Aftertax operating income 1982	Percent change 1981-1982	Combined ratio 1982	Pretax underwriting income (loss) 1982
American General Corp.	202,700	19.9	105.1	(62,900)
American International Group	412,650	19.5	98.2	33,890
General Re Corp.	206,647	16.4	101.8	(15,821)

All figures in thousands of dollars

INSIDE: More court decisions in asbestos coverage disputes Page 2

NEWSPAPER

update

Polaroid settles employee suit

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naming Polaroid, a doctor and social worker employed by the company and an outside physician. A trial began March 7, but both sides agreed to the $1.9 million settlement two days later, according to Thomas E. Cargill Jr. of the Boston firm of Cargill, Masterman & Culbert, which represented Mr. Okerblom.

The money will be paid to Mr. Okerblom, his wife, Theresa, and their 25-year-old son, Lawrence, in monthly installments for at least 25 years. The son, who suffered brain damage and a loss of vision from the attack, will receive more than $1 million.

Polaroid's liability insurer in the case was Travelers Indemnity Co. and the doctor and social worker employed by Polaroid were insured by St. Paul Fire & Marine Insurance Co., Mr. Cargill says.

Polaroid officials could not be reached for comment.

The outside physician will contribute only a minor amount to the settlement, Mr. Cargill says.

Teamsters fund agrees to pay

CHICAGO—The Teamsters Central States Pension Fund has agreed to pay $140 million over 30 years to settle several lawsuits alleging fraud and mismanagement, according to documents filed in U.S. District Court for the Northern District of Illinois.

Minor details in the agreement are to be completed over the next month. The proposed settlement payments will go to Teamsters members who were denied all or part of their pensions as claimed in class-action lawsuits filed in 1976 and 1979 by Teamsters members that raised serious questions about the prior management of the fund.

The settlement agreement and report were filed with U.S. District Court Judge James B. Moran during a hearing in his chamber two weeks ago.

The proposed settlement also was approved by the Labor Department, which also had filed suit against the fund.

California regulator named

SACRAMENTO, Calif.—Bruce A. Bunner, a partner with the accounting firm of Peat Marwick Mitchell & Co. in Los Angeles, has been nominated as the new California insurance commissioner.

Mr. Bunner, 49, a certified public accountant and insurance industry specialist, was appointed to the post by Gov. George Deukmejian March 4. The appointment must be approved by the state Senate Rules Committee.

Mr. Bunner stresses his knowledge of the financial aspects of the insurance industry as his chief qualification for the job.

Senate rejects aviation treaty

WASHINGTON—The Senate last week rejected an international treaty that would have increased to $317,000 from $75,000 the maximum compensation payable to victims of international airline crashes.

Plaintiffs' attorneys lobbied fiercely against the so-called "Montreal Protocols" because the $317,000 maximum benefit limit would have barred higher payments even in cases where an airline's "willful misconduct" caused a crash.

Under the current Warsaw Convention, the $75,000 liability limit does not apply if an airline is proved to have caused a crash by willful misconduct (*BI*, March 7).

The Senate voted in favor of the treaty, 50-42, shy of the necessary two-thirds approval.

Wayward whiskey saved

SAN FRANCISCO—The Atchison, Topeka & Santa Fe Railway will pay for the redistilling of 20,000 gallons of whiskey that almost became the most expensive highball in history.

A 20,000-gallon railroad tank car filled with the whiskey, valued at $500,000 to $600,000, was dumped into San Francisco Bay last November after a storm hit a Santa Fe barge ferrying rail cars across the bay (*BI*, Dec. 6, 1982).

However, the car was refloated several days later and the liquor, which was not contaminated, has been shipped back to the Joseph E. Seagram & Sons Inc. distillery in Lawrenceburg, Ind., to be redistilled, according to a Seagram's spokesman.

A claim will be filed with Santa Fe, "and we expect full recovery," said the spokesman, who refused to reveal the amount of the claim.

Jack Cornelius, director of risk management for the Chicago-based railroad, said the claim would be "well under" $500,000, within the company's $5 million self-insured retention. Santa Fe is prohibited by Interstate Commerce Commission regulations from revealing the amount of the claim.

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Asbestos coverage dispute decided in work comp case

By STEPHEN TARNOFF

State and federal courts are continuing to decide how insurers must respond to asbestos defendants' coverage claims. And for the first time, coverage owed for asbestos injury claims under a workers compensation policy has been decided.

In Champlain Cable Corp. vs. Employers Mutual Liability Insurance Co. of Wisconsin, the Delaware state superior court March 3 in effect ruled in favor of the manifestation theory to trigger coverage under a workers compensation policy for asbestos injuries. This is apparently the first time a court has decided an asbestos coverage question concerning a workers compensation policy.

Until now, coverage questions in asbestos cases have involved comprehensive general liability policies.

That is the case in Commercial Union Insurance Co. vs. Sepco Corp. The U.S. District Court for the Northern District of Alabama Feb. 18 held that coverage under a comprehensive general liability policy is triggered at the time of exposure to asbestos.

The U.S. Supreme Court last week refused to consider how insurance policies should be construed in asbestos cases, leaving the state and federal court systems to resolve the question (see related story).

Because asbestos-related diseases can take 20 or more years to develop, insurers, policyholders and state and federal courts are split over the definition of when injury occurs and when insurance policies come into play.

Several courts, using the exposure theory, have held that insurers on a risk at the time the victim is exposed to asbestos are liable. Others, under the manifestation theory, have held that coverage is not triggered until the disease is capable of diagnosis in the victim.

One court has ruled that all insurers from the time of exposure through manifestation are on the risk.

The workers compensation case involved a suit by Champlain Cable, formerly Haveg Industries Inc., against Liberty Mutual Insurance Co., Insurance Co. of North America and Employers of Wausau, its workers compensation insurers from 1948 to 1972.

Champlain, which was self-insured after 1972, contended that coverage for employees was triggered upon employees' exposure to asbestos and that the insurers

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Eagle-Picher continues to pursue coverage issue

WASHINGTON, D.C.—Eagle-Picher Industries Inc., fresh from a victory in the U.S. Supreme Court, is not finished trying to recover as much insurance as possible to compensate victims of asbestos-related diseases.

The Cincinnati-based company, currently facing more than 16,000 claims, is pursuing another coverage suit against some of its excess insurers in the U.S. District Court in Boston.

That lawsuit seeks the broadest interpretation of its policies so that all insurers will be liable for defense and indemnification from the time victims are exposed to asbestos through manifestation of the disease.

The coverage the company seeks is broader than the coverage it was guaranteed from its primary and second layer insurers last week when the Supreme Court decided not to disturb a ruling of the 1st U.S. Circuit Court of Appeals.

That decision, favoring the manifestation theory of coverage, held that Eagle-Picher's insurers on the risk at the time asbestos-related diseases are diagnosed in victims were liable for defending and indemnifying the company.

The ruling was important to Eagle-Picher because it did not have product liability coverage before 1968 and many of the victims suing it were exposed during the 1940s and 1950s. A decision that would trigger coverage when victims were exposed to asbestos would have left Eagle-Picher without coverage.

But, the disease was diagnosed in many of the victims after 1968 when Eagle-Picher had coverage.

Last week, Eagle-Picher, which had opposed the Supreme Court's review of the appellate court manifestation decision, expressed satisfaction with the decision.

"It's always nice to win," said Brian T. Ken-

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Zomax user files suit against J&J

By DOUGLAS McLEOD

NEW YORK—Johnson & Johnson already faces at least one lawsuit brought by a user of its prescription pain reliever Zomax, and more lawsuits are expected.

Zomax, introduced in 1980 by J&J's McNeilab Inc. subsidiary, has been temporarily withdrawn from the market for relabeling after five people died from allergic reactions to the drug.

J&J has announced that the $40 million cost of recalling the drug from pharmacies, hospitals and other buyers will amount to about $20 million after taxes.

Rosemarie Turino of Winfield, Mass., filed a $1 million suit against J&J and McNeilab in U.S. District Court in Boston on March 7. The suit, before Judge A. David Mazzone, claims that Ms. Turino was treated and released from hospitals several times with rashes and respiratory problems after taking Zomax in October 1981.

The suit claims that J&J was negligent in failing to properly test Zomax for possible side effects and for failing to warn physicians of those side effects.

A J&J spokesman said the company has not yet received any lawsuits alleging injuries from Zomax, and is aware of Ms. Turino's suit only through reports in the

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Iowa insurer to be liquidated

By JERRY GEISEL

DES MOINES, Iowa—An Iowa-based insurance company that collapsed last month with a mountain of liabilities will be liquidated by the Iowa Department of Insurance.

Iowa State Travelers Mutual Assurance Co. of Des Moines is "unsalable," says Iowa Insurance Commissioner Bruce Foudree.

It is difficult to find a buyer for an insurance company when the extent of the liabilities is not known, he added.

Iowa State Travelers' liabilities could exceed $20 million, Mr. Foudree said.

State insurance department officials say it is difficult to compute the liabilities because of a large number of incurred-but-not-reported claims for January and February. The company was taken over by the Iowa insurance department on Feb. 23.

The liquidation of Iowa State Travelers—the first licensed domestic life and health insurance company to fail in Iowa—could take as long as 10 years, state insurance department officials say.

The liquidation decreases the chances that people covered by Iowa State Travelers will get all their medical claims paid.

The greatest impact of Iowa State Travelers' failure probably will be in California, where as many as 12,000 people were enrolled in three multiple employer health insurance trusts underwritten by Iowa State Travelers, according to the California Department of Insurance.

California METs insured by Iowa State Travelers, according to the California Insurance Department, are Multiple Benefits Trust of Van Nuys; National Health Insurance Trust of Huntington Beach and Premier Insurance Administrators Trust of Sherman Oaks.

"We can't hold up much hope that all claims will be paid," a California Insurance Department official said.

Like many states, California does not have a health and life guaranty fund to aid policyholders when an insurer collapses and can't pay claims.

However, as reported earlier, in Illinois, where Iowa State issued as many as 32,000 policies directly, policyholders don't have to worry because Illinois has a guaranty fund to pay claims (*BI*, March 7).

Much of Iowa State Travelers health insurance business was written through the California METs. How-

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errors & omissions

• An article on punitive damages published Feb. 14 incorrectly stated that an appellate court had affirmed a punitive damage award of $7.5 million against International Harvester Co. The court affirmed the award but reduced the amount to $650,000.

Holding the line on costs

Groups track benefit issues in Washington

By JERRY GEISEL

WASHINGTON—The Washington Business Group on Health has never conducted mass mailings in search of members.

Yet, since it was established in 1974 to give major employers a voice in national health policy, it has grown from a handful of members to more than 200 companies.

Its Pennsylvania Avenue headquarters in southeast Washington throbs with activity as staff members try to cope with dozens of phone calls each day from employers who want to tap one of the best Washington hot lines for benefit information.

Willis Goldbeck, the founder and president of the Washington Business Group on Health, says the reason for the group's success is simple.

"More and more companies have become sophisticated about the contribution they can make to health policy. We try to stay on top of the issues to help employers keep abreast on what is going on Washington," Mr. Goldbeck says.

The Washington Business Group on Health is just one of many benefits groups in Washington that have grown enormously in the last few years.

For example, the Employee Benefit Research Institute, a benefits research organization begun by 13 employee benefits consulting firms in 1978, now has 83 members including employers, insurers, public pension plans and accounting and actuarial firms.

Continued on next page

Whom benefit managers can turn to in Washington

Name	Address	Members	Contact	Remarks
American Society of Pension Actuaries	1413 K St. N.W. Fifth Floor Washington, D.C. 20005 202-737-4360	2,000; actuaries, consultants, plan administrators	Chester Salkind, executive director	Mainly concerned with issues that affect small retirement plans. Very aggressive group.
Assn. of Private Pension & Welfare Plans	1201 Pennsylvania Ave. N.W. Suite 340 Washington, D.C. 20004 202-737-6666	550; employee benefit managers, consultants, actuaries, accountants, attorneys, plan sponsors	Ed Davey, executive director	Very diverse membership. Has become more active in the lobbying arena. Represents employers on a wide range of benefit issues.
Employee Benefit Research Institute	1920 N St. N.W. Suite 520 Washington, D.C. 20036 202-659-0670	83; employee benefit consulting firms, insurers, public pension plans, accounting and actuarial firms	Dallas Salisbury, executive director	Benefits research organization. Publishes books and numerous studies on employee benefit issues.
Employers Council on Flexible Compensation	1700 Pennsylvania Ave. N.W. Washington, D.C. 20006 202-393-1728	62; employers that are interested in flexible benefit plans; service providers and consultants can join as associate members	Ivins, Phillips & Barker (legal counsel)	Group founded in November 1981 and has grown rapidly. Informational clearinghouse on flexible compensation plans. High-quality technical expertise.
ERISA Industry Committee	888 17th St. N.W. Washington, D.C. 20006 202-785-4443 (tax issues) 1919 Pennsylvania Ave. N.W. Washington, D.C. 20006 202-828-5000 (other benefit issues)	118; large employers	Mayer, Brown & Platt (tax issues) Vedder, Price, Kaufman, Kammholz & Day (other benefit issues)	Group established in 1974 to represent large employers on ERISA issues. Played a significant role in the passage of the Multiemployer Pension Plan Amendments Act of 1980. Seeking changes in the pension termination insurance program for single employers.
National Assn. of Manufacturers	1776 F St. N.W. Washington, D.C. 20006 202-626-3700	12,000; broad range of manufacturers	Sharon Canner, employee benefits analyst	Business advocacy group. Represents employers on a wide range of benefit issues.
U.S. Chamber of Commerce	1615 H St. N.W. Washington, D.C. 20062 202-659-6000	237,000; 90% have fewer than 100 employees	Michael Romig, director of employee benefits	Business advocacy group. Particular expertise in Social Security and pension legislation.
Washington Business Group on Health	922 Pennsylvania Ave. S.E. Washington, D.C. 20003 202-547-6644	200; large employers	Willis Goldbeck, president	Helps set up business health care coalitions around the country. Top-notch staff knows the ins and outs of pending health issues in Washington that affect large employers.

Cost control with the Blues

In Rhode Island, the Teamsters get new benefit to promote good health

By CAROL CAIN

PROVIDENCE, R.I.—Teamwork netted a savings of about $1.3 million in health care costs for Teamsters Local 251 last year, and the union is praising the Blue Cross/Blue Shield representatives on the team for the high score.

The Teamsters' Health Services & Insurance Plan in Rhode Island is not a typical plan. A history of prudent management has allowed the plan to expand each year, so today its 4,500 members and 5,500 dependents enjoy almost unlimited health care at little personal cost.

But that's not enough for it.

"We have recognized that health education is the next major area of benefit development," said Alexander J. Hylek, one of the four Teamsters plan trustees.

The trustees asked the Blues for a health education program to try to hold down future health care cost increases and, more importantly, to provide another valuable benefit for its members.

The result was a specialized "benefit" that deals with behavior modification.

Teamsters and their families will be able to attend classes or one-day workshops at no cost that cover at least nine health care topics—smoking, stress, weight control, nutrition, exercise, CPR and first aid, alcohol and drugs, back care and prescription drugs—said Celia Gomes, who was hired by the Blues as a health educator for the Teamsters' program.

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Is Blue Cross and Blue Shield Assns., the oldest and largest provider of group medical insurance, a leader or follower in cost containment? The debate between BC/BS and its critics continues (see page 22), but, as the profiles on this page show, some of the Blues plans are introducing cost-control plans.

In Massachusetts, Master Health plan strives to reduce hospital utilization

By CAROL CAIN

WORCESTER, Mass.—This central Massachusetts community of about 280,000 people has two unfavorable distinctions:

- It ranks third in the nation (behind Miami and Boston) in hospital costs per resident.
- It ranks fifth in the nation in days in the hospital per 1,000 subscribers (1,713).

Massachusetts health care is among the best in the country, but based on those statistics and others, businesses and Blue Cross & Blue Shield Assns. of Massachusetts knew it was time for a change.

The Central Massachusetts Business Group on Health is one of several coalitions that has been formed throughout the state in recent years in an attempt to understand the complex system of health care delivery and to make sure rational things happen to maintain quality care but reduce costs, said Gavin D. Robertson, vp of Morgan Construction Co. of Worcester and a member of the coalition.

Mr. Robertson had reason to be concerned. About two years ago he began studying internal health care costs for his 95-year-old company, which employs about 700. The figures he came up with were alarming: Morgan spent $2 million on health care in 1981, compared with $271,630 in 1972—a 435% increase over nine years.

"That can be deceiving because employment can change," noted Mr. Robertson, so he refigured the cost per employee. Those figures were not much better: In 1981, the company spent $1,589 per employee, compared with $371 per em-

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Plan to tax benefits defended by its architect
Page 26

Large employers lead in cost containment
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Outpatient benefits can cut costs if incentives are right
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Tracking benefit issues

Continued from previous page

Similarly, the Society of Professional Benefit Administrators, which represents third-party employee benefits administrators, has seen its membership double to 225 in the last year alone.

The growth in the size of employee benefits organizations in Washington is no fluke.

The passage of several pieces of landmark legislation during the last 10 years—including the Employee Retirement Income Security Act of 1974, the Pregnancy Discrimination Act of 1978 and the Multiemployer Pension Plan Amendments Act of 1980—has made more employers realize that the future of their benefit plans is being shaped now by Washington legislators and regulators.

And more employers know that one of the best ways they can keep tabs on the latest benefits developments in Washington is through their trade associations based in the nation's capital.

Fortunately, there are at least eight major trade groups in Washington formed to address employers' needs (see chart, previous page) and four major insurance industry trade groups monitoring benefit action on the Hill. These groups can provide employers with the latest benefit information and make sure employer viewpoints are heard by federal legislators and regulators.

The groups vary considerably in size. For example, the American Council of Life Insurance, which represents most of the nation's life insurance companies, has 151 professional staffers at its Washington headquarters.

By contrast, Fred Hunt, the executive director of the Society of Professional Benefit Administrators, is the sole professional staffer at the society's Washington office.

But size isn't necessarily related to effectiveness. For example, SPBA's Mr. Hunt played a major role in the recent decision of the Internal Revenue Service to liberalize a 1981 rule and allow trade associations to sponsor 501(c)(9) benefit trusts for members within one state (BI, Dec. 13, 1982).

"The issue was dead and buried, but we helped revive it," Mr. Hunt says proudly.

Some business groups, like the U.S. Chamber of Commerce and the National Assn. of Manufacturers, have been around for decades and effectively lobby on a broad array of issues, including employee benefits.

But other groups have only recently sprung up and stick to one issue.

For example, the 62-member Employers Council on Flexible Benefits, established in November 1981 by about 10 employers, is exclusively concerned with developments that affect companies with flexible benefit plans.

"There was a need to establish links between companies with flexible benefit plans and those that wanted to find out more about the plans," said William Chip, an attorney with Ivins, Phillips & Barker, a law firm that represents the council in Washington.

Some groups trace their origins to the passage of a single law and the problems the law has caused.

For example, the formation of the ERISA Industry Committee or ERIC, a benefits lobbying group that represents large employers, was triggered by the passage of Employee Retirement Income Security Act in 1974.

Since its establishment, ERIC has concentrated its efforts on refining the pension reform law to protect the interests of large employers.

ERIC's Washington attorneys, for example, played a major role in lining up business support for the Multiemployer Amendments Act, the 1980 law that imposes financial penalities on employers that withdraw from underfunded multiemployer pension plans.

Since few ERIC members were likely to withdraw from multiemployer plans, the trade group fought for changes in the law to protect big employers from being saddled with the liabilities of the smaller firms leaving the plans.

Washington-based benefit groups differ in their style. The American Society of Pension Actuaries, whose members include pension actuaries and consultants that provide services to small pension plans, is known for its aggressive, outspoken views.

ASPA, for example, filed a Freedom of Information Act suit to force the Pension Benefit Guaranty Corp. to turn over records explaining why the PBGC only invests in Treasury notes and not in other government-backed securities that yield higher rates of return.

"We are willing to wage public battles," said Chester Salkind, ASPA's executive director. "I worked for the government for 20 years and I know that you have to be aggressive to get attention."

But other groups are much more low-keyed. Mr. Hunt of the Society of Professional Benefit Administrators prefers to work behind the scenes and lobby quietly for changes with regulators, a tactic that paid off during his discussions with IRS and Treasury Department officials on expanding 501(c)(9) trusts so they could be sponsored by state trade associations.

Benefit groups also differ in the way they are represented in Washington.

Most groups have full-time professionals serving as directors. For example, Michael Romig, the U.S. Chamber of Commerce's highly regarded director of employee benefits, is one of four Chamber benefit staffers that represent the Chamber's 237,000 members on issues like Social Security, pensions and health care.

On the other hand, some groups do not employ full-time professional staff members in Washington. ERIC, the benefits lobbying group representing large employers, relies principally on two law firms—Mayer, Brown & Platt and Vedder, Price, Kaufman, Kammholz & Day—to get its views across.

Some benefits groups that have had Washington offices for years have only recently become involved in benefits lobbying.

For example, the Assn. of Private Pension & Welfare Plans, a diverse group whose members include employee benefits managers, pension plan sponsors and benefit attorneys, was not a major force in the Washington benefits community until 1980 when it beefed up its professional staff.

The group hired Jeff Hart, a former high-ranking official at the PBGC, to be its executive director. Mr. Hart made sure that members were kept informed of the latest benefits developments through special newsletters. He also lobbied heavily to try to convince legislators to change certain benefit provisions in the Tax Equity and Fiscal Responsibility Act of 1982.

Some groups can influence the course of legislation even though they are not lobbyists and do not lobby.

For example, the Employee Benefit Research Institute was established in 1978 to provide a source of benefit information to regulators, employers, consultants and the news media.

"Companies wanted an organization that did nothing but research," said Dallas Salisbury, EBRI's executive director.

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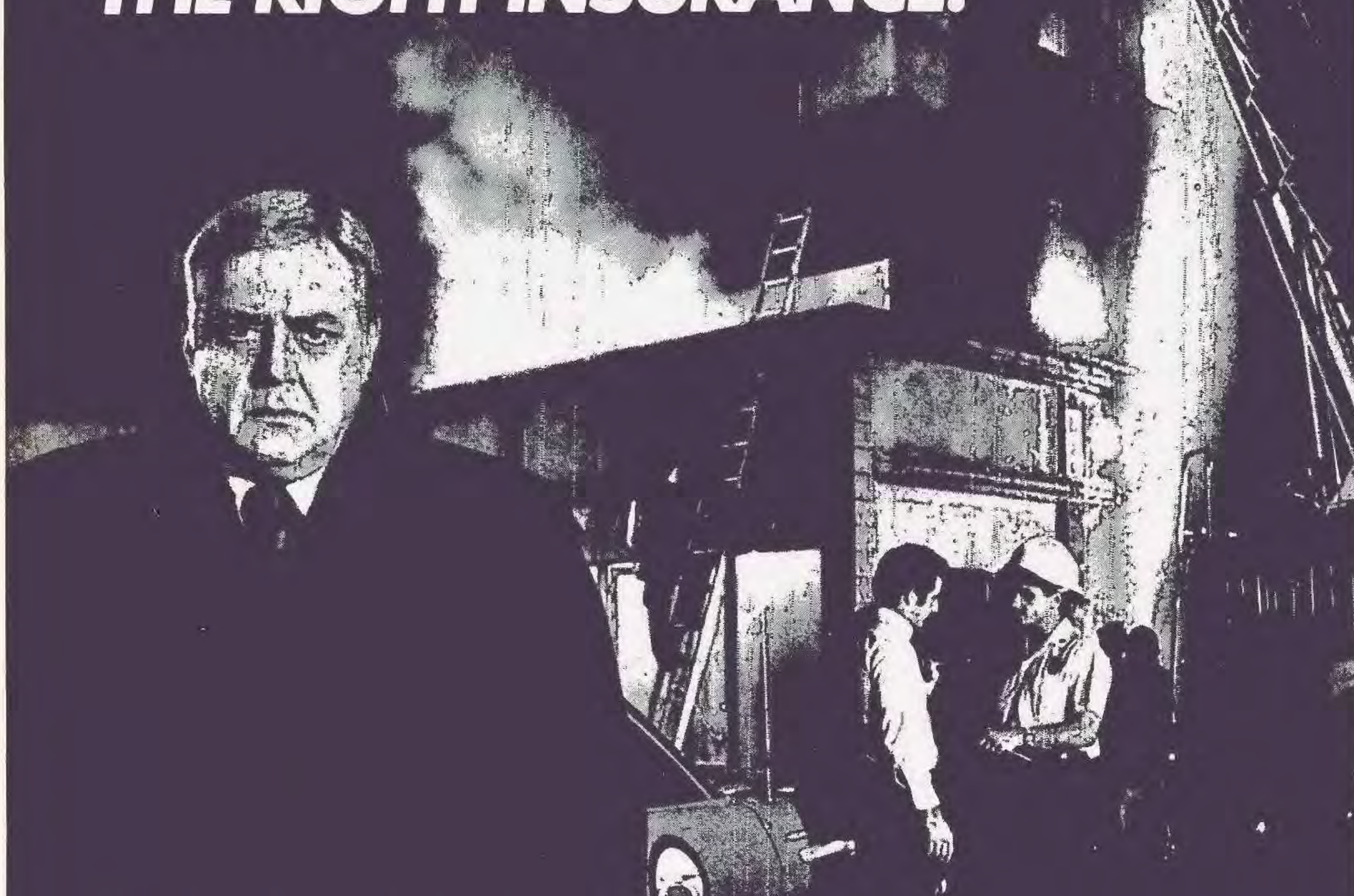

It's too late after your business burns down or your store is vandalized.

That's why it's a good idea to consult an Independent Insurance Agent before you buy your business policy. An Independent Agent represents several companies—not just one. So you can get expert, professional advice on how to select the best business coverage at the best price.

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opinions

Turning ideas into action

CAN HEALTH CARE cost control be yours for the asking?

It's probably not quite that simple, but it apparently isn't impossible, either.

Today's Spotlight Report on controlling benefit costs (see page 3) details some pretty impressive success stories where the plot revolves around a health insurance buyer asking the insurance provider to design benefit plans to curb costs.

Of particular note are the successes of Morgan Construction Co. and Norton Co. of Worcester, Mass., which worked with Blue Cross & Blue Shield Assns. of Massachusetts, and of the Teamsters union, which worked with Blue Cross/Blue Shield of Rhode Island.

In Massachusetts, the Blues developed at the Worcester companies' request a Master Health plan featuring mandatory second surgical opinion, pre-admission review, concurrent review and discharge planning to decrease hospital utilization. The plan is to be marketed to other Worcester employers this summer.

In Rhode Island, the Blues developed—at the Teamsters' urging—a unique "good health" benefit that offers Teamsters members and their families the opportunity to attend free workshops and seminars on at least nine health care topics. The Teamsters health plan already has fantastically good benefits. Now the plan trustees want to make sure the members head off unnecessary use of the benefits by staying healthy.

Morgan, Norton and the Teamsters are to be commended for going to the Blues and telling them what they wanted.

And, on the other side of the coin, the Blues deserve a round of applause for responding.

We chose to extensively profile Blue Cross/Blue Shield's efforts in the area of health care cost containment in this Spotlight Report because it is the oldest and largest provider of group health insurance, making what it does very significant.

But we already can hear the BC/BS critics, who give us a call or write us a letter citing the weaknesses of BC/BS whenever the Blues are profiled favorably. We are aware of the complaints about specific BC/BS plans —rates are high, service is poor, innovative coverage is hard to get—and have reported buyers' reasons for switching their coverage from the Blues.

But setting aside these criticisms for now, we have to notice that many of the 100 individually controlled and designed BC/BS plans have taken steps to be more in tune to the buyers' needs. Just look at the Massachusetts and Rhode Island plans.

And, as former BC/BS President Walter McNerney points out, buyers as little as five to 10 years ago were not asking for cost-containment plans but rather were demanding top-of-the-line medical care with top-of-the-line insurance coverage to pay for it. As BC/BS responded to those demands, it now is responding to buyers' cries to control costs.

With an organization as old and large as BC/BS, it's understandable that change may come slowly. But it can still come.

If you are a BC/BS client, you can easily gauge the Blues' sincerity. Fall in line with Morgan, Norton and the Teamsters and take your ideas to your local Blues plan. See what kind of response you get.

Maybe you won't get as far as you want—or maybe you will get health care cost control for the asking.

letters

How long till METs are regulated?

To the editor: Now that Congress has amended Title III of the Employee Retirement Income Security Act of 1974 to permit states to regulate multiple employer trusts, how long will it take before such regulations are promulgated?

In the past year or so, your magazine has had numerous articles on the "national scandal" of collapsing self-funded METs, which have left behind million of dollars in unpaid medical bills.

Now that state regulators have the clear-cut powers they need to regulate self-funded METs, how long will it be before they, individually or collectively with the help of the National Assn. of Insurance Commissioners, decide how to exercise these powers to restore order and responsibility to the marketplace?

I applaud your interest in the problem and the interest expressed by many state insurance departments. However, let's make sure that appropriate enforcement measures are adopted as quickly as possible.

William L. Lillis
Lillis, McKibben & Co.
Erie, Pa.

There's more security in a trust fund system

To the editor: I was surprised to read in "Limit Social Security benefit hikes" (*BI*, Feb. 28) that 94% of respondents believe that Social Security can be saved.

The system was patched up twice in the 1970s. The 1977 emergency aid was hailed by President Carter "as the guarantee that from 1980 to 2030 Social Security funds will be sound."

So-called Social Security "trust funds" are really just cash-flow accounts confiscating part of the nation's savings and diverting it for immediate comsumption. This is depressing savings rates.

Proposals by the president's Social Security commission may be rubber-stamped by Congress, but they won't cure the system's ills, either.

There have been a number of proposals endorsed by Milton Friedman, William Simon, James Kilpatrick and others that would phase out and replace the system with an individual trust fund system. Legislation that represents the first step has been introduced as S. 541.

This plan must eventually be adopted. The sooner it's done, the less will be the cost and difficulties involved.

James E. Burk
Western Springs, Ill.

No wonder they are 'extremely busy'

To the editor: I couldn't help but take a close look at the risk management consultants' directory in the Feb. 21 issue.

A hasty count revealed: Some 97 risk management consultants with a staff total of about 1,600 professionals served more than 8,000 firms. What is unusual is that such a broad representation of business and industry could operate so proficiently without professional safety and loss-control expertise. Or if it is needed, those 11 certified safety professionals with consultants have been extremely busy.

Last time I checked, the indentification of loss potential and the implementation of controls to minimize or eliminate loss costs were integral to risk management.

Remember: If you prevent the loss, you never have to worry about transferring or insuring against it. It's no wonder gold mines get richer for plaintiffs' attorneys; just keep putting risk managers or risk management consultants on the stand as safety expert witnesses.

Samuel P. Eatherly
Director of Safety
St. Luke's Episcopal Hospital
Texas Children's Hospital
Texas Heart Institute
Houston

Facing economic reality

To the editor: Your editorial, "Saving Social Security" (*BI*, Feb. 28), supported a front-page article reporting results of a survey of 124 benefit managers.

Although I take issue with a number of the so-called solutions to the problems of Social Security, I want to address the suggestion of "...gradually raising the Social Security retirement age."

Those individuals advocating increasing the retirement age apparently suffer from tunnel vision as to the total economic problems in this country. Raising the age requirement at which an individual is entitled to receive full benefits under the Social Security Act is as an inducement for individuals to stay in the labor market, thus occupying a position that might be occupied by some of the unemployed youth of our country. Our most critical problem is unemployment.

Usually, older individuals' appetite for consumption of houses, automobiles and other items is minimal, whereas younger people in the labor market, in their family-forming years, have significant needs, but not the economic wherewithal.

My suggestion that advocates of advancing the retirement age are suffering from tunnel vision is based on upon the observation that rarely a day goes by that the media isn't reporting about an employer offering inducements for individuals to retire early.

Therefore, advancing the retirement age is counterproductive to the realities of the world and ignores the critical need for employment throughout the country.

R. Guregian
Vp-Personnel and Labor Relations
Grand Trunk Rail System
Detroit

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Benefit issues abound

Continued from page 6

Act, which slashed tax rates by 25% over a three-year period.

But that hefty tax cut, along with other changes in the tax law, has led to the biggest budget deficits in U.S. history. And taxing benefits is now viewed by policymakers as one way to ease those deficits.

"Benefits are viewed as the fat cats," says Fred Hunt, executive director of the Society of Professional Benefit Administrators, a 225-member trade group representing third-party employee benefit administrators.

"Legislators say that deficits have to be reduced. They will come back again and again to tap the benefits well," predicts Michael Romig, director of employee benefits for the U.S. Chamber of Commerce.

And offense against such new assaults has begun. One of the fastest growing coalitions in Washington is one largely organized last year by the Health Insurance Assn. of America to lobby against any tax on health care benefits.

That coalition has grown in less than a year from 10 to 12 trade groups to about 100. It also is one of the few coalitions that has brought employers, insurers and labor unions together on the same issue.

Yet there are those who question the strength of the coalition.

"What if the Finance Committee puts out 10 different options to raise revenues," asks a lobbyist with an insurer trade group. "Employers might agree to a health care tax if they are presented with a revenue option they dislike even more, like an increase in corporate taxes."

Benefits could be tapped in other ways to raise revenues. Last year, for example, Congress approved a provision in the Tax Equity and Fiscal Responsibility Act that slashes the maximum annual contributions companies can make to their defined benefit and defined contribution plans.

Those maximum limits for both defined benefit and defined contribution plans are frozen until 1986.

But some legislators like Rep. Daniel Rostenkowski, D-Ill., chairman of the House Ways and Means Committee, are considering freezing them beyond 1986.

But the taxation of benefits isn't the only benefit area federal legislators will be looking at.

One of the hottest benefit issues in Congress right now is sex discrimination legislation, H.R. 100 and S. 327, that would bar employers from providing smaller retirement benefits to female retirees than to males.

That legislation, proposed in the House by Rep. John Dingell, D-Mich., and in the Senate by Sen. Robert Packwood, R-Ore., had been slumbering for years and attracted little interest.

That is no longer the case. Some 200 members of Congress are cosponsors of the legislation. And while the administration has yet to back a specific bill, President Reagan says he backs pension equality for women.

"Momentum for the (sex discrimination) legislation has been gaining ever since the Senate Commerce Committee passed a bill last year," said A. Linwood Holton, vp and general counsel for the American Council of Life Insurance.

If legislation were passed equalizing pension benefits for men and women, the greatest impact would fall on financially pressed state and local government since public employers are much more likely to offer defined contribution plans. Such plans pay smaller benefits to women than men because they live longer and collect benefits over a longer period of time.

Private employers usually offer defined benefit plans where the employee's benefit is based entirely on his salary and length of service; no sex distinctions are made.

No one knows what the cost would be to equalize pension benefits for men and women. But New York City officials recently said that the city would have to spend $800 million.

Insurance industry lobbyists say their goal now is to modify the legislation so that pension benefits would be sex-neutral for future pension plan participants.

Raising current female retirees' pension benefits to the level provided to men could bankrupt some public pension plans.

Other pension issues are likely to crop up this year. For example, preventing employers from dumping their underfunded pension plans on the Pension Benefit Guaranty Corp. is an "issue that won't go away," says Dallas Salisbury, executive director of the Employee Benefit Research Institute, a benefits think tank.

The vulnerability of the PBGC, set up in 1974 to guarantee workers' and retirees' vested pension benefits, became evident last year.

During fiscal 1982, the agency was hit with $200 million in claims from employers that folded their pension plans.

And most disturbing, according to some pension experts, is that the claims that the PBGC was forced to swallow last year may only be a taste of what is to come.

More and more companies are recognizing that it may be cheaper to fold their pension plans and dump the liabilities onto the PBGC than continue to pay for the plans.

Under the Employee Retirement Income Security Act, the PBGC has to guarantee pension plan participants' vested benefits if the employer folds the plan with insufficient assets to pay benefits.

Faltering companies have discovered that the plan termination fee of 30% of their net worth is a penalty without teeth and they are willing to pay that price to fold their plans.

This prospect is a major concern to some large employers. Members of the ERISA Industry Group, a benefits lobbying group representing large employers, feel they shouldn't have to pay for other companies' underfunded pension plans through higher PBGC insurance premiums.

Employers now pay an annual insurance premium of $2.60 per pension plan participant for termination insurance. The PBGC wants the premium raised to at least $6, but some believe it could climb as high as $100.

Business groups, like the ERISA Industry Committee, say the PBGC insurance program needs to be tightened to make companies liable for their pension promises.

But the drive to overhaul the PBGC insurance program has been stalled for more than a year. Some small employers fear that their futures could be threatened if their pension liabilities were increased or were more difficult to unload.

In addition, a business consensus on pension issues has been difficult to achieve ever since Congress passed the Multiemployer Amendments Act, the 1980 law that imposes financial penalities on companies that withdraw from underfunded multiemployer pension plans.

Many small employers stayed on the sidelines during that legislative battle while big companies fought for the bill.

However, the small employers that have since left multiemployer plans have been hit with enormous withdrawal liability claims. They resent the role large companies played in the passage of the act and are suspicious of new pension proposals backed by large employers. ■

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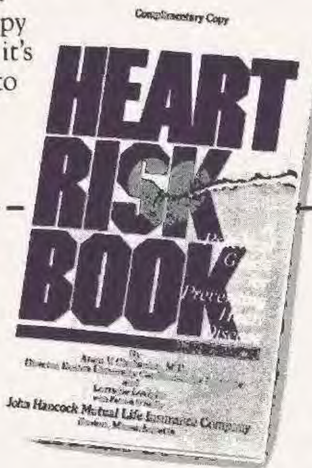

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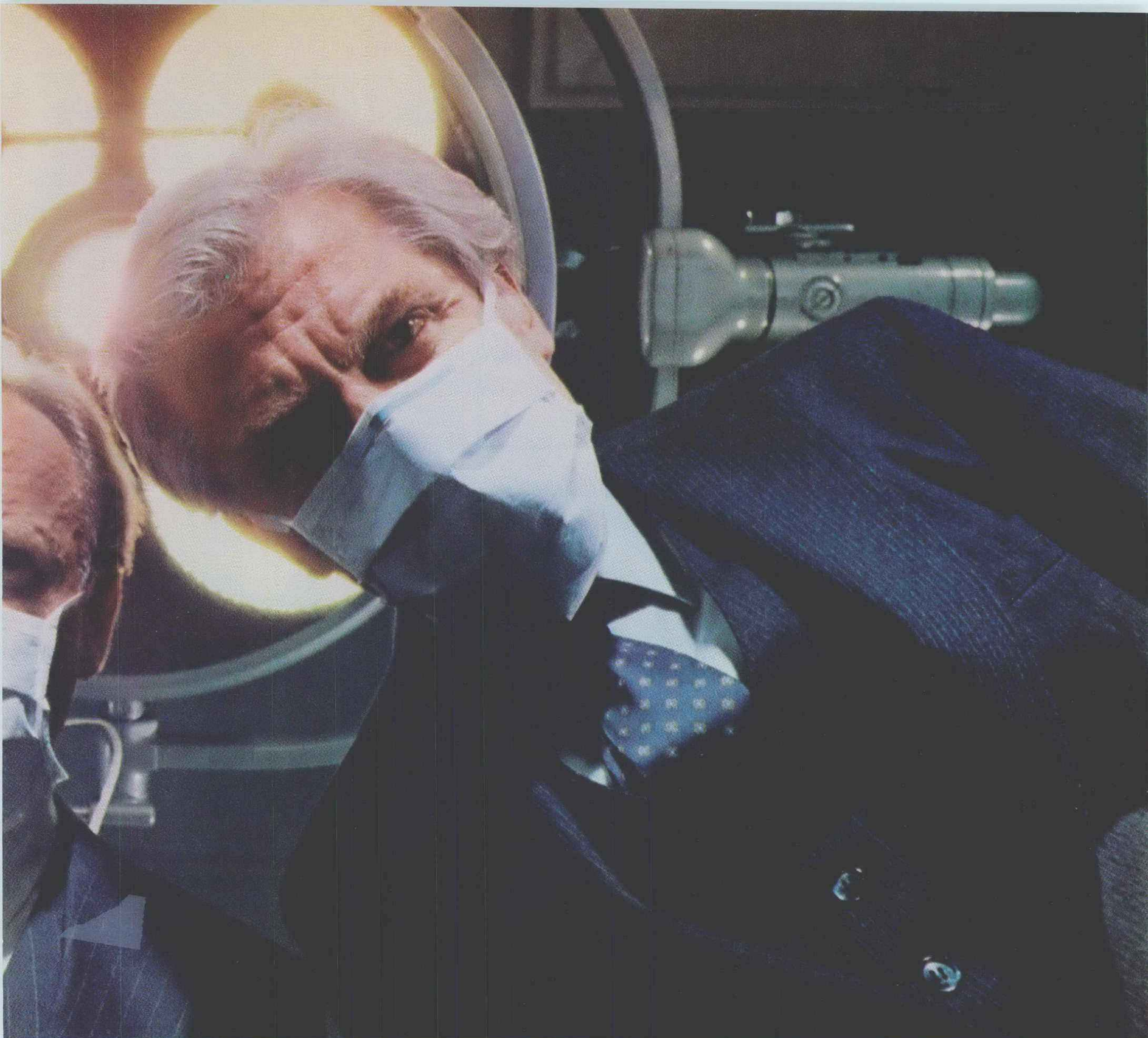

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'Good health' benefit ready

Continued from page 3

Ms. Gomes also will be available throughout the year as a resource person for Teamsters with special questions or problems.

"I believe in prevention and this new program deals with preventive measures. . .We know that certain diseases can be prevented if people watch their risk factors," Ms. Gomes said.

This "good health" benefit was announced in October and will be kicked off with a family health fair called "Health Stop 83" on March 20 at the Teamster Hall in Providence.

"We've always provided health education, but this is the first time we've structured a benefit like a product that we could price and sell," said Walter Pickford, a spokesman for Blue Cross/Blue Shield of Rhode Island.

More than 500 families have already indicated they will attend the afternoon fair, which will feature aerobics and biofeedback demonstrations, blood-pressure screening, glaucoma testing and a number of self-evaluation tests.

The booths at Health Stop 83 will give Teamsters families a hands-on experience to learn what can be done to maintain their health, reduce the risk of illness, its costs and consequences.

Instant education from the one-day event, however, is not the goal of the fair. The demonstrations and tests are expected to stimulate an ongoing desire for good health. Almost every booth will have sign-up sheets for the classes and workshops that will be held evenings and weekends throughout the year at sites all over the state.

Mr. Hylek

To determine those initial classes, Ms. Gomes surveyed Teamsters last fall. For the past several months, she has also worked with Teamsters volunteers at evening gatherings to inform members about the new benefits.

Since the good-health benefit was announced (to the plaudits of government and medical officials throughout the state), several other large Blue Cross/Blue Shield subscribers have asked for a similar program, but have been put off until this one is tested and perfected, said Mr. Pickford.

The health education benefit will cost the Teamsters at least $50,000 this year in premiums. How much will it save?

"We're not working on saving. . .we're sowing seeds for a benefit change; we hope in a period of years it will lessen (health care) costs," Mr. Pickford said. "This is not a quick fix."

Health care costs will continue to rise nationwide because of technology and inflation. "What we're attempting to do is moderate one (area) of health care costs," he said. And that area is utilization.

The good-health benefit, believed to be the only one underwritten by a health coverage provider, is expected to become a prototype benefit throughout the Eastern Seaboard, where innovative health programs are a way of life.

This educational program follows the road of success frequently traveled by the Teamsters local and BC/BS of Rhode Island, which linked up in 1954.

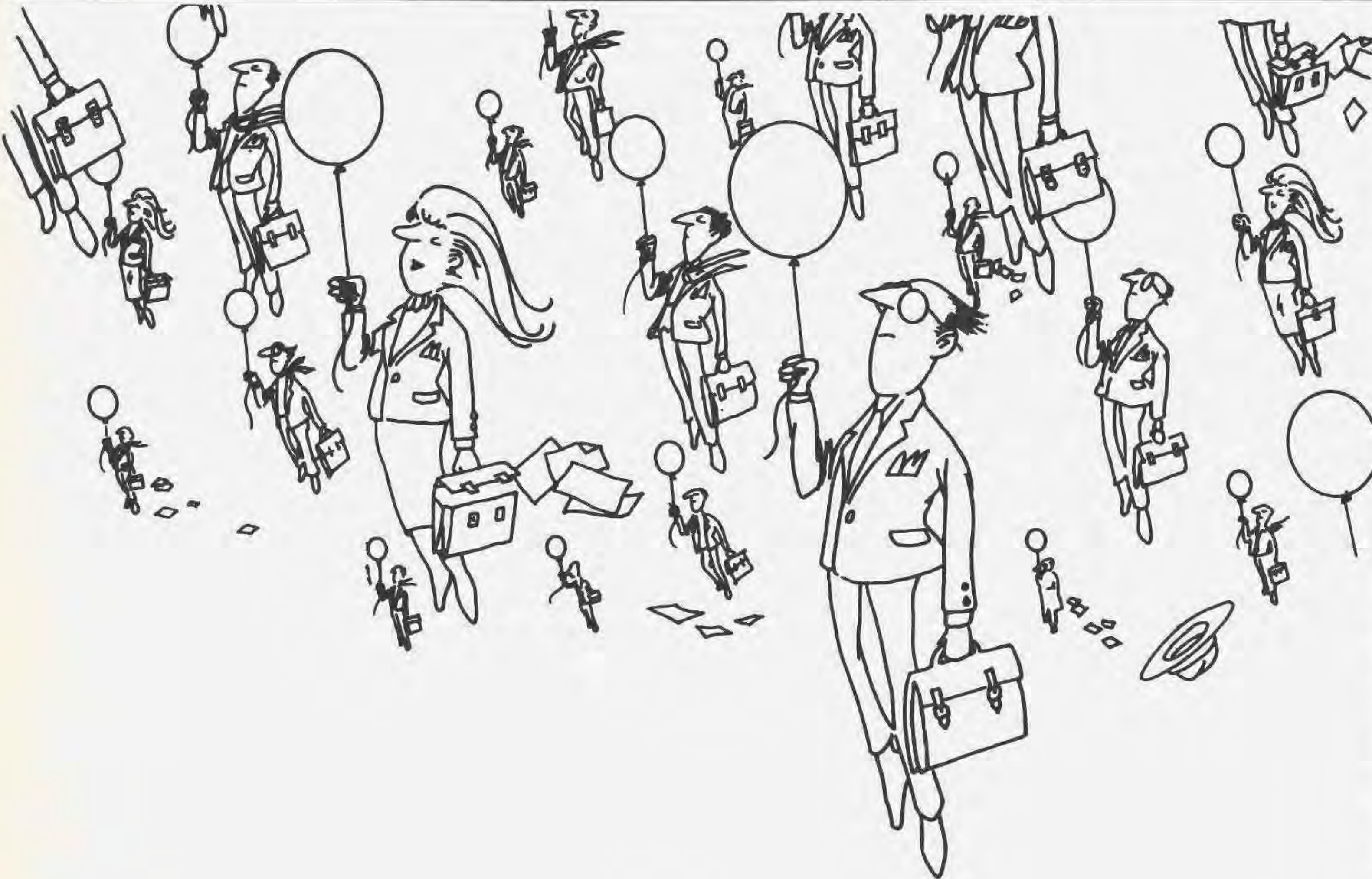
Over the years, by using invested funds, the union has been able to expand and build its health care coverage so that members have virtually inexhaustible hospital benefits (730 days of fully paid semiprivate hospital care) in addition to $1 million major medical coverage with no deductibles and 80%-20% coinsurance for the first $2,000. When bills pass the $2,000 mark, the plan picks up 100% of costs.

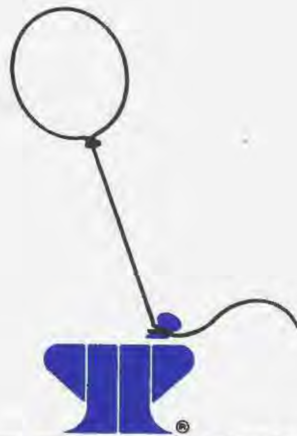
"When 1980 arrived, our financial position was such that we were able to give benefits that far exceed any benefits in the United States," said trustee Samuel Malkin, president of Samuel's Enterprises in Providence.

"But the trustees felt that unlimited care was not enough," said John O'Connor, vp of marketing for BC/BS. "The trustees were watching, asking if there was a way we could do more to further blunt health care costs," he said, explaining how the good-health benefit was conceived.

Going back to BC/BS was a natural step for the trustees who had

Continued on page 16





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Cost containment stressed

Continued from page 14
worked hand-in-hand with the health association for many years in pioneering cost-containment measures.

Through Blue Cross/Blue Shield discounts, prospective reimbursement programs and other built-in cost-containment procedures like utilization review and coordination of benefits, Mr. Hylek of the Teamsters estimated the union's health plan saved $1.3 million last year.

"All of our programs are cost-conscious," said Rhode Island BC/BS President Douglas J. McIntosh.

But he stresses that BC/BS of Rhode Island does not believe in containing costs simply by passing them back to the consumer.

That's avoiding the problem, not solving it, he says.

Blue Cross/Blue Shield programs try to get right down to the cost of care—the way it's provided and utilized, Mr. McIntosh said.

Nine years ago, the association began its prospective reimbursement program. The association sits down with all Rhode Island hospitals annually to negotiate how much hospital costs will increase overall "to cap it and manage it," Mr. McIntosh said.

Mr. McIntosh

Since the program's inception, Blue Cross/Blue Shield believes there has been an accumulative savings to the community in excess of $120 million, compared with national average cost increases.

Last year, there was a savings of $5.5 million to Blue Cross/Blue Shield subscribers, but because the negotiated hospital costs also apply to non-subscribers, the statewide savings were estimated at more than $18 million, said Lawrence A. Ross, administrative assistant, Blue Cross/Blue Shield.

Because of this prospective reimbursement program, hospital costs in Rhode Island have been less than the national average.

Same-day surgery programs, pre-admission testing and home health care are other cost-containment programs that Blue Cross/Blue Shield expects to result in a $60.5 million cost savings/avoidance for fiscal 1982, on claims in excess of $259 million.

But to achieve such savings, it took several years of internal and external education and a workable relationship with subscribers and providers.

Display racks with brief brochures about the various alternative cost-savings programs are set up in the hospitals. "That's educating our subscribers at the time of utilization," Mr. Pickford said.

Health care alternatives (such as home health care and same-day surgery) are explained to subscribers when they join the plan, but are often forgotten until needed, Mr. Pickford.

These alternatives are part of every basic Rhode Island BC/BS contract and account for more than $3.4 million in estimated savings during the past year.

The alternatives drive people out of hospitals and drive costs down, Mr. McIntosh said.

Reasonable and customary charges, still being used by physicians throughout the country, were abandoned in 1976 by Blue Cross/Blue Shield of Rhode Island and replaced with a capping program worked out with physicians which is similar to the hospital prospective reimbursement program.

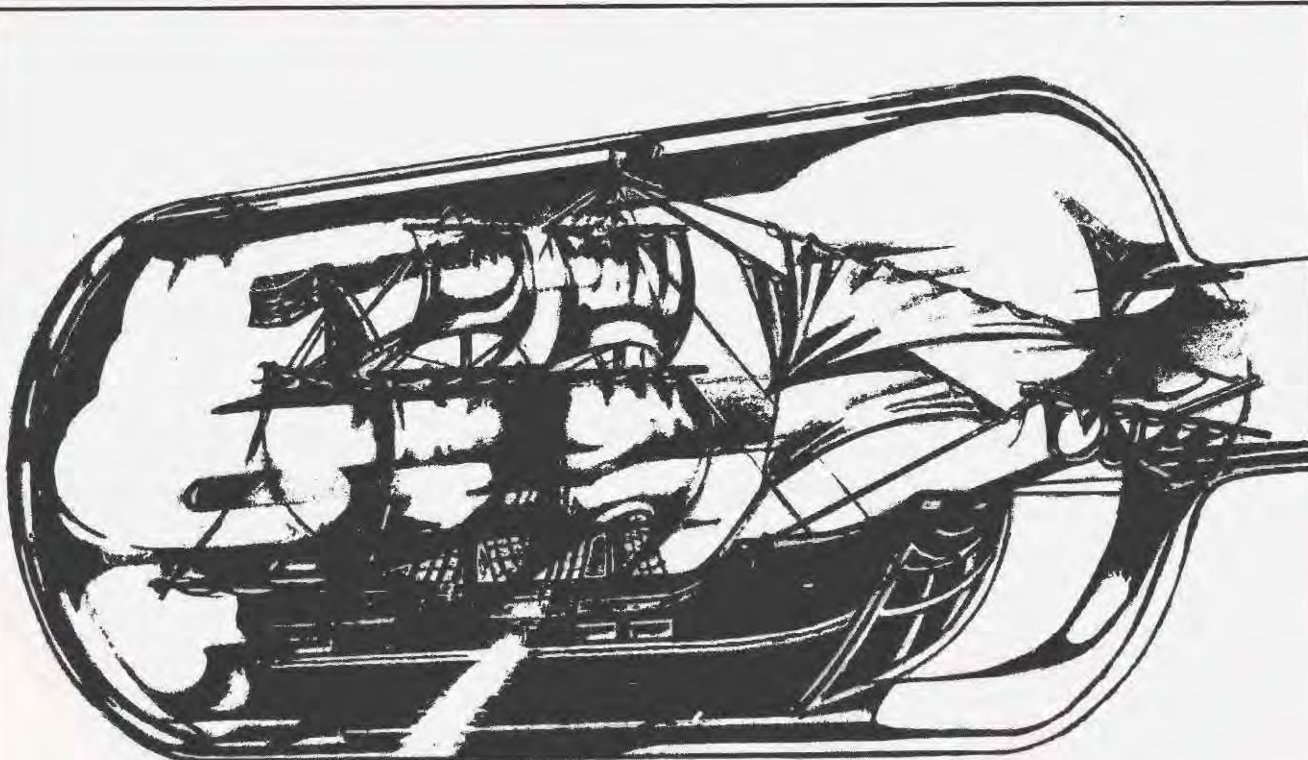
About 90% of the physicians in the state have agreed to the charges set out in the program.

Working with the hospitals and physicians is what really has worked for the association. For example, Blue Cross/Blue Shield, the Rhode Island Medical Society and the Hospital Assn. of Rhode Island have explored health care alternatives together since 1974, looking for efficiency and cost-effectiveness.

Building on that relationship, Blue Cross/Blue Shield approached the medical society last year with a list of procedures that could be done on an ambulatory basis.

"It was on their initiative that we studied the list and made an approval," said Norman A. Baxter, executive director of the medical society.

"And I don't think that's unique, but (rather) an illustration of how we work with them." ■



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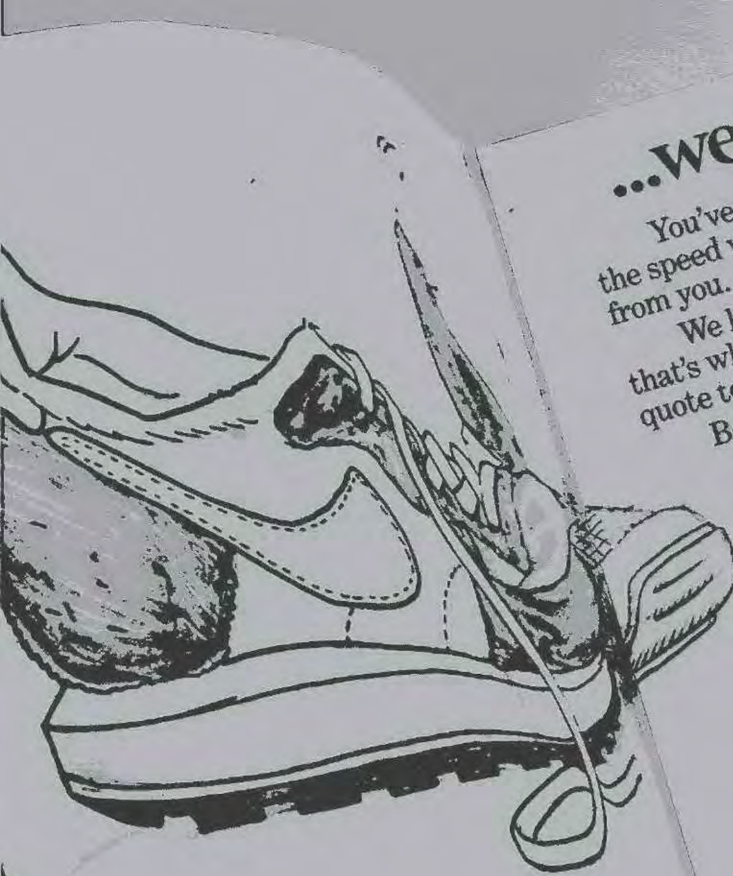

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Worcester firms ask Blues to help control costs

Continued from page 3
ployee in 1972—a 428% increase.

That was the genesis to "get into this thing (the health care cost-containment issue)," according to Mr. Robertson.

After talking with consultants about various strategies for curbing the rising costs, plan redesign came out at the top of the list. And, the company took its concern to Blue Cross & Blue Shield.

At about the same time, another business in the coalition—Norton Co. with about 4,000 employees—approached the Blues with the same challenge: Impact health care costs without cost shifting or sacrificing quality care.

The result is a comprehensive BC/BS plan called Master Health, that went into effect Jan. 1 at both Morgan and Norton.

The concept is expected to be introduced in other Worcester companies this summer, according to Fay Donohue-Rolfe, director of the BC/BS Worcester regional office.

A decrease in hospitalization utilization is a chief goal of the plan.

"It's hard to measure a goal, but I'll be upset if we do not have a 20% reduction in bed days," said Morgan's Mr. Robertson.

The new medical plan is a managed care program featuring mandatory second surgical opinion, pre-admission review, concurrent review and discharge planning.

Blue Cross & Blue Shield have been involved with cost-containment activities, like utilization review and employee education, for years. But this package was different.

"I never saw all four done at once, with input of the subscriber business," Ms. Donohue-Rolfe said.

Under the plan, all admissions to Massachusetts hospitals for non-emergency or non-maternity care must be reviewed by BC/BS before the patient enters the hospital.

The purpose of this pre-admission review is to eliminate unnecessary hospitalization and increase the use of outpatient service whenever possible, Ms. Donohue-Rolfe said.

BC/BS guarantees an answer to this review within 48 hours in the form of a letter to the doctor, hospital and patient, she said.

If the admission is approved and the employee enters a hospital, the concurrent review process takes over, and the Blues stay in contact with the hospital to check length of stay and appropriate use of hospitalization.

The hospital utilization review coordinator and physician determine when a hospital stay will end and if care will be continued in another health facility, like a skilled nursing care center. After this discharge planning is completed, no further benefits will be paid by BC/BS if the patient decides to stay in the hospital.

The mandatory second surgical opinion requirement applies to seven surgical procedures that studies have shown are often not necessary, Ms. Donohue-Rolfe said. The procedures are hysterectomies, removal of gall bladders, knee surgeries, removal of hemorrhoids, hernia repairs, removal of tonsils and adenoids and dilation and curettage.

All costs associated with obtaining a second, or even a third, surgical opinion are covered in full.

But, the Blues will pay none of the cost of these seven procedures unless the patient obtained a second opinion.

Communication to the employees, as well as to medical care providers, was the key to making the plan work, Ms. Donohue-Rolfe said.

"It was important that they (the employees) knew if they didn't get a second opinion, there wouldn't be any benefits," she said.

This communication process started at Morgan last April, Mr. Robertson said. In a company newsletter, he explained that 1982 health care costs were $900,000 above the 1981 figures. "Wouldn't it be nice if that went into profit sharing?" Mr. Robertson asked.

Employees were told about things they could do to hold down the costs, like asking the hospital or their doctor about charges they don't understand and questioning items on hospital bills.

The next step was to explain the new plan at face-to-face meetings.

"We saw all of our 750 employees in one day," Mr. Robertson said, noting the day started at 7:30 a.m. and concluded at 11 p.m.

Hourlong meetings of 25 to 30 employees were held simultaneously at the company's two locations in Worcester.

The cost of the meetings, which were held on company time, was not computed, but Mr. Robertson said that communication of the new plan was integral to its success and had to be done well.

"When you develop a plan like this, you have to be ready for a lot of work in terms of education," Ms. Donohue-Rolfe said.

BC/BS put together booklets, slides and posters for the communication effort, while Morgan published items in the in-house publications and wrote the script—"a carefully worded script," according to Mr. Robertson.

Employees had to understand that the new plan was not cheap; there still was quality care, he said.

"As in any plan, there were changes, and changes tend to be suspect. But we presented it in the best light," Mr. Robertson said.

There were a few take-aways in the plan, but much more was added, he noted. For instance, doctor's office visits are now paid in full and benefits have been added for skilled nursing, visiting nursing and hospice care.

Another reason Morgan employees had to know the details of the new plan was because they had the choice between it or one of two health maintenance organization options.

The HMOs were introduced in 1980 when Morgan decided to freeze its share of health care premiums at 90%. Because the premiums for BC/BS coverage exceed the premiums for HMO care, Morgan employees who choose HMO coverage pay nothing toward the premium.

Since 1980, there has been a gradual exodus by employees from the old Blue Cross & Blue Shield plan to one of the HMOs, Mr. Robertson said. About 60% of the employees still have coverage from the Blues, while the remainder are split between the two HMOs.

The HMOs "pretty much cover everything in full," Mr. Robertson said, noting there is a co-payment of $2 per office visit for one HMO and $3 for the other.

Employees who belong to the BC/BS plan pay $21 per month for family coverage ($7.60 per month for an individual), with a $100 deductible per person. "I'm a strong believer of employees paying something," Mr. Robertson said.

He's also a believer in competition and is excited that this new cost-containment plan may eventually reduce the cost of the Blues coverage, making it more competitive with the HMOs.

To continue this impact, a couple of preferred provider organizations probably will be introduced by the end of the year, Mr. Robertson said.

"I'm married to nobody. I want good coverage for our employees, with good claims handling," he noted.

The initial feedback to the Master Health plan has been good, according to Ms. Donohue-Rolfe.

"The second opinion surgery. . .they liked it. They said 'I'm not questioning my doctor, it's Blue Cross and Morgan.'" A voluntary second surgical opinion program instituted earlier did not work because the employees felt awkward challenging their doctors.

"And people love getting a review and then knowing 'It's OK, I'm going to get covered,'" Ms. Donohue-Rolfe said.

"These were spinoffs we didn't anticipate," she said, adding that there was some concern among the physicians about the mandatory second opinion, but it wasn't revolutionary.

"Everybody's been working together," she said. "We all tend to underestimate employees, but they know all about costs, they know something has to be done." The Master Health plan—which didn't really change benefits, but only the way they are managed—is "good health," according to Ms. Donohue-Rolfe.

"We try to participate in as many forms (of cost containment) as we can, to put our position out to try to influence the direction of health systems," said Leon S. White, assistant vp of health care administration for Blue Cross of Massachusetts.

Matching resources with needs has been a BC/BS philosophy since the early 1970s, Mr. White said, "but now it's being more aggressively pursued." ■

'It's hard to measure a goal, but I'll be upset if we do not have a 20% reduction in bed days after implementing the Master Health plan, says Gavin D. Robertson, vp of Morgan Construction Co. of Worcester.

Mr. Robertson

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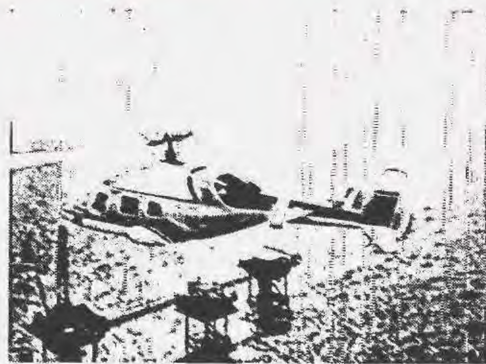
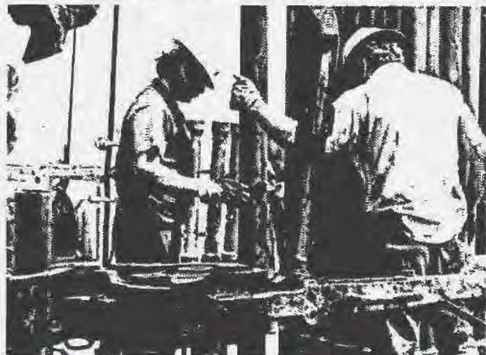

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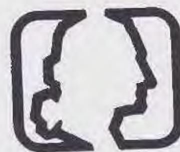

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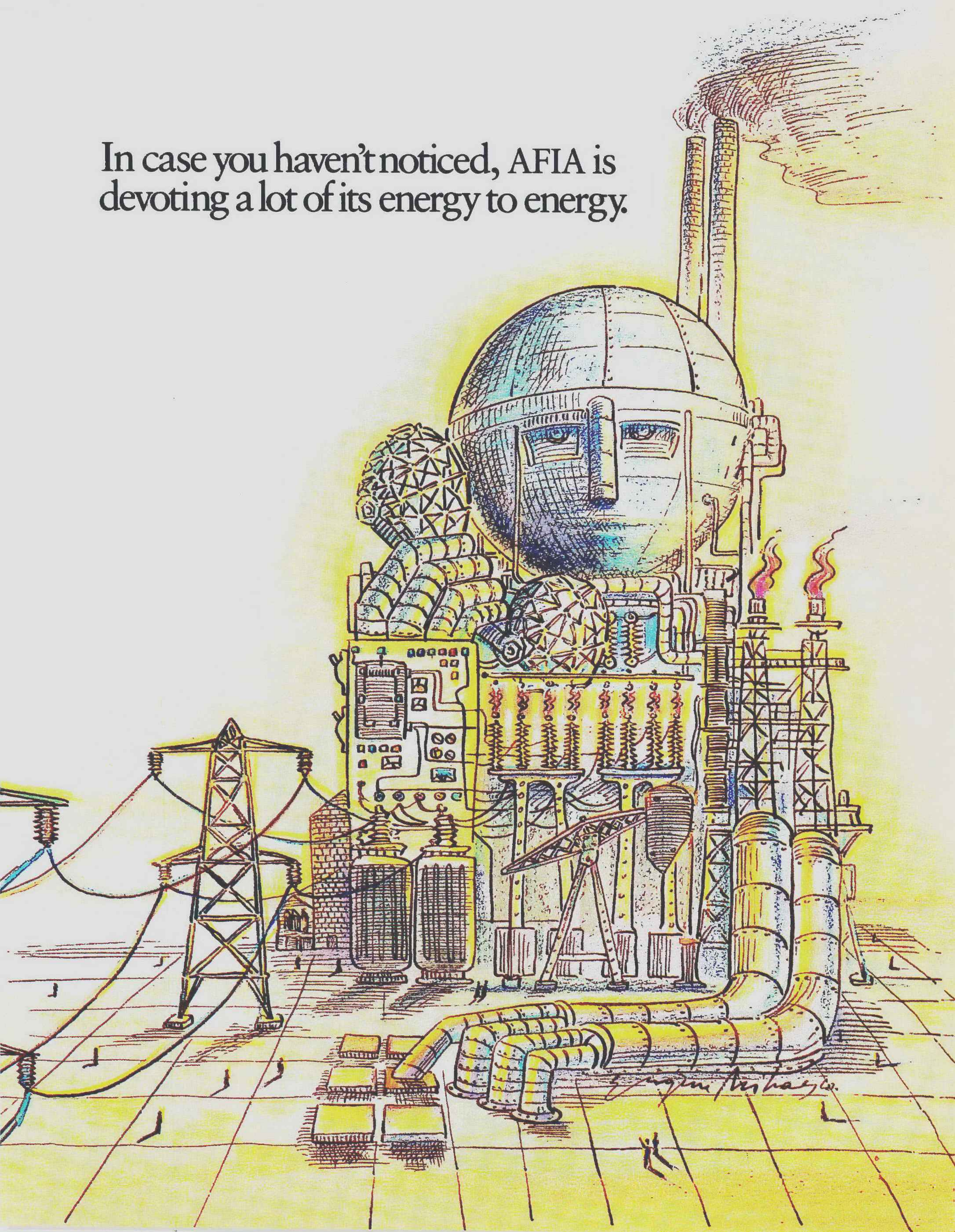
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Blues' cost-control claims stir debate

By CAROL CAIN

Are the 100 Blue Cross and Blue Shield plans leaders in health care cost containment or reluctant followers?

Blue Cross & Blue Shield Assn., the national association that acts as a coordinating agency for the 100 individual plans, says it is a leader. And some of its clients enthusiastically back up this claim (see stories on page 3).

But critics, health care providers as well as consumers, say BC/BS is a follower that must be pressured into introducing innovative plans.

BC/BS officials, however, say the association has not dragged its feet on cost containment but rather was responding to what buyers wanted during particular periods.

Despite this fact, it was a leader in many areas of cost containment, they say.

"The whole subject of cost containment evolved," said Walter McNerney, who was president of the association for 20 years until his resignation in 1981. He now is consulting and helping develop innovative delivery systems and working with industries to help make them better buyers of health care benefits.

"As demands became (greater), the Blues tended to identify more with the buyers," Mr. McNerney said. "There's no question that any major institution must serve the buyers' prejudices and, in fact, the buyers were more concerned about purchasing good, high-quality care in those (early) years."

Now, buyers want plans with cost-containment features and flexibility, said Lawrence Morris, BC/BS senior vp of professional and provider affairs.

Mr. Morris

"We have now injected flex, to be responsive to a variety of demands," Mr. Morris said.

Specifically, BC/BS developed a Metamatrix System 18 months ago—a comprehensive program "that covers just about anything imaginable," Mr. Morris said.

The system allows buyers a choice in services, size of deductibles and coinsurance provisions and flexible financing. It also allows for flexible approaches to limiting employees' out-of-pocket costs.

All the local plans are committed to this new program, Mr. Morris said, but will apply it differently, depending on local businesses' needs.

BC/BS often has been criticized for its lack of deductibles and coinsurance provisions that cost-containment advocates say make consumers more aware of health care costs. But these provisions have popped up more often in local BC/BS plans in recent years and are now part of the Metamatrix program.

However, Neil Hollander, BC/BS executive director of health care services, is quick to point out there is no evidence yet that coinsurance provisions in a health care plan help contain costs.

The Metamatrix System is only one of BC/BS' latest efforts in a long line of cost containment experimentation, its officials stress.

"We've done more in experimenting in the area of cost containment than anyone," said Mr. Hollander. Since the 1960s, Blue Cross has been experimenting with utilization review, contractual relationships with providers and pre-admission testing. It was also a pioneer in hospice care for the terminally ill.

Mr. Hollander

Individual Blue Cross and Blue Shield plans in western Pennsylvania and Ohio instituted the concept of utilization review in the 1960s, Mr. Hollander said.

Second-opinion surgery, ambulatory surgery and workplace screening for hypertension are other areas where Blue Cross and Blue Shield took the lead, Mr. McNerney said.

They are still part of the cost-containment efforts today, along with newer ideas like a medical necessity program and "good health" education programs.

The medical necessity program, starting in some local plans as early as 1976, was developed with the help of medical educators and practitioners to identify a list of medical and surgical procedures that contribute to the cost of health care, but in many instances do not make parallel contributions to the quality of care. Almost all of the 100 local Blue Cross and Blue Shield plans use this program and have discontinued payment on 85 procedures listed as outmoded or of unproven value, unless there is justification from a physician.

New cost-containment measures are introduced almost annually by BC/BS, which says none of its efforts were total failures.

"Some were more stubborn to implement, but none didn't work," Mr. McNerney said.

Alternative delivery systems, like health maintenance organizations, are among recent cost-containment efforts that have been hard to implement. "Some markets are just not ready," Mr. McNerney said.

HMOs have more of a tradition on the West Coast than on the East Coast, Mr. Hollander said. "And, that makes them more salable on the West."

Forty-eight Blue Cross and Blue Shield plans, however, are operating or providing services to 79 HMOs, enrolling more than 1 million subscribers.

Different plans in different areas of the country providing different benefits is the strength of the association, its officials say.

"The Blue Cross and Blue Shield strategy is to tailor the programs to meet the needs of the local environment," Mr. Hollander said.

But having different plans sometimes makes it difficult for benefit managers with plants in different locales. And buyers' opinions of BC/BS differ according to which plan they are dealing with.

"Each unit within the state is as different as night and day," said Frank Morgan, vp of human resources for Berol Corp. in Danbury, Conn. "Some are good and some are bad."

A frequent complaint is that the BC/BS plans are not responsive to change or the need for cost containment.

Continued on page 24

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Blues, critics debate cost-control claims

Continued from page 22

"We tried to have them write our health incentive plan (*BI*, Nov. 15, 1982), but they didn't want to. . . ," said Mr. Morgan. "Maybe it was too new, too innovative; maybe too much work."

On the West Coast, the Los Angeles Department of Water and Power had medical care coverage through Blue Cross until 1979, when it became self-insured.

"Rates increased tremedously and services decreased," a manager there said. "There was no cost containment; they paid anything across the desk."

Competitors of BC/BS question if it is doing a better cost-control job and if it really is a trailblazer.

"Everybody says they do cost containment," said Tom O'Hare, director of health care management programs for the Health Insurance Assn. of America, a trade association that represents the interests of 338 commercial health insurance companies. "Everybody does, but in varying degrees. (The Blues) are no different from anything any of our companies offer," he said.

For instance, Prudential Insurance Co. in Newark, N.J., has zeroed in on six areas of cost containment: second surgical opinions, pre-admission review, home health care, a hospital audit program, hospice care and mental health quality assurance.

Connecticut General Life Insurance Co. of New York, a unit of CIGNA, has similar cost-containment activities, including benefit plan reviews, employer-employee education, second-opinion surgery, hospital utilization review, the combination of analytical expertise with data processing systems and the technical support to business coalitions.

"(The Blues) traditionally have been wedded to hospital and service contracts and are somewhat slow in innovating outside of hospital care because of their hospital alignment," Mr. O'Hare said.

"They're far from trend-setters. . .only a step ahead of Medicare and Medicaid in terms of its government orientation," another critic said.

"We find the Blues are not interested in anything but maintaining their market; and in the long run, that's detrimental," Mr. O'Hare said.

BC/BS covers almost half the nation's population

Blue Cross & Blue Shield Assn. is the largest and oldest provider of group medical benefits.

It has secured 35% of the group and individual health care insurance market with its 100 local plans, serving more than 102 million people in the United States—almost 50% of the population.

Of those, about 85 million are regular Blue Cross and/or Blue Shield plan subscribers, which include persons in the Federal Employees Health Benefits Program.

The other 17 million are served by Blue Cross & Blue Shield through Medicare and military dependents programs.

In 1981, BC/BS paid out more than $60 billion for more than 404 million claims.

Blue Cross and Blue Shield became a joint corporation—Blue Cross & Blue Shield Assn.—in 1982, after operating under one management since 1978. Before that, each association operated separately.

Blue Cross & Blue Shield Assn. is best described as the coordinating agency for the 100 individual plans. It is not quite an operating organization, nor is it a trade association.

"There's certain things we want them (local plans) to do in the same way. . .but we don't want to try to impose a single set of ideas for all environments," said Lawrence Morris, BC/BS senior vp of professional and provider affairs.

The 100 Blue Cross and Blue Shield plans are individual non-profit organizations that operate, almost in all cases, under special state regulating legislation. This non-profit standing is the main difference between Blue Cross and Blue Shield plans and other insurance companies.

Another difference is that most Blue Cross and Blue Shield plans, unlike commercial insurance companies, have contracts with hospitals and doctors. Because of these contracts, participating hospitals will admit a Blue Cross plan subscriber without a deposit or other financial assurance. The provider usually bills the Blue Cross and/or Blue Shield plan directly. For this reason, they often are described as prepaid plans.

The concept behind Blue Cross can be traced back to Dallas in 1929. At that time, Justin Ford Kimball, executive vp of Baylor University, and a group of school teachers worked out an agreement with the university hospital.

For 50 cents a month, the 1,356 teachers were guaranteed 21 days of hospital care.

Other groups of Dallas employees joined the plan, and the idea spread to other parts of the country shortly thereafter, with each locality adding its own refinements.

Each plan enlisted a single hospital to serve its members, but by 1932, the plans included several hospitals to give subscribers a choice.

The blue cross was first used as a symbol in 1933 by E.A. VanSteenwyk, the first executive of the Hospital Service Assn. of St. Paul., Minn., one of these service groups. He used the cross on stationery and printed material to identify the program.

That symbol was officially adopted six years later and was revised in 1972 when the name and mark were transferred from the American Hospital Assn. to the Blue Cross Assn.

The accurate beginning of the Blue Shield concept is not as easy to trace. Some historians say it has its roots in county medical prepayment bureaus, which came into existence shortly before the turn of the century in the Northwest. Others say it dates much further back.

The first Blue Shield-type plan began in 1939 in California as California Physicians' Service. It provided physicians' services to employee group members who earned less than $3,000 annually.

The Blue Shield name and symbol were first used in Buffalo, N.Y. The name and symbol were registered officially in 1951 for Blue Shield plans.

Throughout the years, many Blue Cross and Blue Shield plans began to work together, and often were said in the same breath.

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Benefit tax plan would cool costs, its architect says

The tax-free status of group health insurance benefits is adding fuel to the roaring fires of medical care inflation, the Reagan administration says.

To help snuff that inflation, the administration has offered a controversial proposal to tax employer-provided health insurance contributions that exceed $340 a year for individual coverage and $2,100 for family coverage.

The major architect of the health care tax proposal is Dr. Robert Rubin, assistant secretary for planning and evaluation at the Department of Health and Human Services.

Business Insurance interviewed Dr. Rubin to find out how and why he thinks a health benefit tax would work, as well as to ask his views on what he believes employers and insurers can do to control health care costs.

Dr. Rubin, who has been an HHS assistant secretary since June 1981, is responsible for developing the department's legislative program and other major initiatives. He also oversees research activities.

He previously was an associate professor of medicine and assistant dean for government affairs at the Tufts University School of Medicine.

Business Insurance: In 1982, health care costs, according to the Bureau of Labor Statistics, rose almost three times as much as the Consumer Price Index. In previous years, health care costs also increased substantially more than the CPI. What are some of the reasons that this trend has continued?

Dr. Rubin: Predominantly, both consumers and providers view health care as free. They do not view price as an important variable in the medical marketplace. When people think they are getting goods and services at no cost, they tend to consume or provide more of it.

BI: How would a health care tax change that trend? How would it cool medical care inflation?

Dr. Rubin: We know insurance has hidden the cost of health care in general and hospital care in particular. For example, in 1950, the cost of a day in the hospital was $15 a day, while in 1980 it was $245 a day. When one factors in inflation and uses constant dollars, then the average (daily) cost in 1950 was $22 and the average cost in 1980 was $99 a day. That is a 450% increase in 30 years.

As a result of the broad and rapid growth of comprehensive insurance, out-of-pocket expenditures for the consumer went down from 30% (or $7) to 10% (or $10), roughly speakly.

As hospital costs were increasing 450%, the consumer saw roughly a 30% increase in out-of-pocket expenditures. This has been a trend that has been mirrored in other areas of the health care marketplace.

The tax-cap proposal, by putting a limit on the amount of tax-free insurance that an employer could provide an employee, would make the employee cost-conscious in the sense of wanting to purchase an insurance policy that fell under the tax cap.

In summary, what it would do would be to reintroduce price as a variable in the consumer's part of the equation in terms of purchasing health care.

BI: Under the administration's proposal, an employer's annual health care contribution that exceeds $840 for indi-

Continued on facing page

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Continued from facing page
vidual coverage and $2,100 for family coverage would be taxable income to the employee. How did you derive those figures? Why a cap at those levels?

Dr. Rubin: We believe that is a level that impacts only a third of the people with employment-based health insurance. Yet, it is a level that one could reasonably across the country purchase an adequate level of health insurance benefits. Initially, very few people would be affected by the tax cap, although clearly it would be in the minds of all workers that receive employment-based health insurance. It gives people an opportunity to adapt to the changing situation.

BI: Are there any particular working groups that would definitely be over the proposed caps?

Dr. Rubin: Clearly, automobile workers would be over (the cap) by a substantial amount. The latest information that we have—it is difficult to get precise numbers—is that their benefit average is $300-plus a month.

BI: The tax cap was included in the Department of Health and Human Services budget, which was submitted to Congress in late January. Has the proposal been drafted in legislative form?

Dr. Rubin. Yes.

BI: Have you lined up a congressional sponsor?

Dr. Rubin: No, not that I am aware of at this time. But that is not unusual given the time sequence of where we are.

BI: A few technical questions. . .What health care services would be included in the cap? Hospital and Medicare care only? What about vision and dental benefits? Short-term or long-term disability benefits?

Dr. Rubin: In general, health benefits would be covered under the cap pretty much as defined by Medicare. Long-term disability would not be covered. Generally, that is included in a separate insurance package.

Vision care would be covered under the cap as would most probably dental care. That is a detail that we need to put the final judgment on.

BI: So, a decision hasn't been made yet on dental?

Dr. Rubin: Not a final decision.

BI: Insurers argue that if such a cap is imposed, the first services to be cut will be preventive care.

As a result, insurers say, this would lead to greater health care cost inflation. What is your response?

Dr. Rubin: I have not the slightest idea why they would make that kind of statement. Logically, services that are cost-effective would be the last services that a company would want to get rid of and/or an employee would want to get rid of. The name of the game is to get the most bang for your buck.

Consequentially, a service that is cost-effective is one that ought to be retained particularly if it has a low marginal cost. I would reject that hypothesis. I also would underline that it is only a hypothesis since it is unclear if anybody that has cut back on benefits has done these kinds of things.

A good example of how one could restructure an insurance program is provided by the Du Pont Co. in Texas. They had offered a traditional first-dollar, comprehensive, no-questions-asked insurance coverage. Then, they redesigned their benefit package to have some front-end coinsurance and deductibles, but provided much stronger back-end or catastrophic coverage than the current plan had.

'Initially, very few people would be affected by the tax cap, although clearly it would be in the minds of all workers that receive employment-based insurance,' Dr. Rubin says.

What was gratifying to me, and what would fly in the face of what some people would have you believe, is that 47% of the workers chose the actuarially more correct, better-designed plan in the first year.

My understanding is that in the second year of this program over half of the workers have gone to this program that emphasizes some first-dollar cost sharing, but a much-improved catastrophic program.

That is the real-life trend that I would expect to see happen across the country rather than the doom and gloom that is forecast by the insurance companies.

BI: Insurers also say that health care costs vary considerably across the country. As a result, a uniform tax would be discriminatory against those workers who are employed in areas where health care costs are the highest. What is your response?

Dr. Rubin: The cost of living also varies across the country. It costs more to live in large urban areas than small rural areas. It costs more to live in a city like Boston than a city like Washington.

I haven't noticed that the Internal Revenue Service allows one to discount for living in those areas on your income tax. What we are talking about here is tax policy. The tax policy in this country has been historically applied equally across the board—north, south, east and west. This administration has no intention of changing that policy.

BI: Would this argument be true for small employers who pay proportionately more for health insurance than large employers because of greater administrative expenses? As a result, employees at small firms would be much more likely to run up over the cap than workers employed at large firms. Is that fair?

Dr. Rubin: There are two responses. First, companies having fewer than 10 employees are less likely to have health insurance programs than large employers.

Secondly, those groups that do have insurance tend to have very adequate insurance whose costs may not be as low as large national employers, like General Motors. On the other hand, there is nothing to prevent brokers from bringing these groups together and offering them the buying power of a combined, larger entity. That is an example of American ingenuity working.

It is clearly something that the administration looks favorably upon. Every employer will seek ways to minimize their out-of-pocket costs. I would think there would be lots of people who would offer new services, such as insur-

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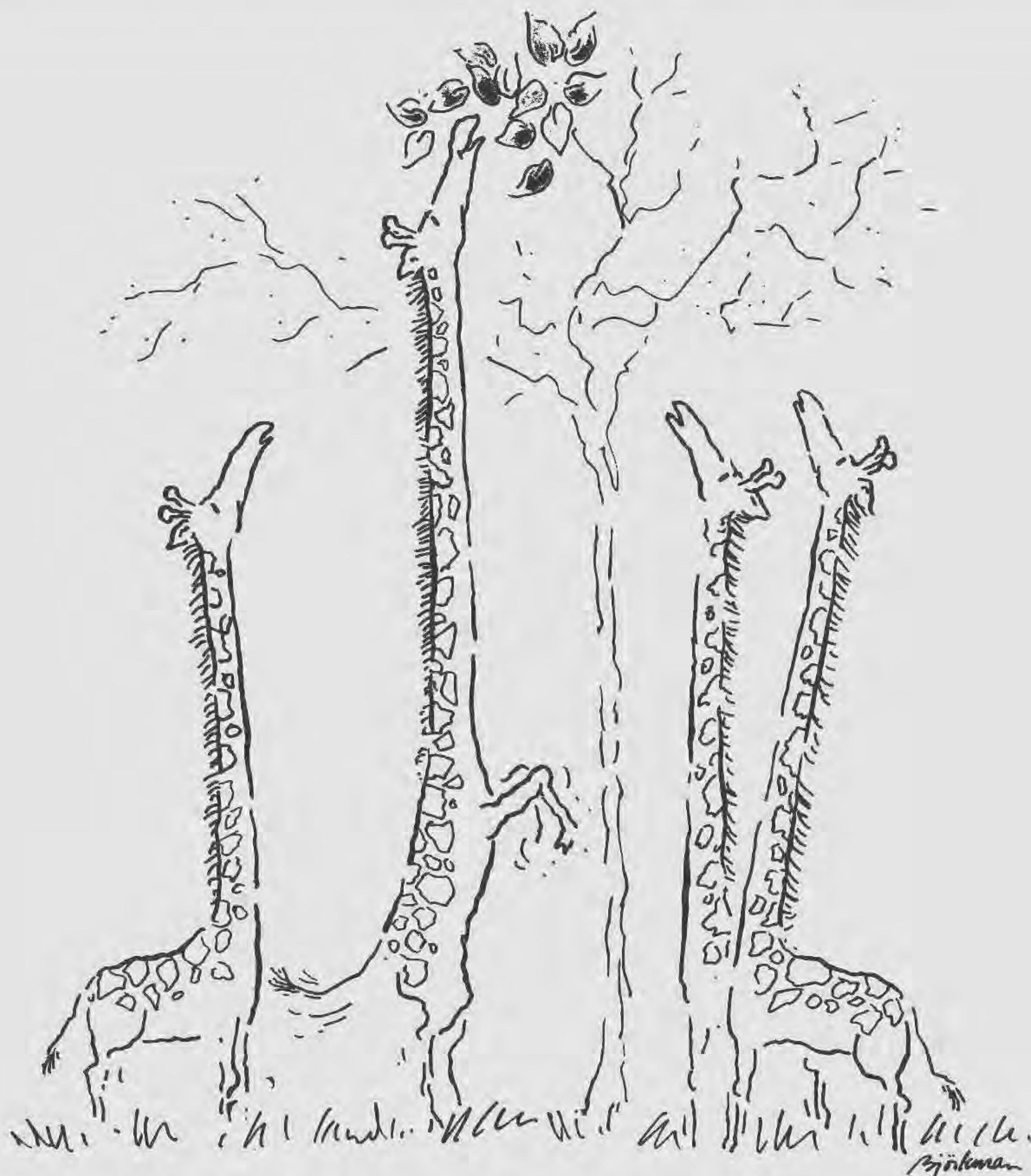

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Proposal won't burden self-insurers: Rubin

Continued from previous page
ance companies and brokers, to help them in that regard.

BI: As many as one-third of all employers to some degree self-fund their health care programs. Some of these employers are very concerned that a tax cap could cause major administrative problems. They feel it would be difficult to calculate a premium cost on a per-employee basis. For example, how would one calculate claims incurred one year but not paid until the following year? Does the tax cap pose considerable problems for employers that self-fund?

Dr. Rubin: I'm not an expert on either the Internal Revenue Service tax code or on companies organized to (self-fund) benefits. But basically the tax cap in terms of self-insured companies works relatively simply: The total amount of dollars paid out by a particular company for health benefits defined by law, divided by the number of employees that company has, represents an imputed premium that the company pays. . .There are administrative details that would have to be worked out.

BI: Assuming the tax cap is enacted, do you envision the need for regulations to help employers comply with the law?

Dr. Rubin: I don't know of a single statute that is passed that doesn't have to be implemented by regulation.

BI: But in your view, the self-insurance accounting issue is not an obstacle that cannot be overcome?

Dr. Rubin: No. Clearly, it is a complicated factor. And it is one that we, the Treasury Department and the Joint Committee on Taxation have worked very hard on to minimize the administrative complexity of this particular bill. We think we have been reasonably successful.

BI: Recently, the administration proposed that hospitals that treat Medicare patients be reimbursed on a prospective-payment system. The payment would be based on which one of 467 diagnostic-related groups a patient fell into. That proposal only applies to Medicare. Why didn't you propose an advance payment system for all payers?

> 'We have to get over the fact that insurers. . .are not passive payers of bills,' Dr. Rubin says.

Dr. Rubin: This administration does not believe that it is the business of the government to interfere between the private contractual arrangements of two private entities, namely insurers and other providers. There is nothing to preclude other payers from using a prospective pricing mechanism that they mutually agree is an appropriate way to settle their accounts.

BI: Is there not a risk that if hospitals lose revenues with a DRG Medicare system, they might try to recoup any revenue loss by charging private payers more?

Dr. Rubin: There is absolutely no law on the books that requires private payers to pay more. We have to get over the fact that insurers and companies that employ insurers are not merely passive payers of bills. They have to be cognizant of the costs they are incurring. The evidence indicates that when they are aggressive in trying to hold down costs, they are successful. There are multiple examples of that across the country.

BI: Then you don't believe cost shifting is a problem as the Health Insurance Assn. of America says?

Dr. Rubin: It depends on how you define cost shifting. Medicare pays 100% of allowable Medicare costs. That is no more or no less than the statute requires us to pay. It is true that we do not pay for telephones and televisions in hospital rooms. It is equally true that most insurance companies do. If that is cost shifting, then we are guilty.

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Continued on page 32

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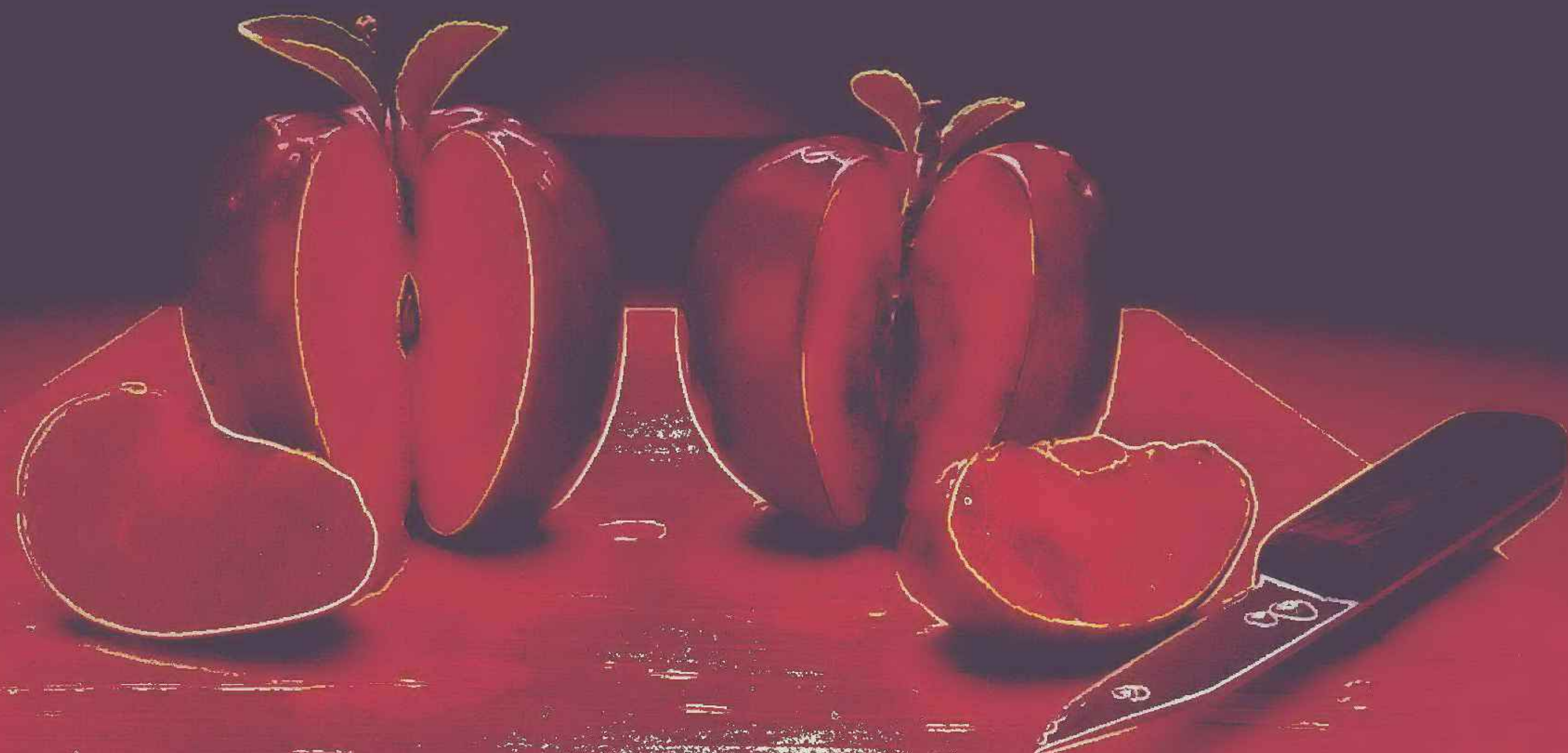

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Claims Payment Control	19 Computerized Edits on every claim		Few controls (varies by plan)
Post-Payment Audit	Yes, in-house and field auditors		Rarely
Utilization Review	Computerized Activity Reports		Rarely
Claims Processing Costs	Less than 71¢ per claim		From $5.00 to $10.00 per claim
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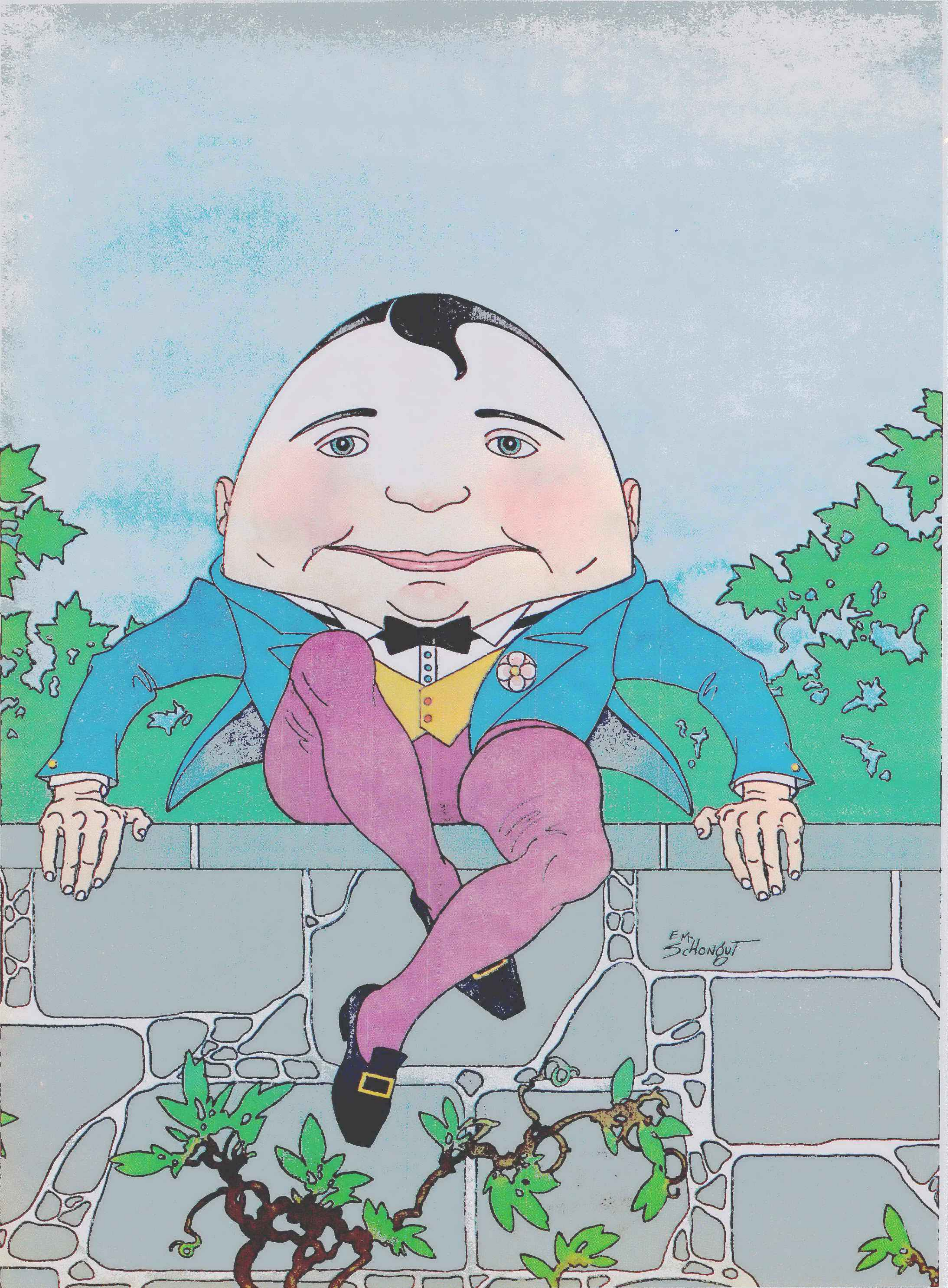
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So, we're saying that while there may well be costs incurred by hospitals that aren't being compensated for under Medicare. . .the reason is that the Medicare statute doesn't allow it. And these are costs that may well be unrelated to health care and that private insurance companies choose to pay when those bills are presented.

'We believe if given proper economic incentives, which our package contains, we can control the rate of rise of health care costs while still providing high-quality health care for all our citizens,' Dr. Rubin explains.

Clearly, if one is a passive payer of bills, then one pays the bills that are presented. If one is aggressive on cost control, then one begins to question what is behind those bills, and we've seen that some of those costs stop either because hospitals alter their behavior. . .or those costs simply disappear.

BI: What is your advice to employers on what they should be doing to hold down health care costs?

Dr. Rubin: Clearly, what they need to do is to know what is behind the costs they are incurring. If they self-insure. . .an aggressive utilization review plan has shown, at least by John Deere Co., to decrease hospital utilization by at least 30%.

In situations where an employer is a major user of a particular health care facility, there is nc question that the employer can negotiate reasonable rates for its employees. . .perhaps through the promise of prompt payment and perhaps through other standard business practices that they negotiate with other suppliers that they deal with.

In areas where there are multiple providers but single employers frequently using that sort of leverage, a preferred provider situation is another mechanism that employers can use to help to control costs.

All these methods have been tried and proven successful across this country.

BI: What is the administration's position on different employers banding together to form health care cost coalitions? Are there any antitrust problems?

Dr. Rubin: The administration has encouraged business (health care) coalitions. . .in (the) Maricopa (decision), the Supreme Court suggested as long as purchasers of health care banded togther to deal with health care costs, there are no implicit antitrust violations. I can't see that there would be if businesses got together to deal with health care costs. Where they need to be careful is the inclusion of health care providers in that group. And they should consult their appropriate legal counsel before proceeding.

BI: Any other comments on this administration's commitment to cooling health care costs?

Dr. Rubin: There are two paths that one can take to control health care costs. One path is through utility-type regulation of the health care industry, which has been proposed before and clearly failed. This will probably be proposed again if the administration's alternative is unsuccessful in controlling health care costs.

Our preferred choice is to recognize that health care is not different from anything else in this economy. People are responding to the current perverse incentives in the system.

What the administration is seeking to do is to remove those roadblocks, or perverse incentives, and to allow the market to operate in an orderly fashion.

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Group hopes to cut costs by monitoring hospital stays

CLEVELAND—Employers, insurers and local hospitals are banding together to reduce lengthy hospital stays for non-acute care patients in the Cleveland area.

The group, Utilization Review Coordinating Council Inc., through the assistance of a physicians' peer review organization, is trying to curb escalating health care costs by reviewing hospital admissions and conducting follow-up reviews every three to five days a patient is hospitalized.

The program, which begins this month, is designed to reduce the number of unnecessary hospital admissions and shorten the hospital stays of non-acute care patients who do require inpatient care to completely recuperate.

For example, patients who are found not to need hospitalization will be referred by the reviewing agency to an outpatient facility for further care.

And, hospitalized patients who are found to no longer need inpatient care will be advised to go home to recuperate.

Many employers participating in the program should realize a 10% to 30% reduction in hospital utilization, both in the number of hospital admissions and in the number of days of hospital care, contends Bruce C. Myhre, president of the Health Care Review Systems Inc., the reviewing agency that will operate the program.

"We have no control over the increase in health care costs, but we can control the number of people who go to the hospital and how long they stay," explains Mr. Myhre.

"Reducing the length of hospital stays could produce some significant cost savings for some of the area's large employers," explains Larry Sturgis, executive director of Utilization Review Coordinating Council Inc.

Cost savings will vary from employer to employer, depending upon the size and age of its workforce and the number of admissions and days of care eliminated by the program, he says.

Under the program, the reviewing agency will conduct an admission review to determine whether the employee should be hospitalized. If the patient is admitted to the hosptial, the agency then reviews the patient's charts once every three to five days, depending upon the ailment or surgery involved.

However, the agency does not assign any targeted lengths of stay and reviews each case on its own merits.

The reviews are conducted by nurses affiliated with the agency in consultation with physicians. Following the review, the agency will make recommendations to the patient, the attending physician, the hospital and, finally, to the coalition.

If the attending physician disagrees with the recommendation, he or she can appeal the decision to a panel of physicians who have no involvement in the case.

If the patient is unhappy with the decision, he or she can appeal their case to the Cleveland Academy of Medicine.

If all appeals are exhausted and the patient remains in the hospital, the coalition will recommend that his or her health insurer decline to cover any charges incurred after the recommended stay was completed.

So far, about 25 Cuyahoga County hospitals have joined the program, Mr. Sturgis says, adding that others have expressed an interest in the idea.

Several major Cleveland employers that are members of the coalition include Reliance Electric Co., Republic Steel Corp., TRW Corp. and Stouffers Inc.

And, insurers like the Metropolitan Life Insurance Co., The Equitable Life Assurance Co. of America and John Hancock Life Insurance Co. have pledged their support to the program.

The program, Mr. Sturgis explains, offers cost-cutting incentives to the hospital as well as the employer. Hospitals are encouraged to participate because it will mean "higher volume and early bill payment," he says. ■

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Larger employers leading the way in controlling costs

By SALLIE J. DRURY

Big business is leading the way in health care cost management and middle-sized businesses are following. But small employers are limping in the distance.

A survey of 1,420 U.S. companies by consultant William M. Mercer Inc. of New York showed that 31% of all the respondents have developed a formal health care cost management strategy within the past two years. And, of the 976 companies (69%) that have not developed such a strategy, 37% plan to develop one in the coming year.

However, another 28% have no plans for a cost-containment program although the survey shows employers expect health care costs to rise 16% to 20% this year.

By far, the largest companies, based on number of employees, are doing the most to contain costs.

Approximately half of the responding companies with more than 25,000 employees already have established cost-containment programs—47% of those employers with with 25,001 to 50,000 employees and 56% of those with more than 50,000 workers.

Another third of these two groups combined do not have established programs, but plan to develop one in 1983.

Meanwhile, a significant number of mid-sized employers have established cost-containment strategies. Some 35% of employers with 5,001 to 10,000 employees have cost-containment plans while 32% of those with 10,001 to 25,000 employees have plans.

Half of the employers with 10,001 to 25,000 employees that do not have a strategy yet say they will develop one this year. A little more than 40% of those with 5,001 to 10,000 employees will establish such plans this year.

Among companies employing 1,000 to 5,000 workers only 29% have a cost-containment strategy in place, but another 47% plan to develop one this year.

In contrast, only 27% of the companies with fewer than 1,000 employees have established a cost control program in the past two years. An overwhelming 73% have not, but only 28% of them plan to develop one in 1983. That leaves more than 40% of these companies without plans to contain runaway health care costs.

Thirty percent of these small companies said one of their biggest obstacles to controlling costs is that health service providers do not cooperate with them to keep prices down. In contrast, this was a complaint of only 16% of companies employing between 25,001 and 50,000, and 19% of companies employing more than 50,000.

Continued on page 38

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Lack of cooperation can hurt

Continued from page 36

Small employers may lack the clout of corporate giants in bargaining with hospitals and physicians for such cost-saving techniques as preferred provider organizations.

Among total survey respondents, getting the cooperation of health service providers is a problem for 25%.

But the biggest problem in controlling costs among total survey respondents is educating employees and communicating health care information.

Thirty-two percent of all the respondents cited this as a problem. And, companies employing 10,001 to 25,000 felt it most strongly—42% cited communication as the major problem.

Only 20.4% of the companies employing more than 50,000 agreed, however. For this sector, obtaining data on plan utilization was the biggest problem cited by 22.2% of the respondents.

This appeared to be a much larger problem for them compared with the other size groups. For example, only 18% of companies employing between 25,001 and 50,000 cited this as a problem; only 12% of companies employing 10,001 to 25,000; 12% of companies employing 5,001 to 10,000; 13% of the companies employing 1,000 to 5,000; and 6.9% of companies with fewer than 1,000 employees.

Sixteen percent of the total survey respondents said internal administration and management is their biggest cost management problem. The largest percent of companies citing this problem again was among firms employing more than 50,000. More than 20% said internal administration got in the way of controlling health care costs.

Among all the survey respondents, lack of cooperation from unions was cited as a hindrance to cost control by only 6.2%. And, government cost shifting and intervention was cited by only 2.1%.

The size and makeup of plan participants was a problem for 4.7% of the respondents. Interestingly, this was cited as more of a problem by the two groups on either end of the size spectrum.

Lack of cooperation from insurance providers and rising premiums are problems for 3.3% of all responding companies, but all of those respondents are companies with 25,000 or fewer employees. No company from the two largest employer groups cited insurance providers as a problem, indicating that smaller employers, again, may lack the clout that size can bring in negotiating rates and coverage.

Despite the obstacles in trying to hold down health care costs, one solution to growing expenses seems to be raising deductibles or establishing higher copayments for benefits. Mercer's survey shows that 33% of all employers have raised deductibles or have established higher coinsurance provisions in the last two years.

The larger employers are the leaders in raising deductibles, with 52% of companies employing 25,001 to 50,000 employees taking this step and 46% of companies employing more than 50,000 increasing employees' share of their health care bills.

This step has been followed by only 37% of companies with 10,001 to 25,000 employees; 32% of those with 5,001 to 10,000; 28% of those with 1,000 to 5,000; and 33% of those with fewer than 1,000 employees.

Although increased deductibles can make employees more cost-conscious, some companies may shy away from this form of cost containment. The reasoning is that hospitals foresee increased bad debts if a greater financial burden is placed on employees. The hospitals will then raise the price of their services, foiling benefit managers' savings plans, Mercer consultants say.

Another method of cost reduction identifies trouble spots—those employees who use inefficient health care providers, for instance.

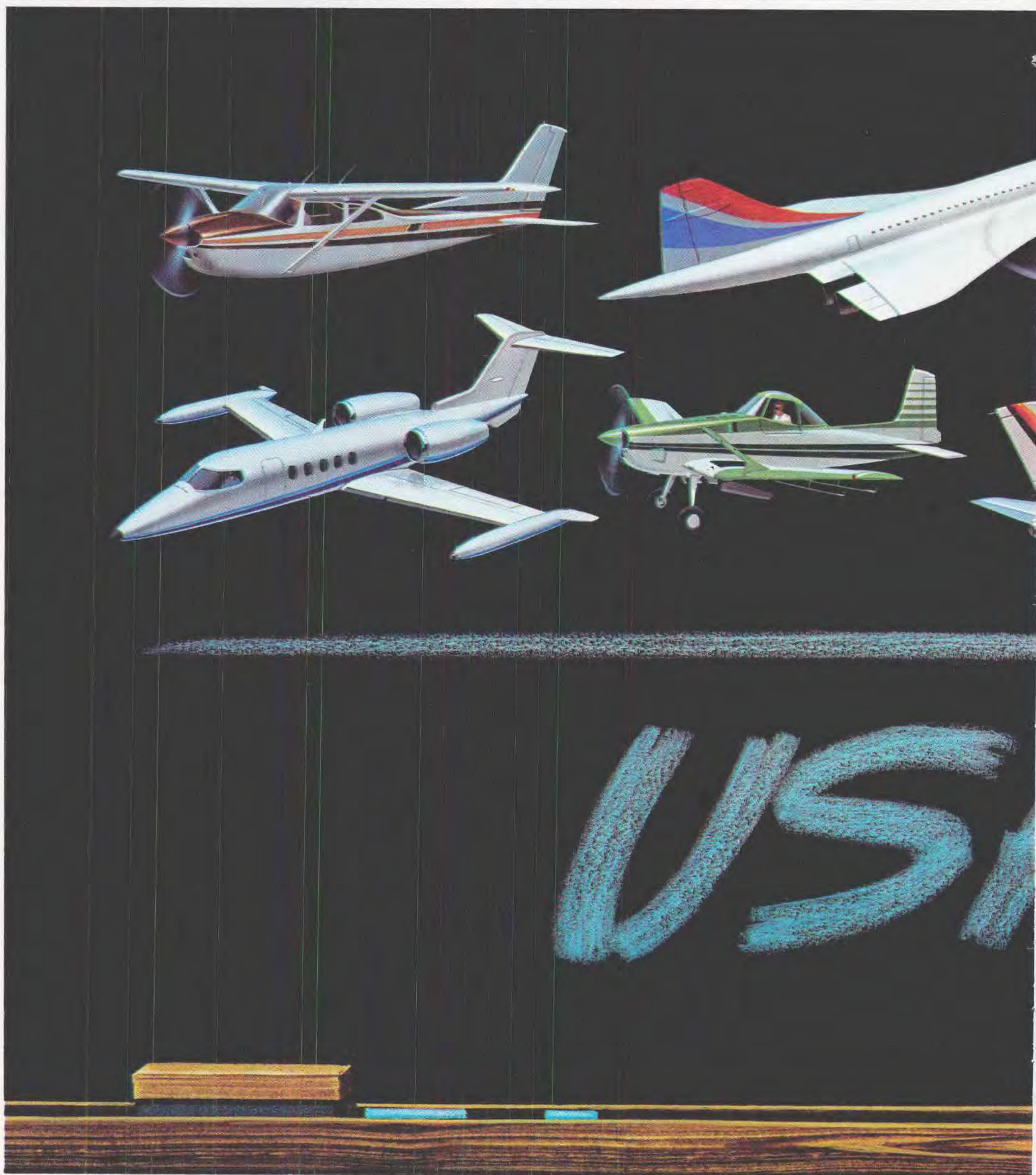
Mercer calls this method a "case-mixed, diagnostic-based data analysis of health care expenditures." Companies using this method gather statistical data from claims to determine reasonable and customary charges, frequency of diagnosis among employees and frequency of claims per employee.

Using this data, companies also can determine which employees use services in excess of national or regional norms and prepare cost management incentives for the targeted employee.

Continued on facing page

Health care cost-containment plans

Company size by no. of employees	Have recently developed	Will develop this year
Fewer than 1,000	26.8%	28.3%
1,000-5,000	28.8%	46.9%
5,001-10,000	35.1%	41.2%
10,001-25,000	32.4%	49.6%
25,001-50,000	46.9%	37.5%
Over 50,000	56.3%	29.2%
All respondents	30.6%	37.0%



The not-so-common

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Few firms target cost reduction goals

Continued from facing page

Using this data, companies also can determine which employees use services in excess of national or regional norms and prepare cost management incentives for the targeted employee.

Some 39% of the surveyed companies that practice or plan to practice cost management said their company's cost management strategy does include this diagnostic based data analysis. The larger the company, the more likely it was to use this analysis. Seventy-three percent of the companies employing over 50,000 workers tracked diagnostic based data; 43% of the companies employing between 5,001 and 10,000 did; and 24% of the companies employing fewer than 1,000 did.

However, a Mercer spokesman said there may have been some confusion about the question. "A diagnostic based data analysis is a rather sophisticated strategy. Frankly, we were surprised at the number of respondents who said they had DRGs (diagnostic related groups). They may not have understood the question."

Of those trying to hold down costs, only 14.6% have targeted a reduction goal. The average savings targeted by all respondents with saving goals was 6% to 10%.

Again, more larger companies have targeted goals than have smaller companies.

Some 13% of the smallest companies had a reduction goal. The percentage having goals then rises with the size of company to a maximum 25% for companies employing from 25,001 to 50,000. However, among companies with more than 50,000 employees, only 12.5% had a reduction goal.

And, 50% of the largest employers and 40.0% of the next largest group targeted a smaller savings: 0% to 5.0%.

The companies employing the fewest were less decided in their savings goals. They ranged from nothing to 5% to 11% to 15%.

Although small businesses are far behind in cost-containment programs, Carson E. Beadle, director of practice development at Mercer, believes the efforts of the larger employers show a decided challenge to health care costs.

"These findings suggest that this may be a very important year in the long-term effort to control health care costs," he said. "With so many companies projecting serious efforts to slow the health care cost spiral, we may even look back on 1983 as a turning point."

Breaking down the 1,420 respondents to the Mercer survey according to size shows:

- 650, or 45.8%, of the companies surveyed employ fewer than 1,000.
- 399, or 28.1%, employ from 1,000 to 5,000.
- 148, or 10.4%, employ from 5,001 to 10,000.
- 111, or 7.8%, employ from 10,001 to 25,000.
- 64, or 4.5%, employ from 25,001 to 50,000.
- 48, or 3.4%, employ more than 50,000.

•

Copies of the survey results are available by writing Dept. 99, William M. Mercer, 1211 Ave. of the Americas, New York, N.Y. 10036.

BI benefits conference scheduled

CHICAGO—Mark your calendars now for the *Business Insurance* Communicating Employee Benefits Conference, to be held in Chicago Oct. 31 and Nov. 1.

The conference, which brings together experts on employee benefits communications, will expose you to the most important new developments in effective communications of employee benefits.

At a time when the cost of employee benefits continues to rise, it's important to be sure employees are using their benefits wisely and that they appreciate the corporate investment in their benefit plans.

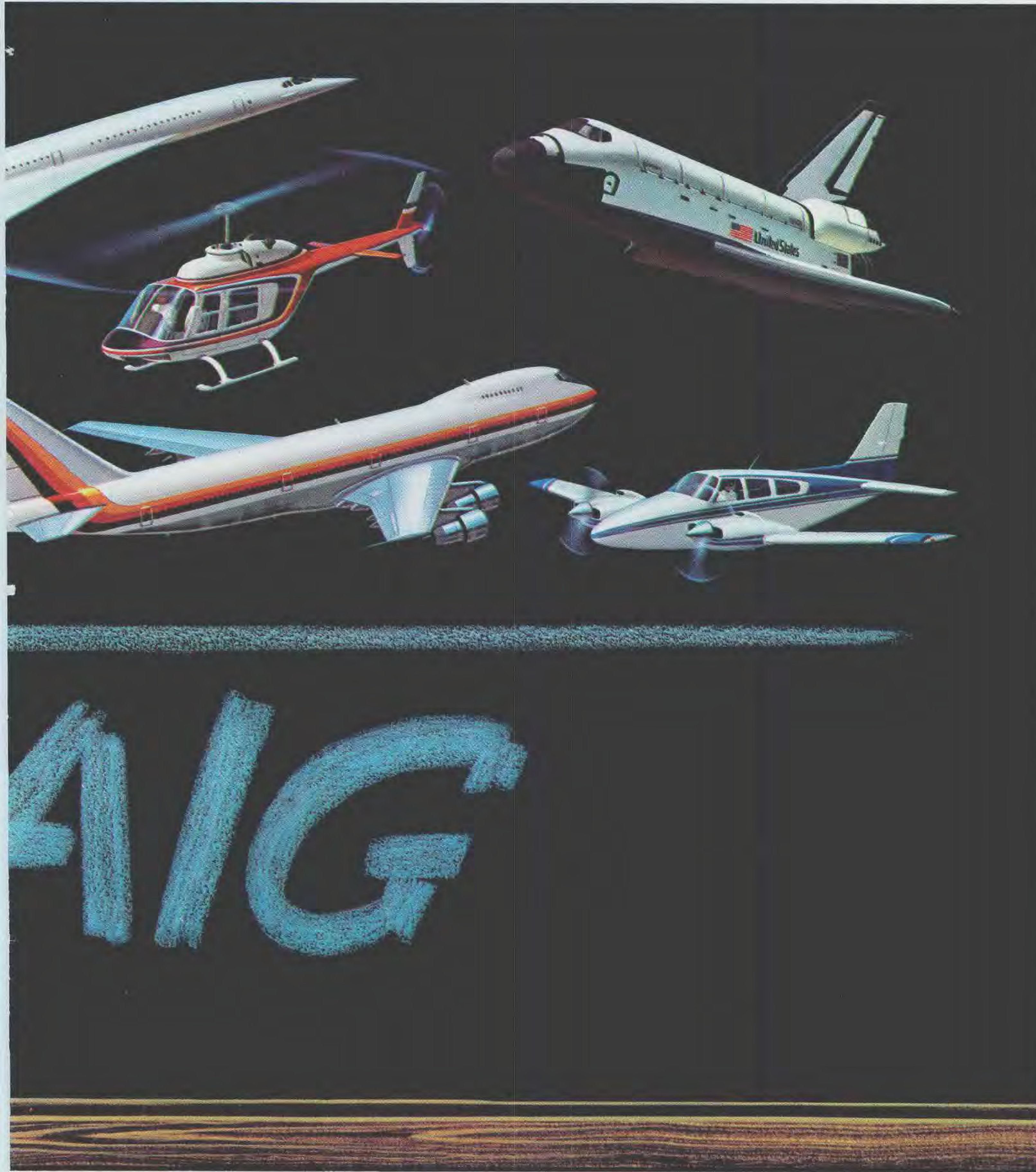
In addition, the winners of the annual *Business Insurance* Employee Benefits Communications Competition will receive their awards at a dinner for all conference participants Oct. 31.

The conference will be held at the Knickerbocker Hotel, located just off North Michigan Avenue on Chicago's Gold Coast. *Business Insurance* will offer reduced hotel and airline rates to registrants.

The registration fee is $495, with a 10% discount offered to the second participant from the same company.

Promotional and informational displays will be available for companies that wish to distribute materials to participants.

To receive more information and a registration packet or display details, contact the Communications Services Department, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017.



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PATCHING MEDICAL COSTS

Only 'radical surgery' by all involved will lower the high price of health care

By George E. Gale III

EMPLOYER-SPONSORED benefit plans represent more than 80% of the medical coverage in the United States. It stands to reason that the efforts to control medical costs should emanate from such plans. The participants in these plans include employers that pay most of the cost, employees and their dependents who utilize the services, administrators and insurance companies that provide insurance, the federal government through Medicare and Medicaid and the medical providers that dispense services.

Eventually, it will take all elements to resolve the total problem—which is like the United Nations agreeing on the elements of world peace and then implementing them.

Therefore, let's focus on what the first three participants—the employer, the employee and the claims payer—have been doing to contain medical costs and if the present options being used make sense or are only a Band-Aid approach for a serious wound.

Medical cost containment can be divided into three basic areas: cost reduction, cost sharing and cost shifting.

Cost shifting is the system utilized by the government to "reduce" the rise in Medicare and Medicaid costs. By paying only for the direct hospital expenses, all indirect expenses are shifted to non-Medicare/Medicaid patients and eventually become an additional cost for employee benefit plans.

According to the National Assn. of Health Underwriters, it is estimated that the cost of cost shifting is approximately $6 billion. At present, there is very little we can do about it.

The other two areas, cost reduction and cost sharing, do give each participant in employee benefit plans an opportunity to work toward immediate cost containment. Yet, are present approaches to cost containment really effective or will they cost more money and generate more problems down the road?

In a sense, cost reduction to employers and employees can only be achieved if medical providers will reduce their charges, utilization of services is reduced and alternative, less-expensive treatments are established.

There does not seem to be a reduction of costs by the medical providers; utilization continues to increase; and the costs of alternative medical procedures in general have tended to increase as they are used.

Appropriate self-funding by eligible employers has produced some savings by allowing them to maintain their own reserves and reduce administrative costs. Employers, however, are generally not implementing effective cost-reduction measures for claims, which are approximately 80% or 90% of their total costs. For public consumption, cost-containment propaganda appears to be numerous government committees, Senate hearings, insurance company articles, hospital reports, untold seminars and union disclaimers. This has led to employer frustration and resignation.

What then can be done today by employers and employees and payers to reduce costs? Here are a few ideas:

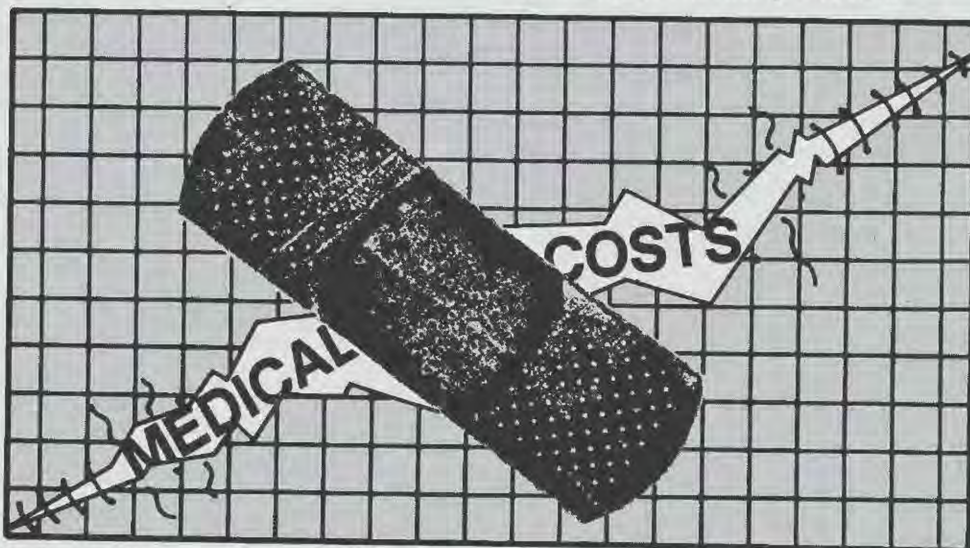
- Consider eliminating direct assignments. In this provision, the employee never sees the bill; it is sent by the medical provider to the insurer or plan administrator for direct payment to the medical provider.

Of course, this will require involvement by employees, which is exactly the point. Employees must become involved if employers really have any intention of containing medical costs. By reviewing the bills, employees might notice charges for services never received, such as an extra day in the hospital. This would allow the participating employees have realized paid-claim reductions up to 18% from use of this service.

- Eliminate coverage for Friday and Saturday non-emergency hospital admittance and Sunday admittance unless surgery is to be performed on Monday. An employer might be surprised at the cost of this "convenience."

These cost-reduction procedures will stimulate immediate cost containment. If your insurance company says it can't provide these services, policy changes and other meaningful innovations, look for an insurer who can. You, the employer, are paying for these services, so pay only for the services you want.

None of these procedures will eliminate any benefits your employees enjoy. These changes do require that employers communicate effectively with their employees to also recognize the level to which medical costs have risen.



Graphic: Amy Palmer

- Be willing to share such confirmed savings with the employee. Remember these additional savings would not have been found without the employee's help.
- Demand thorough coordination of benefit investigations by the insurer or third-party administrator. Three percent to 8% coordination-of-benefit savings are far too low, since approximately 60% of employees have working spouses.
- Check on overall efficiency of your claims-paying company, whether it be an insurer or third-party administrator. An employer may feel it got a deal for a lower administrative cost, but the excess of claims being paid can far exceed costs of a first-class claims paying company.
- Implement a true home health care program. Home health care has been a part of major medical benefit plans for years.

The home health care plan fallacies are that they usually require a 20% contribution by the employee vs. no contribution for in-hospital care; have limited coverage; and are controlled by each home care entity providing service, which is like Jesse James guarding your bank. A correctly monitored home health care program, with active participation by employers, is one of the most effective cost-reduction tools available today.

Our company participates with Home Health Care Services Inc. and during 1982, employees so that they fully understand what is occurring and how it affects them. The results of a recently published Towers, Perrin, Forster & Crosby survey (*BI*, Feb. 7 and 14) indicated that employee communications is not a major concern among employers. This attitude is very shortsighted. How else will employees understand why certain changes are necessary?

Additional employer savings can be obtained by cost sharing. Many present cost-sharing concepts are Band-Aids. Blue Cross/Blue Shield and some insurance companies are suggesting that certain medical procedures should be paid on an outpatient basis unless they are emergencies (see story, page 44).

It doesn't take long for patients and medical providers to learn how to make a non-emergency situation an emergency. To control unnecessary one-day hospital stays, consider requiring an employee to pay for the first day of room and board charges with miscellaneous charges paid by the plan—a form of co-payment.

If your plan is self-funded and your state has mandatory auto no-fault insurance, change your plans so that the automobile insurer must pay a share in case of an accident. This is different from the standard coordination of benefits. Under most coordination of benefits in most states, the employer plan can still end up supplying primary coverage.

Many employers are opting for the Band-Aid approach of requiring additional employee contributions to the present benefits plan. It doesn't take long for employees to determine that if they are putting money in, they will use the plan in order to recapture their contribution.

With a little more effort, a benefit plan can be designed to include co-payments; employees who stay well will save money, the plan saves money and the employees will make their contributions only if they utilize the program. Again, the TPF&C survey published in *Business Insurance* indicated that employers see plan design as a secondary concern. Is it because employers are shortsighted rather than taking the long view and the time to review and implement effective plan-design changes?

Some plans are beginning to offer co-payments but still have some 100% payments for hospital and accident charges. Give thought to eliminating any 100% payments for in-hospital and accident charges. The 100% feature may be an invitation to use the most costly, easiest form of treatment.

An increase in out-of-pocket expenses should be considered. According to a Hewitt Associates survey (*BI*, Jan. 24), just 40% of the 659 major employers are increasing annual deductibles of $150 or more in plans covering salaried employees. The $100 deductible of 10 or 15 years ago is just plain unrealistic. Also consider 50% co-payment of the first $300 to $700 of all charges and 80% co-payment for the next $2,000. Co-payments rather than deductibles make the charges more palatable, as the plan can say with pride that it is always participating.

The California $500-payment concept pays up to $500 to an employee who does not spend it on medical care. This feature will eliminate some medical payments to providers, but the cost to the employer is the same. The dollars are just paid to a different person. As an alternative, consider an employee-reimbursement bank plan based on length of employee service. The bank plan would apply only to certain out-of-pocket medical, dental and related expenses with a predetermined out-of-pocket amount that will always be the employee's responsibility. This concept gives recognition to long-term employees.

The cost-reduction and cost-sharing concepts that have been mentioned produce results. They require an employer to give some active time, effort and direction to their insurer and/or administrator. As in any cure, one or two changes will not be enough. A combination of effort and implementation is needed.

If employers don't demand realistic and meaningful changes, they will continue to get Band-Aids and higher medical costs. Keep in mind that the insurance companies and third-party administrators work for you—you pay their bills and charges. The Band-Aid approach may produce some short-term results for the corporate quarterly statement, but long-term results can and will be adversely affected.

The procedures that have been outlined can be initiated by companies of all sizes, through their insurance companies and third-party administrators. This planning can and will show immediate results. ▪

George E. Gale III is president of Total Group Services Inc. and Total Compensation Services Ltd. in Grand Rapids, Mich.

perspective

You need the right company and the right time

Deciding to self-insure health benefits?

By Wallace E. Jeffs

Mr. Jeffs writes: "The article concerning self-funding of health benefits was well written, but perhaps misleading, since 'everybody' isn't doing it (BI, Jan. 31).

"It is very possible that as many as one-fourth to one-half of the very largest companies in the United States, the giants of industry, have turned to self-funding some of their health benefits. However, a sizable portion of companies, large and small, remains with insured plans."

The following article is Mr. Jeffs's view of the savings the can be derived from self-funding and the possible pitfalls.

THERE COULD NOT BE a worse time than now to establish a self-funded health plan.

With companies searching for every possible way to conserve cash, many employers have succumbed unwisely to the new health care funding marvel that's touted as the vehicle that will take profits from insurers and give them back to employers.

Unfortunately, most employers who purchase these plans do not have a very clear idea about the relation among potential premium savings, premium deferrals (which are not necessarily savings) and the other expenses found in a self-funded health care plan.

Self-funding is essentially the bearing of a defined risk by the party at risk, i.e., the employer, not an insurance company.

When self-funding includes the processing and payment of claims by the party at risk, it becomes self-insurance.

To begin with, self-funding is not for the small employer. A small employer may generally be considered to be any company with fewer than 1,000 insured employees or with less than $1 million in annualized medical insurance premium.

Most group insurance plans are returning 85% to 90% or more of paid premiums in loss payments. Self-funding bypasses the 85%-plus payout element under most group plans and concentrates on three potential savings in the administrative area, which comprises the remaining 10% to 15% of paid premiums.

The savings are:

- Tax savings at 2.35% of earned premiums in California.
- Insurance company administrative cost savings.
- Cash-flow savings, which is not really a reoccurring annual savings. It is really a one-time deferral of 20% to 25% of premium that is normally held by the insurer as claim reserves for losses incurred but have not been paid yet.

Let's look at each area of savings.

The first is taxes. A company can save 2.35% on taxes in California. A small, 250-employee company will probably have an annualized medical premium of $200,000 to $250,000. The maximum savings in taxes will be 2.35% or $4,700 to $5,870.

The second is insurance company administrative cost. This savings is often referred to as the insurer's retention. Most retentions are split into six parts: taxes, commissions, general (operating) expenses, claims processing, risk sharing and profit.

Of a 12% retention, for example, a typical split for a brokerage might be:

- Taxes—2.35%
- Commissions—2.50%
- General—1.65%
- Claims processing—3.50%
- Risk sharing—-1.00%
- Profit—1.00%

Of that 12%, here's what you won't save.

Under general expenses, your company will have to contract for legal, accounting and other services. These costs may well exceed the 1.65% general expense cost.

For claims, the main question is, "Can a company or a third-party administrator handle them as inexpensively as an insurance company?"

Under risk-sharing cost, that will be converted to reinsurance. In most cases that does not provide as much protection as risk sharing or company pooling and generally costs more to secure.

Here is what you will save.

Under taxes, self-funding avoids premium payment, and therefore, premium taxes. However, many state legislatures are studying this maneuver to see if they can recapture those taxes.

Brokerage commissions will no longer have to be paid, although you may have to pay part of that savings for consultant services.

As for insurance company profit, you save that expense totally.

Now the cash-flow savings. As stated, this is really not a savings but rather a deferral, which a company must pay back if it ever cancels a self-funded plan or re-enters an insured plan.

When an insurer pays for claims incurred before the cancellation date, the company gains a period of time during which essentially no losses have to be funded because the insurer is continuing to pay claims from the company's reserve.

This reserve deferral in most cases would equate a 20% to 25% savings for the $250,000 risk, a deferral savings of $50,000 to $62,500.

This is the reason that proponents of self-funding say a company can save 20% to 30% of premium—an approximate $70,000 savings ($5,870 plus $62,500) on a $250,000 premium. However, this is the first-year cash-flow deferral plus tax savings only. After the first year, there is no cash-flow deferred savings and only the tax savings applies.

Another point to consider is that many insurance companies allow premium payment after a normal 31-day grace period. Some insurance companies actually extend premium payment deferrals up to 45, 60 or even 90 days, which may diminish most of the projected cash-flow savings.

speaking out

A misconception created by those favoring self-funded plans is that an employer may remove almost all risk from a self-funded plan through reinsurance. The reinsurer is thought to pick up losses that are in excess of the fund the employer pays toward the plan. This is not so. As in any business, reinsurance arrangements are sold on the basis that the reinsurers expect to make a profit.

Most reinsurance programs will assume losses over a specific annual amount per claim, say $25,000 or $50,000. In other words, they pay the excess loss only. Let's look again at the employer with a $250,000 annual premium. A $25,000 or $50,000 loss is really not generally covered by reinsurance and one or two such losses could immediately create an adverse loss ratio that would diminish an employer's cash flow.

> A misconception created by those favoring self-funded plans is that an employer may remove almost all risk through reinsurance. The reinsurer is thought to pick up losses that are in excess of the fund the employer pays toward the plan. This is not so.

Reinsurers will also assume losses more than a certain aggregate amount of stated loss, say $50,000 or $100,000 or more of reinsurance for aggregate claims more than the $250,000 expected to fund normal losses. This type of insurance is often referred to as stop-loss. However, in most stop-loss plans there is a deductible between the losses paid by the employer, say $250,000, and the area where an excess insured loss is picked up by the reinsurer.

Reinsurance removes little of the immediate risk to the employer, who is expected to pay for any normal losses that occur.

Self-funding means a company pays for its own losses as they occur. Under an insurer plan, a company pays a premium that is usually guaranteed for a 12-month period at a rate generally based on expected losses.

Therefore, under a self-funded plan, if losses exceed the projections, the company generally pays the excess losses. Reinsurance comes into the loss-payment area only after satisfaction of expected losses, actuarially determined, and generally after the employer picks up a good part of losses.

Under an insured plan, if losses exceed projections, the insurer pays for a company's claims no matter what the amount and how inadequate the premiums may be within a policy year, or the guaranteed-rate period.

The essential question is, does an employer want to assume the excess loss risk, or does it want an insurer to assume the risk?

There are two cardinal rules on establishing self-funded plans.

- When nationwide health care claims are on the rise, don't self-fund! Claims are currently rising at the highest rate in a decade or two.
- When there is a threat of a recessionary period, don't self-fund!

During sluggish economic periods, employees fearing layoff tend to take care of any health-related conditions immediately. Loss incidence moves up as employment rates turn down.

Because of inflation, we have increasing labor costs (especially within hospitals), increased hospital and physicians' professional liability costs, increased costs due to advanced medical technology and a downturn in employment. There's no worse time than right now to establish a self-funded plan.

Also, many buyers concentrate cost-controlling efforts on the 10% administrative area rather than the 90% that goes for loss payment.

Through health care cost-control programs including plan design; proper employee communications; effective administration; preventive medicine; generic drug use; use of pre-admission testing, ambulatory surgery and second surgical opinions; and use of coordination-of-benefits programs, an employer might save 5% to 15% on that 90% of loss payment every year.

On the $250,000 risk, that would amount to $11,250 to $33,750 annually—more than the tax savings and the cash-flow reserve deferral spread over a two- or three-year period.

Also, under many self-funded plans the employee has no funding mechanism to provide for continuing coverage when employment is terminated. Under an insurer group plan, the ability to convert from a group to an individual policy is an indispensible option for a terminated employee.

Despite all these reasons against self-funding, is a self-funded plan for anyone? Yes. The organization that should seriously consider a self-funded plan during good economic times is:

- A large employer, preferably with 1,000 or more employees and a minimum annualized medical insurance premium of at least $1 million, but preferably $2.5 million or more.
- A company with steady revenue with few highs and lows. A utility company is one example.
- A company with a steady workforce and little turnover.
- A company with the financial capacity to fund its own losses during periods of financial stress.
- A company with a strong in-house staff to monitor all areas of medical insurance administration.
- A company with in-house, or access to, well-qualified consultants for actuarial, legal, claims payment and other areas. In most cases, the insurer's advice is only partially or no longer available.

If an employer has all or most of these elements, including the in-house experts, it has the corporate strength to make self-funding viable. If a company doesn't have these elements, be careful. It may be initiating a potential economic calamity. In a small employer's case, self-funding is seldom recommended. ▪

Wallace E. Jeffs is president and chairman of Association Administrators & Consultants Inc., a third-party administrator in Irvine, Calif.

legal briefs

Valid marriage not necessary to get benefits

IS A PERSON who pays insurance premiums for nearly six years to insure his "spouse" barred from collecting benefits for her death because their union was not a legal marriage? Not according to the Louisiana Supreme Court.

Phillip Jackson, an illiterate state employee, was insured under a Continental Assurance Co. group policy. Beulah Jackson was enrolled for life insurance in 1973 as his spouse. Premiums were deducted from Mr. Jackson's check. Beulah died in 1979 after living with Mr. Jackson for 35 years. The policy provided that it could not be contested, except for non-payment of premiums, after being in force for two years. Continental contested liability because it was unaware, until after Beulah's death, that the parties were not married. The trial court dismissed the suit.

The appellate court said that eligibility could be contested only if allowing coverage extended to a risk beyond that contemplated by the insurer in the policy. According to the court, "One who is, for all practical purposes, a spouse should not be barred from recovery by an irrelevant legal status." *Jackson vs. Continental Casualty Co.*, Supreme Court of Louisiana. April 5, 1982, *rehearing denied* May 14, 1982 (*BI*/01/F.-$5).

Imagined disability

A disability is real even though its causation was imaginary. The test is whether the employee was sincere in his believing that the disability was due to a real injury, ruled a Louisiana appellate court.

Francis Hughes, a mechanic, was injured at work when parts of a vehicle fell on his chest. His physical injury was slight and his doctor prescribed a back brace. However, Mr. Hughes continued to have lower back pain that did not respond to treatment. Another doctor believed his tension about his condition added to his pain. Further examination revealed only mild back spasm and psychiatric consultation was recommended. He refused, filed for permanent total disability benefits and lost in the trial court.

The appellate court said that Mr. Hughes should not be barred from recovering compensation simply because of his peculiar emotional makeup. His minor physical injury produced a permanent disability with both physical and emotional causes. It was satisfied that there was no evidence the rehabilitation program was designed to deal with disabilities like his, which were partly psychological. *Hughes vs. Webster Parish Police Jury*, Court of Appeals of Louisiana, May 10, 1982 (*BI*/03/F.-$5). ■

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5 for Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the opinion number.

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Outpatient benefits need right incentive

By MARGARET LeROUX

Outpatient surgery can cut a deep swath into escalating group health insurance costs, benefit managers, consultants and insurers say.

But for savings to be substantial, health plans should mandate outpatient surgery for some procedures, provide incentives for employees to choose outpatient surgery or use strong communications devices to promote its use. For example:

- Blue Cross & Blue Shield of North Carolina has saved $1.9 million since beginning a communications program in 1980 to increase the use of outpatient surgery, according to Jeanne T. Cardi, coordinator of the North Carolina Blues' cost-containment programs.
- The state of Illinois saved "about $1 million" during the first year of a program that requires ambulatory surgery for certain procedures, says Tom Wall, manager of the state government's group insurance division.

Outpatient surgery is one cost-containment measure that "almost everybody has in their plan," notes George Heiring, head of the benefit communications division of Hewitt Associates, a consulting firm based in Lincolnshire, Ill. "What's needed is a sweetener so that the measure can produce cost savings."

According to a survey released last month by the Health Insurance Assn. of America, 85% of the employees with employer-provided group health insurance have coverage for outpatient surgery, but it's not known how many plans have provisions to convince employees to not check into the hospital.

Mr. Heiring suggests that employers increase the amount of coverage they will provide for outpatient surgery compared with inpatient procedures.

"Encourage use of outpatient surgery by reimbursing (outpatient procedures) at 100% and inpatient at 80%," Mr. Heiring said. "Employees are going to utilize the option if they know it's money out of their own pockets."

Some companies are taking that advice.

At North American Rockwell Corp. in Los Angeles, a redesigned health plan that includes outpatient surgical incentives "encourages patients to be wiser users of their hospital benefits," said Kent Fails, the company's employee benefits manager. The plan, underwritten by Metropolitan Life Insurance Co., provides "more of an incentive for ambulatory surgery, paying 100% of charges instead of 90%," Mr. Fails said.

Before the company unveiled its new plan last October, Mr. Fails said that Rockwell employees had no incentive to have surgery performed on an outpatient basis because the old plan fully covered both inpatient and outpatient charges. He expects the outpatient incentive to help hold the line on the company's health costs, but says it's too early to tell how much it will save.

Hewitt's Mr. Heiring says that communications is an important part of any effort to expand the use of outpatient surgery. He says the employees are eager to use the option because "most people don't look forward to being in the hospital. Most employees realize health care costs must be contained."

Companies that provide outpatient surgery options should make clear to employees what is included and how the option works. "Be candid and straight and don't try to bury it," he says.

But despite Mr. Heiring's advice and Rockwell's example, many companies cannot or do not stress outpatient surgery.

Frank Carter, assistant manager of group insurance at Inland Steel Co. in Chicago, notes that it is im-

Continued on facing page

Outpatient surgery sites serve need

Health care providers are helping employers hold the line on costs by building special facilities solely for outpatient surgery.

At North Carolina Memorial Hospital in Chapel Hill, the largest state-owned hospital, a spokeswoman said that cost was among prime considerations when the hospital opened its Day-Op suite 11 years ago.

"We consider it a more effective utilization of hospital beds," the spokeswoman said, "since people who undergo outpatient surgery are basically healthy."

More than 275 different surgical procedures are performed at the Day-Op center, which includes two operating rooms, a recovery area and lounges, all located within the hospital.

About 45 outpatient surgeries are performed each week at the hospital at a savings of about 50% of what the same surgeries would cost on an inpatient basis, the spokeswoman explained.

In Fayetteville, N.C., the year-old Ambulatory Surgery Center is part of a trend that one of its founders predicts "will be the next major national trend in health care cost containment."

Dr. John Henley Jr., one of the surgeons who founded the center, has good reason to be so enthusiastic. One of the two hospitals the center competes with "lowered its fees by 50% to compete with us," he pointed out.

The lack of an outpatient surgical facility at a local hospital gave Dr. Henley and 26 other surgeons the idea to build their own center.

"We got so fed up with waiting for our hospital to build an outpatient surgery center that we did it on our own," he said.

About 13 surgeries per day are performed at the Ambulatory Surgery Center and 45 area surgeons are members of the staff at the new center.

"We've streamlined things so we're more efficient," Dr. Henley said.

"We don't need to maintain a staff as large as a hospital," he points out.

The average surgery at the Ambulatory Surgery Center costs $360, while room and board alone at most North Carolina hospitals costs about $300 per day.

"When you remove the patient from a hospital setting, you can see some incredible savings," he said.

The most often-performed surgeries at the center include tubal ligations, dilation and curettage and implantation of tubes to aid ear drainage. ■

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GMD Benefits the World

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possible for many companies to differentiate coverage for outpatient and inpatient care because union contracts often can require that the employer fully cover all medical procedures.

And Steve Gorchoff, a vp at Citibank in New York, wonders if incentives are really needed.

Mr. Gorchoff explains that "a fair number of surgical procedures are already being done on an outpatient basis" and questioned the advisability of offering an incentive "for something which is already being done."

But some of the employers and insurers that are actively promoting outpatient surgery provisions say they are saving money.

Blue Cross & Blue Shield of North Carolina is actively communicating an outpatient surgery option for seven procedures and is saving money in the process.

For example, in 1980, the first year of the North Carolina BC/BS ambulatory surgery program, savings totaled $749,966 for 1,771 outpatient surgeries.

Since that time, the number of outpatient surgeries that BC/BS has reimbursed has risen 52% and savings have ballooned to $1.9 million, according to Ms. Cardi, who adds that it costs an average of $500 less to have a procedure performed on an outpatient rather than an inpatient basis (see chart).

The surgical procedures included in the BC/BS plan are:

- Eardrum drainage, tonsillectomies and adenoidectomies.
- Dilation and curettage.
- Laparoscopy with tubal ligation.
- Hernia repair.
- Removal of breast lumps.
- Vasectomy.
- Adult circumcision.

Ms. Cardi attributes the Blues' success to its strong communications program.

"We worked hard to promote the outpatient surgery program to employers in the state.

"We encouraged employers to use their own staff to tell employees about the program," she said, adding that the insurer also furnished fact sheets and brochures detailing the option.

In addition, BC/BS encouraged employers that had formal health education programs to use them as forums for explaining the outpatient surgery plan.

The state of Illinois is using an even tougher approach by mandating that its 185,000 employees and covered dependents have 67 surgical procedures done on an outpatient basis for claims to be reimbursed by its insurer, Blue Cross of Chicago.

From July 1981 through June 1982, the state saved $1 million by denying 1,658 claims for unnecessary inpatient surgery, Mr. Wall says, adding that the state did pay 1,693 claims where a medical reason was given for inpatient surgery.

This $1 million savings does not include the money saved from the thousands of surgeries that were performed more inexpensively on an outpatient basis. Mr. Wall says the state is still in the process of developing a data system to track how much the outpatient surgical program is saving.

Before the program, a procedure like a breast biopsy commonly required at least two days of hospitalization, Mr. Wall said. "Now there are pre-admission tests done on an outpatient basis, admission is on the day of surgery and, if the results are benign, the patient can usually be released the same day."

Communications were also a big part of Illinois' program. Bimonthly newsletters listed and explained the procedures for which outpatient surgery is mandatory, according to Mr. Wall. The state's benefit booklet was rewritten to include the new outpatient surgery requirements, he says, adding that "a big 'alert' was on the cover of the booklet and the pages where the outpatient surgery explanations were noted."

The state also worked with Blue Cross to communicate the program to the state's hospitals and physicians.

But, he concedes that it was difficult to communicate to doctors and hospitals "that we're not trying to hinder quality."

That concern is shared by the American Medical Assn. A spokeswoman says the AMA is worried that mandatory outpatient surgery programs have "the potential for interference with the decision-making process that takes place between the physician and patient. We're fearful the element of choice might be taken away."

But insurers respond that group insurance plans with mandatory outpatient surgery provisions allow hospitalization if a medical reason is indicated by the surgeon.

The success of employers that now have mandatory or incentive outpatient surgery plans on the books is leading others to consider doing the same.

For example, Bob Gamble, a benefits official at A.C. Nielsen Co. in Northbrook, Ill., says the company currently does not differentiate coverage between inpatient and outpatient surgery.

However, he adds, "We have a laundry list of cost-containment features that we're looking at, and perhaps reimbursement at a higher rate for outpatient surgery is something we should take a closer look at."

Another Chicago-area employer, Bally Manufacturing Corp., says it has instructed its broker to examine whether it should add an incentive for outpatient surgery, says Lenore Metlack, a member of the company's benefits department. ■

Percentage of surgery performed on an outpatient basis in North Carolina

Procedure	1979	1982*	Percent increase
Eardrum drainage, tonsillectomy and adenoidectomy	21.1%	31.0%	46.9%
Dilation and curettage	22.3	37.0	65.9
Laparoscopy with tubal ligation	39.2	61.3	56.4
Hernia repair	3.0	3.4	13.3
Removal of breast lump	22.5	41.9	86.2
Vasectomy	83.5	91.8	9.9
Adult circumcision	15.5	35.8	130.9
Total	**25.0**	**38.0**	**52.0**

Source: Blue Cross & Blue Shield of North Carolina

*First six months

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Many cost-containment tools available: Morgan

By CAROL CAIN

Like Jules Verne and H.G. Wells, Frank Morgan is not afraid to look ahead. The vp of human resources at Berol Corp in Danbury, Conn., has been credited with formulating innovative benefit programs. In this article, Mr. Morgan shares his ideas on how benefit managers can contain costs, as well as his view of what benefits will be like in the 1990s.

Most employee benefit managers are stressing health care cost containment in 1983, just as they did last year.

However, benefit managers with an eye toward the future should also take a look at other issues like government regulation, accelerated pension vesting and the increase of the mandatory retirement age, one of their peers says.

But cost-containment approaches and "health care cost reduction" will continue to be the focus of most benefit managers' scrutiny, says Frank Morgan, vp of human resources at Berol Corp. in Danbury, Conn.

For example, employers looking for a way to contain costs should examine switching to self-insurance, he suggests. "Companies that haven't looked at that, should."

It also makes a lot of sense to review and adjust coinsurance levels annually, according to Mr. Morgan.

"But reduction is what's going to have to happen.

"I see more incentive/disincentive plans," he said, explaining that incentive plans encourage employees to spend their health care dollars wisely, while disincentive plans penalize employees who abuse their benefits.

"The employer-consumer is the linchpin in this whole medical system," he points out.

Wellness programs, like smoking cessation clinics and blood pressure checks, should be offered by a cost-conscious employer if they can be offered on a cost-effective basis, Mr. Morgan says.

While employee wellness is not a moral obligation or concern of a business, Mr. Morgan believes that healthier employees can mean increased productivity. He also reasons that lifestyle changes can reduce health care utilization and thus reduce costs for the companies.

Some cost-containment devices do not have widespread applications, he says. For example, health maintenance organizations do not offer a solution to health care inflation that can be used everywhere.

"In the right community, with the right set of attitudes and critical mass, they're an excellent option," he says. "The problem is that you do need a critical mass to make it work. . .a certain population density to make it viable."

HMOs also require an attitudinal change on the part of employees that's not evident across the country, he suggests. "They work well on the West Coast, but they've been there since the '40s; there's more willingness there.

"I don't see a tremendous growth in HMOs, but there will continue to be an independent or collection of physician provider systems. . .an increasing number of partnerships, associations, etc. . .combining a group of specialties," Mr. Morgan predicts.

These physician provider systems will somewhat resemble HMOs, but they won't be federally registered as most HMOs are. "But they will be financially viable and people will have a free choice," he points out.

Another cost-containment trend that will probably expand is employer health care coalitions. "Major companies are fed up with having no clout," Mr. Morgan explains.

For example, Berol is a member of a coalition that also includes American Can Co. and International Business Machines Corp. that has made it known to hospitals that they represent "lots of employees." That has led to the election of representatives from the corporations to hospital boards of trustees.

But benefit managers worried about their budgets should look at more than just health care. For example, there's Social Security.

"If we don't do something about solving the solvency, we'll have a lot of people very disappointed," he says.

Mr. Morgan says that he doesn't think Social Security will be abolished, but "it will represent a smaller percentage of (retirement) income in the future," and more pressure will be exerted on corporate pension plans to make up the shortfall.

Employees between the ages of 50 to 65 don't have time to make up a reduction in anticipated Social Security benefits and will look to benefit managers for alternatives, Mr. Morgan explains.

Furthermore, last year's Tax Equity and Fiscal Responsibility Act has serious pension implications for top executives by limiting the amount of qualified benefits they can receive, he says, which will affect executive recruitment, compensation and retention formulas.

Mr. Morgan believes that companies will accept a moral obligation to make up any pension shortfalls for executives rather than tell them the law has changed and they have to take it on the chin.

"Long-term. . .that says to me we're going to have to rethink the entire pension issue, particularly with regard to higher executives," he says.

The evolution of 401(k) salary reduction plans is another reason benefit managers should give some thought to restructuring their pension programs.

The "401(k) business" is one ray of sunshine for benefit managers, he explains, adding that Berol is thinking about forming such a plan and that other companies should do the same. But he advised benefit managers to defer any action until the final 401(k) regulations are issued.

In the meantime, companies should investigate their options, talk to consultants and gather data to be prepared to talk with senior management about implementing a salary reduction plan when the regulations are issued.

One of last year's burning benefit issues—givebacks—is still around

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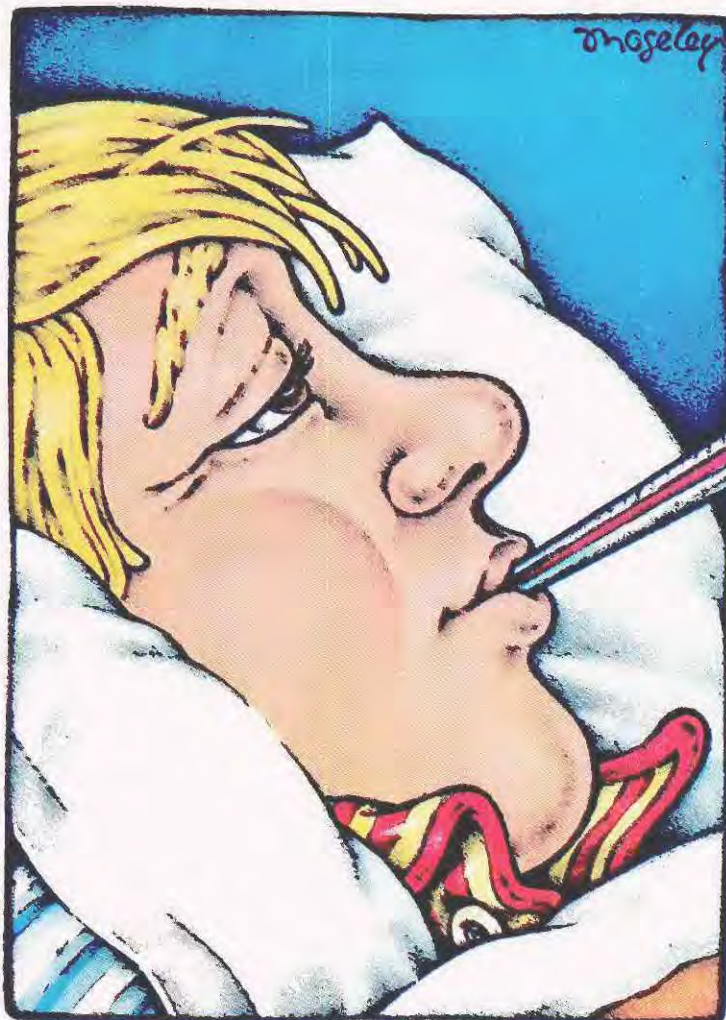

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this year, Mr. Morgan says, but only certain hard-hit industries, like the auto industry, will have to deal with it.

If the economy turns around and gains strength, most employees will immediately forget about the bad times and ask for benefit increases, he explains.

Some employers, like Berol, avoided the question of benefit concessions by restructuring their medical plans, Mr. Morgan comments (*BI*, Nov. 15, 1982). More and more companies will totally redesign their plans in the next several years, he adds.

Besides these immediate problems, Mr. Morgan says that benefit managers can expect big changes in the coming years.

"I think we're going to see more government involvement in pensions and medical benefits. It could be good or bad, depends on what they do.

'The one thing that worries the living daylights out of me is if the government (decides) now is the time for socialized medicine or government-sponsored medical plans,' Mr. Morgan says.

"The one thing that worries the living daylights out of me is if the government (decides) now is the time for socialized medicine or government-sponsored medical plans," Mr. Morgan says.

"I don't think this country can afford it, or that it will increase the quality (of medical care) one iota."

But, he says, a national health system, like Great Britain's, seems unlikely in the United States because people have a different attitude about health care. "And the cost, if examined, will be way beyond any sense."

But America as a whole—and benefit managers in particular—will continue to grapple with the problem of adequate health care for the unemployed, the poor and senior citizens, he says.

It will be up to the private sector to solve those problems, Mr. Morgan comments, explaining that companies must make individuals better health care consumers.

Pushing back the retirement age seems inevitable, he says, adding that initially it will hurt industry but, in the long run, it "probably will be a healthy move."

If older workers stay on the job longer, there will be less demand for newcomers, which could increase unemployment, he said. "But in the long term, it'll be good; some people should retire at age 40 and some people, never."

Accelerated pension vesting and pension portability also seem inevitable and should be prevalent by the 1990s if not sooner, Mr. Morgan says. In the past, employers did not have the data systems to keep track of pension credits earned at different companies, but the technology boom has changed all that.

One of the largest benefit headaches facing employers is also pension-related: How should a company account for the huge liabilities created by defined benefit plans?

"There's something afoot in (the accounting) profession and, if implemented, there will be far-reaching implications," he said.

Current accounting practices, Mr. Morgan explains, do not state the future liabilities an employer faces from the underfunding of defined benefit plans. If accounting procedures change to truly reflect the burden, "It will make defined benefit plans as popular as a dodo bird," he says.

Already, many employers are terminating their defined benefit plans and replacing them with defined contribution plans, he says.

Mr. Morgan says Berol is investigating that very idea, but it is waiting until the final 401(k) regulations are published before changing its defined benefit plan.

"I'm really torn on this issue. I'm not so sure that what they (the accounting profession) may do doesn't make good accounting sense," he said. "It's like one of those lurking-in-the background issues: If companies haven't thought about it and aren't prepared, they'll be caught in a bad state."

Looking far into the future, Mr. Morgan sees the entire work environment being altered by a mix of technology, the economy and social change.

"I see the following happening: a trend line that's related to energy, its use and cost and availability. . .that line is going upward. On the other hand are microchip computers (and) communication via satellite—a trend line that is coming down.

"In my opinion, those lines already crossed and the difference between them is increasing," he explains.

"Look around. We're using energy in an inefficient way. You leave a heated building, go into a heated car. . .I think in the future more work and education will be done at home."

Mr. Morgan uses that assumption, plus all the current and continuing issues that face benefit managers, to compile a profile of an employee of the 1990s, something that employers should keep in mind while designing benefit plans for the current decade.

The employee of the future will be white-collar with a computer at home and in the office, so he or she can work at home at least one day per week, if not more often, he says.

And, through those computers, employees will be able to instantaneously receive an update on their finances, including all pertinent information about their employer-provided benefits.

"All the software for that exists presently," Mr. Morgan notes. "If I were a company that provided hard-copy benefit statements, I would keep an eye on this trend."

The company medical plan of the 1990s will have a relatively high deductible and coinsurance level. It will offer a built-in incentive for wise health care utilization in the form of a cash or deferred payment.

The medical plan also will make second opinions for surgery mandatory and all claims over a certain amount will automatically be computer-checked.

Employees will also be able to use their computer terminals to receive medical education and information about providers.

"An employee will be able to use this data base to answer questions, like what a hernia is, and also to get information about the quality and costs of providers," Mr. Morgan says.

In addition, employees will participate in company-sponsored wellness, family and stress counseling programs, Mr. Morgan says, adding that it's less expensive to treat stress than the resulting medical problems.

"At present, there is a stigma attached to this type of counseling. But as companies begin to sponsor it, it will become more and more accepted," he says. ■

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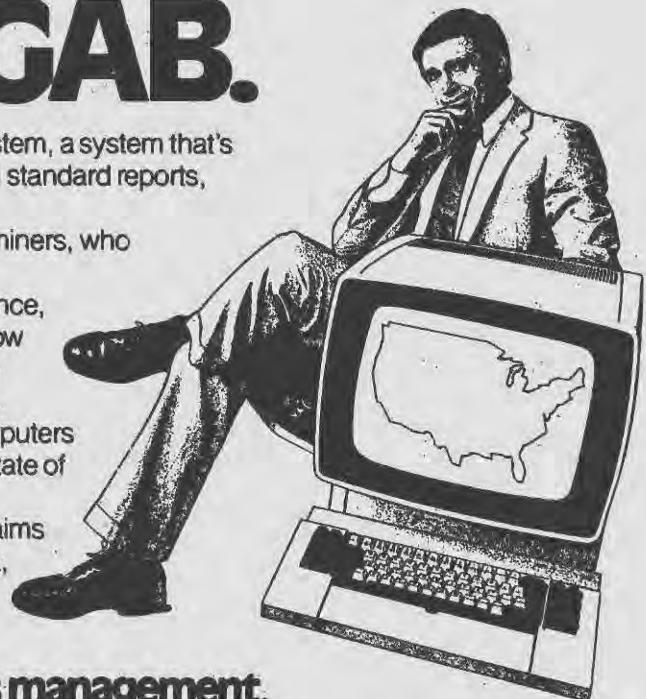

GAB The state of the art of claims management.

Illinois firms lauded for fitness programs

By LAURIE F. SIEGEL

Companies around the nation are opening on-site health centers in the hope that healthier employees will be more productive and less likely to file medical claims.

To help spread the word about employee fitness programs in Illinois, the Governor's Council on Health and Fitness has singled out seven state employers as having superior health promotion facilities. They are:

- Fel-Pro Inc. in Skokie.
- Atlantic Richfield Co. in Harvey.
- Dart & Kraft Inc. in Northbrook.
- CF Industries Inc. in Long Grove.
- Signature Financial Marketing Inc. in Evanston.
- Baxter Travenol Laboratories Inc. in Deerfield.
- A.E. Staley Manufacturing Co. in Decatur.

The council cited these companies' fitness programs to encourage other employers to visit their facilities and perhaps open their own centers, said James Liston, the council's executive director.

A member of the council visited each facility before the awards were announced, Mr. Liston said, adding that "the main component we look for is fitness centers with ongoing fitness opportunities on a daily basis."

The council examined many different programs when judging the centers, including health screening, stress testing and management, aerobic dancing, exercise equipment, tailored exercise prescriptions, employee assistance programs, nutrition and weight control programs, smoking cessation and back care.

In addition, the winning facilities must be available to all employees and must be open to visits from other interested firms. Records must be kept on participation levels and health seminars must be available to all employees without charge.

Fitness centers pay off in two ways, experts say. First, they offer employees free or low-cost fitness activities, a valuable employee benefit in light of the current interest in exercise. Second, improved employee wellness can mean big savings for an employer.

For example, a New York Telephone Co. study showed that its nine wellness programs saved $2.7 million in absenteeism and medical costs in 1980. The programs cost $2.84 million, while the company estimated they saved it $5.54 million (*BI*, Oct. 4, 1982).

The types of facilities and programs offered by employers vary widely. Here's a brief explanation of the programs cited by the Illinois council:

- At Fel-Pro, the Skokie-based automotive seals and products manufacturer, employees can leave the noise of the manufacturing line behind and work out in a 2,400-square-foot gym, designed by company Health/Fitness Coordinator Sharon Chausow.

The gym is equipped with slantboards, treadmill, Universal weight-training equipment and stationary bicycles. In addition, one- to five-mile outdoor jogging paths have been mapped out.

A doctor's permission and an interview are required before an employee can start working out. After a battery of tests, Ms. Chausow recommends an individual workout program. Employees are charged a $27 fee for the tests, but that is refunded if the employee participates for six months.

About 550 of Fel-Pro's 1,500 employees use the center. Annual operating costs run about $12,000, compared with a start-up cost of about $31,000, which included exercise equipment, carpeting, music system and two locker rooms with 36 showers.

About 27 classes, for members only, are scheduled each week on subjects like weight control, dance and muscular fitness, stress management and back care. "Aerobic classes have really taken off and the women have become more involved in weight training," Ms. Chausow said.

Outside instructors teach seminars that focus on nutrition, alcohol abuse, smoking cessation and preretirement fitness and health.

The programs are showing results, Ms. Chausow said.

Participants in a June 1982 stop-smoking clinic reported increased levels of activity and a more positive mental attitude. And, data collected on a group of workers using the 2-year-old facility since it opened show that strength, endurance and cardiovascular rates have improved while weight, blood pressure and body fat percentages have declined.

Ms. Chausow promotes the center through posters, message boards, a members' newsletter and three or four contests a year. Trophies, medals and fitness items, like sweatpants and T-shirts, are awarded after walking, jogging or cycling a certain distance.

Suggestions, heard through employee forums and annual member surveys, may be implemented after evaluation by the center's staff, she said. Members now receive periodic progress reports and updates on the programs offered.

"It's difficult to prove that the program saves money," Ms. Chausow said, adding that information on the cost effectiveness of the center will be available in a few years.

Receiving the state citation "was not a big deal," she said, "because we have one of the best fitness centers in the state."

- At Atlantic Richfield's facility in Harvey, employees use a health site managed by Fitness Systems, a Los Angeles-based outside vendor.

Atlantic Richfield spent about $50,000 on renovating an empty room and purchasing a treadmill, rowing machine, abdominal boards, Universal weight equipment, stationary bicycles and a cross-country ski simulator. In ad-

Continued on facing page

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Continued from facing page
dition, there's a half-mile outdoor jogging path. The health site was opened in 1979.

Aerobic classes are offered six times a week and a weight training class is held once a week. An outside firm, Vasquez Management Consultants of Wasborth, Ill. hires instructors to teach three seminars annually on such topics as coping with stress, burnout and dealing with depression.

Although the facility is open all day, peak times are midday and before and after work. The locker room, with alternating hours for men and women, is equipped with a sauna and showers.

A $130 annual fee paid by about 170 of the facility's 480 employees covers health screening and a personalized fitness program.

"Actual costs of operating a fitness facility show that the benefits of the program exceed the cost by three times," said Fitness Director Tom Merry. "Starting a fitness program is like any other business decision. There are risks involved." A key element when building a wellness program is proper planning, Mr. Merry said. Proving that healthier employees increase productivity and morale is difficult, but studies show that benefits far outweigh costs, he added.

"Retesting (after the initial screening) showed marked improvement in mobility, muscular tone, cardiorespiratory conditioning and a decrease in body fat percentage. People say they're more productive and able to live a more active lifestyle."

After kicking off the program in 1979 with an open house, members have been kept updated through a quarterly newsletter.

Mr. Merry has steered away from initiating contests, which foster competition. Members can receive a gold star for exercising within a prescribed heart rate for 500 minutes, but participants cannot chart more than 20 minutes at a time.

"We want people to come here for a good solid workout that fills the needs of middle-aged adults," he said.

- At Dart & Kraft, a manufacturer and distributor of batteries, appliances, plastics and food products, a free health center was launched a year and a half ago.

About 50% of its 428 Northbrook employees use the fully equipped facility. "I think we have a good representation of all levels (of employees)," said Denise Hasler, program director.

Dart & Kraft's facility, like Atlantic Richfield's fitness center, is supervised by Fitness Systems. Screening, retesting and tailoring exercise programs to meet individual goals are conducted at both companies.

A 12-week "Chub Club" helps employees trim waistlines. Aerobic classes, taught three times a week, are attended by 20 to 30 people. In-house personnel lead seminars on smoking cessation, postnatal exercises and computer and desk job exercises to reduce neck and eye stress.

"The center is a benefit because fit employees are much more productive. They feel that the company is concerned about them as individuals," a company spokesman said.

Measuring benefits in terms of dollars saved is difficult, Ms. Hasler said. "How can you put a dollar value on employees feeling good about themselves?"

- At CF Industries in Long Grove, there's a fitness center not only to make employees healthy, but to provide statistics on how healthy they really are. The company, a manufacturer and distributor of chemical fertilizers, has a data retrieval system that evaluates employees' exercise progress both inside and outside the facility.

Before arranging individual exercise programs, employees submit a medical questionnaire and a physician's approval form.

Participants also sign a waiver of liability releasing CF from responsibility if employees injure themselves using the facility or while undergoing tests at Fitness Monitoring, a Lake Geneva, Wis.,-based company that conducts employee health evaluations for the company.

The initial investment of about $40,000 covered treadmills, rowing machine, stationary bicycles, cross-country ski simulators, laundry service, a music system and two locker rooms, each with showers, sauna and lockers. Less than $40,000 annually is needed to maintain the center, which has morning and afternoon hours, said William Eppel, director of personnel development.

The economic climate hasn't really affected the program, Mr. Eppel said, although CF won't add a proposed running track until the economy improves.

About 130 employees pay the $115 annual health center fee. An incentive program encourages commitment by partially or totally refunding the annual fee. Those who exercise three times a week for one year are completely reimbursed. Employees receive an 80% refund for exercising about twice a week and those who work out about once a week get 60% back.

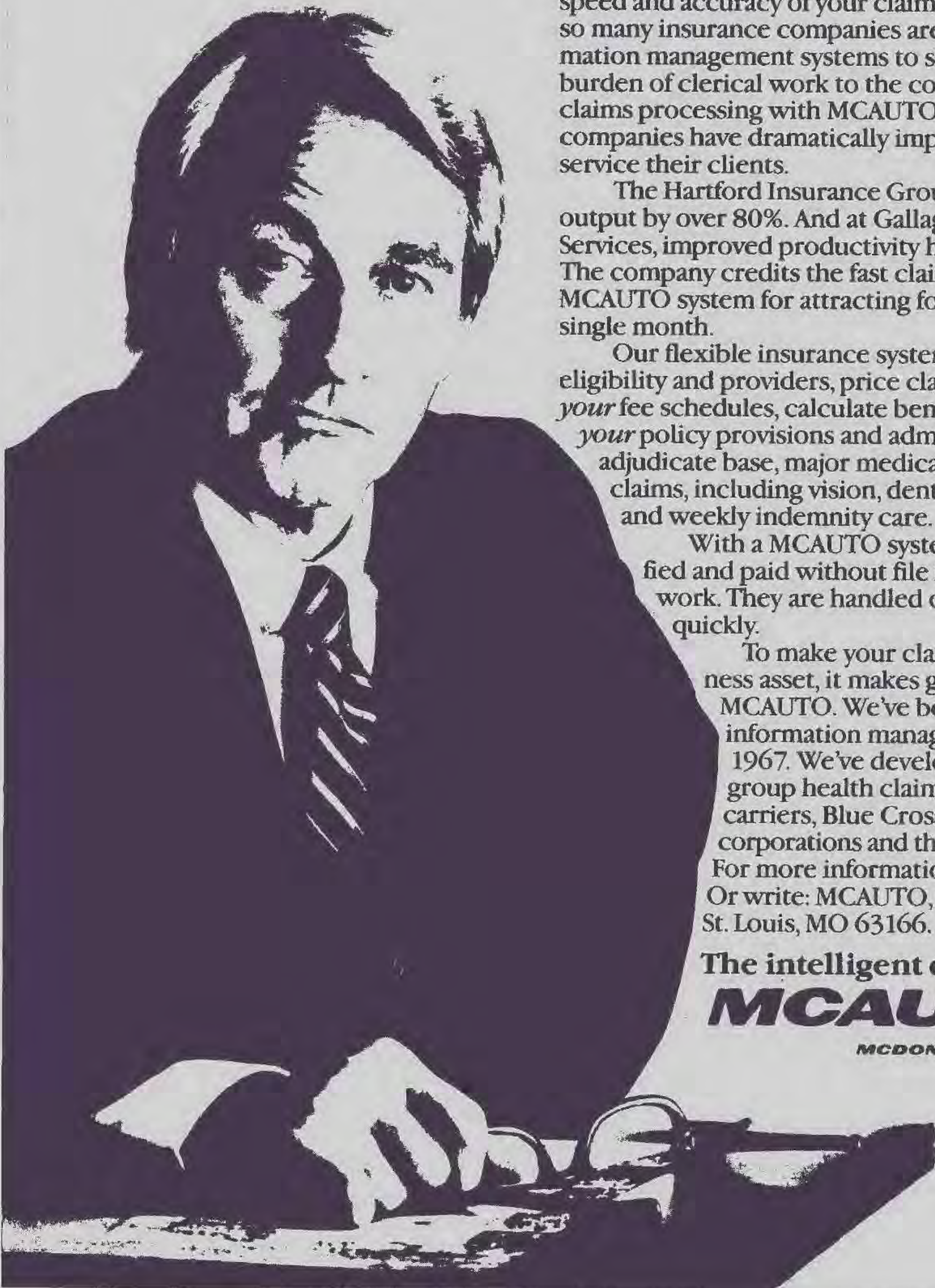
"The center is primarily for the employees' benefit and secondarily for the company's benefit," Mr. Eppel said.

Measuring changes in absenteeism and turnover rates is difficult because those rates have always been low at CF. "People feel better about themselves. I think that has had an impact on their working ability," he said.

Retesting CF employees after six months in the exercise program showed that most workers had reduced their risk of coronary disease. Employees can go to Fitness Monitoring in Schaumburg, Ill., or for a

Continued on next page

Photo: Laurie F. Siegel
A Fel-Pro employee pedals an exercise bike at the fitness center.



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Employers offer variety of fitness activities

Continued from previous page

more comprehensive evaluation that measures 15 risk factors, like blood pressure, body fat percentage, cardiovascular fitness and tension and stress (*EI*, Sept. 21, 1981).

• At Signature, the Montgomery Ward & Co. direct mail-marketing subsidiary in Evanston, nearly every activity presented by a commercial health club or spa is offered.

Almost 30% of the company's 400 employees use the gym, which is equipped with a racquetball court, treadmill, rowing machine, Nautilus weight equipment, stationary bicycles, a cross-country ski simulator, a half-court basketball court and an aerobic-exercise machine that operates on hydraulic pressure. Up to five joggers can be paced by a lap timer and a series of flashing lights around a 1/7-mile banked track circling the gymnasium.

"Everybody is screened very thoroughly prior to joining the program," says Lori Smith, employee fitness director. After employees complete medical questionnaires, Ms. Smith conducts a series of tests, including an electrocardiograph and treadmill testing. Tailored exercise programs are based on test results and employees' goals.

Classes and seminars are open to all employees. Aerobic classes are held midday three times a week. Seminars, taught by outside specialists, focus on herpes, first aid, foot care, self-defense, back care and cardiopulmonary resuscitation.

The company renovated a warehouse to build the 7,000-square-foot facility. Men and women alternate using the larger of two locker rooms, which has a sauna and whirlpool.

"Our program really wants to mix management with hourly workers," said Ms. Smith. Wearing T-shirts and shorts, stripped of corporate titles, employees are in an entirely different environment in the fitness center than in the office, she said.

The primary goal of the 2-year-old facility, which was first used to market health programs to other businesses, is to promote the health of Signature's employees, based on the premise that unhealthy employees are less productive.

"We're looking for data that demonstrate that fitness is good business," Ms. Smith said.

After the initial investment, the costs have been minimal, she said, adding that the $12.50 monthly fee that participants pay covers about 20% of annual operating costs of about $70,000. "I would like to be able to show that the center is cost-effective."

Preliminary studies found that participants file fewer insurance claims than employees who don't exercise, and when participants do file claims, they're for smaller amounts.

A computer in the center aids in the research by evaluating test results. After exercising, employees log their activities into the computer, which calculates how many calories they burned off.

"I think all health programs should consider a computer," Ms. Smith said, explaining that it saves time and paperwork.

Although membership increased by 20% in two months, it's difficult keeping employees enthused about exercising, she said. "People haven't been as responsive as I would like."

One way to encourage interest in fitness is through promotion. Besides developing a brochure, Ms. Smith says she will offer discounts for non-members.

The most significant factor that makes or breaks a health program the support of top management, Ms. Smith said, adding that Signature's center has the solid support and participation of the corporate administration.

• At Baxter Travenol Laboratories, a manufacturer and marketer of medical products, the health promotion facility was started on-site in a former storage area.

The 4-month-old, 4,000-square-foot gym is open to 6,000 Travenol employees working at five major sites in northern Illinois.

Voluntary health screening assesses weight, height, blood pressure, flexibility, aerobic fitness and body fat percentage. Results are discussed individually to determine a suitable exercise program.

About 700 people attend one-hour aerobic classes that are booked solid throughout the week. Although the center is open all day and on Saturdays from 9 a.m. to 1 p.m., 90% of all workouts are during lunch hour and before and after work, said Daniel India, corporate fitness manager.

Employees can reserve a workout period up to three days in advance because the center is packed at peak times, with about 95 employees exercising.

Seminars, taught by in-house personnel, have discussed proper foot care, smoking cessation and nutrition and weight control.

The center includes rowing machines, minitrampolines, Universal Gym and Nautilus equipment, stationary bicycles, a music system, two locker rooms and a 1.5-mile jogging path.

About 750 employees pay a $50 annual fee to use the facility staffed by five supervisors.

Awards and incentives will be offered once the novelty of the facility wears off and there's a decline in attendance, Mr. India said. About 2,000 people walked through the facility when it opened and a free-membership drawing spurred initial interest.

Upper management is very supportive of the program, which is important, Mr. India said.

"It's not a facility built for executives, but a facility built for employees. I think companies that provide more benefits for their employees care more for their employees as people.

"The aim of the program is to encourage employee fitness. The only return we are interested in is employees using the facility. Hopefully, the cost is minimal and the benefits are great," Mr. India said.

"We don't want to generate records. We are not trying to look at absenteeism and turnover rates," he said, adding that so many variables affect those figures that it would be hard to say that only physical fitness is responsible for decreases.

• The health facility at A.E. Staley Manufacturing Co. in Decatur, a corn and soybean refiner, is a pilot program that is not yet open to all employees. Staley officials declined to be interviewed.

However, the Staley health center was cited by the Governor's Council on Health and Fitness because the company encourages fitness for all employees through various seminars and recreational activities, even though the fitness center is open only to executives. ■

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Employee Benefits Board Survey	DEC 20	Dec 8
	DEC 27	Dec 14
RIMS PREVIEW/CAPTIVES OFFSHORE	APR 25	Apr 12
Risk Management Board Survey	JAN 3	Dec 20
MARKET PREVIEW/INFO FOR BUYERS	JAN 10	Dec 27
	JAN 17	Jan 5, '83
	JAN 24	Jan 12
	FEB 7	Jan 26
	FEB 14	Feb 2
RISK MANAGEMENT SERVICES	FEB 21	Feb 8
Employee Benefits Board Survey	FEB 28	Feb 15

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comings & goings: buyers

Gulf & Western names Peter Butler to new post

Peter A. Butler, 48, has been promoted to vp-risk management at Gulf & Western Industries Inc. in New York.

In this newly created position, Mr. Butler will retain responsibility for the company's property/casualty insurance worldwide.

Mr. Butler was formerly assistant vp-risk management and has served as risk manager for the company since 1976.

He has also been corporate insurance manager with General Dynamics Corp. in St. Louis, director of administrative services at Jonathan Logan Inc. in New York and Caracus, Venezuela, and corporate general auditor of Bates Manufacturing Inc. in Portland, Maine.

He received a bachelor of business administration degree from the University of Miami in Coral Gables, Fla. He is a deputy member of the Risk & Insurance Management Society and the Institute of Internal Auditors. Mr. Butler reports to Senior Vp William Flatley.

* * *

Diane F. Wyzga, 30, is now risk management associate for National Medical Enterprises Inc. in Los Angeles.

In this new position, Ms. Wyzga will create and develop a professional liability, claims management and loss-prevention program for the company, which owns and manages health care facilities nationwide.

A registered nurse, Ms. Wyzga was most recently the administrative supervisor for Salinas, Calif., Memorial Hospital. Prior to that, she was a staff nurse at the University of Virginia Medical Center in Charlottesville.

She received a bachelor of science degree in nursing from St. Anselm's College in Manchester, N.H., and a master of science degree and nurse practitioner certification from the University of Virginia in Charlottesville.

She is currently pursuing a law degree at the University of West Los Angeles. Ms. Wyzga is a deputy member of the Risk & Insurance Management Society as well as several nursing societies and honoraries.

She reports to M. Ray Hodges, vp & risk manager.

* * *

Sharon A. Urban, 28, has been named insurance analyst at G.D. Searle & Co. in Skokie, Ill. In this new position, she will assist with property/casualty insurance, loss prevention and control and workers comp.

Ms. Urban was previously a claims specialist with Wausau Insurance Cos. in River Forest, Ill., and a claims adjuster with INA Corp. in Chicago.

She received bachelor of science and master of science degrees from Marquette University in Milwaukee and is currently pursuing a master of management degree at the Kellogg School of Management at Northwestern University in Evanston, Ill.

She reports to Paul Morrison, property/casualty insurance manager.

* * *

United Telecommunications Inc. of Kansas City, Mo., has promoted **Tina M. Knabe**, 25, to insurance coordinator-pension, trust and insurance department. Ms. Knabe will coordinate the department's insurance program, including surety bonds.

She joined the company as secretary of the department in May 1980 and was promoted to insurance assistant later that year.

Ms. Knabe received a certificate in general insurance from the Insurance Institute of America in Malvern, Pa., and is now pursuing a Chartered Property/Casualty Underwriter designation. Ms. Knabe reports to William R. Shirley, director of risk management.

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comings and goings: industry

Phoenix Mutual appoints Gummere chief executive

John Gummere has been elected chief executive officer of Phoenix Mutual Life Insurance Co., a group and personal lines insurer based in Hartford, Conn. He succeeds **Robert T. Jackson**, who is retiring.

Mr. Gummere was most recently president and chief operating officer of Phoenix Mutual. He is also director of Phoenix Equity Planning Corp. and Phoenix General Insurance Co., both wholly owned subsidiaries. He has been with the company since 1949.

Mr. Jackson, who joined the company in 1939, has been chief executive officer since 1978.

Other insurer changes:

George S. Minor elected executive vp and chief executive officer of Millers Mutual Insurance Assn. in Alton, Ill. He replaces **E.J. Roennigke,** who retired. Mr. Minor most recently was vp and chief operating officer at Millers.

John Murphy appointed vp-claims for Allianz Underwriters Inc. in Los Angeles. He was most recently Los Angeles claims manager for Northbrook Insurance Co.

Bertram W. Sealy named vp of field operations-Eastern division for United States Fidelity & Guaranty Corp. in Baltimore. Mr. Sealy had been vp of the insurance engineering and audit department.

Francis N. Graham and **Frank T. Mure** were promoted to vps at Utica Mutual Life Insurance Co. in New Hartford, N.Y. Mr. Graham is vp-national accounts. He had been an assistant vp and manager of national accounts. Mr. Mure is vp-home office claims. He was previously an assistant vp.

Al Rodriguez and **Bill Pezzutti** elected vps at Peninsular Fire Insurance Co. in Jacksonville, Fla. Mr. Rodriguez was elected vp-underwriting. He was formerly a senior consultant at RIMCO Risk Management Inc. in Dallas. Mr. Pezzutti was elected vp-claims. He had been an assistant vp-claims at Peninsular, an McM Corp. subsidiary.

Excess/surplus

William J. Ormond promoted to vp-claims of Colony Insurance Co., a surplus lines insurer in Warwick, R.I. He retains his present duties as regional claims manager for Waite Hill Services Inc., a claims management and consulting firm. Both Waite Hill and Colony are subsidiaries of Figgie International Inc.

Benajmin D. Wilcox named executive vp of The Blades Group, a subsidiary of Crum & Forster. He previously was senior vp, managing Blades' energy division. Also, **John E. Fox** promoted to senior vp and **Ollie N. Rivers** to vp-administration for Blades.

Reinsurers

A. Nord Bjorke elected vp of the newly formed reinsurance specialty lines department of United States Fidelity & Guaranty Co. in the home office in Baltimore. Mr. Bjorke had been a consultant for USF&G.

Other suppliers

Dennis L. Huffman appointed president of Constitution Rehabilitation Co., a subsidiary of The Travelers Corp. in Hartford, Conn. He previously was national director and chief operating officer of Constitution Rehabilitation.

Y. John Lee named president and chief operating officer of Lansing B. Warner Inc., the newly acquired Wausau Insurance Cos.' insurance management subsidiary in Chicago. He succeeds **Morris R. Eddy**, who becomes vice chairman and chief marketing officer at Warner. Mr. Lee most recently was vp-broker operations at Wausau.

Thomas S. Baily named president of Professional Risk Management Consultants Inc. in Pittsburgh. He was previously a principal in two Western Pennsylvania brokerages.

Gwyn R. Shuel named vp and treasurer of Frank B. Hall Management Co. in Engelwood, Colo., a subsidiary of Frank B. Hall & Co. that specializes in self-funding and captive feasibility studies. Ms. Shuel previously was assistant vp and controller.

Agents/brokers

Joseph M. Rosenthal elected senior vp of Reed Stenhouse Inc. Mr. Rosenthal was vp for the broker. He will continue to direct the Reed Stenhouse National Aviation Unit with responsibilities for expanding the broker's aviation business in the United States.

Kenneth R. Schaeffer named vp and general manager of the Northern California Division of Republic Hogg Robinson Insurance Brokers Inc. Before his appointment he was sales manager of the division, located in Burlingame, Calif.

Shelby V. Timberlake Jr. named vp of Murray, Schoen & Homer Inc. in Bronxville, N.Y., where he will specialize in bloodstock, livestock and ocean marine coverages. He previously was a vp in the New York office of Johnson & Higgins. ■

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License B-137

Tillinghast acquires consultant RIMCO

Tillinghast, Nelson & Warren Inc., the Atlanta-based actuarial and consulting firm, has acquired RIMCO Risk Management Inc., a Dallas-based risk management consultant.

Tillinghast paid an undisclosed amount to RIMCO's parent, McM Corp., for all of the consulting firm's stock.

Tillinghast acquired RIMCO to expand its operations in the Southwest, particularly in the oil, gas and contracting fields, says W. James MacGinnitie, a managing principal at Tillinghast.

RIMCO will continue to operate in its present offices as a division of Tillinghast under the direction of Charles R. Lee, a RIMCO vp.

George M. Betterley will continue as managing principal of Tillinghast's risk managment division.

Keith C. Kakacek, RIMCO's president, is expected to leave the firm to pursue other activities. The decision was his own, says Mr. McGinnitie, adding that "we would have loved to have him stay."

License amended

First Security Insurance Corp. of Buffalo, N.Y., has amended its license with the New York State Insurance Department to allow it to write almost all lines of property/casualty insurance.

A stock insurer initially licensed in 1980, First Security had been limited to writing fire, inland marine and auto liability and physical damage risks, according to its chairman, Norman F. Ernst Jr.

The license amendment will allow First Security to market a number of specialty programs, particularly for general liability and homeowners' risks, Mr. Ernst pointed out.

Between 1981 and 1982, First Security increased its policyholders surplus from $900,000 to $1.3 million.

First Security also will move its offices to 180 Oak St., Buffalo, N.Y. 14203. Telephone numbers are unchanged.

Reorganization

Crown Life Insurance Co. of Tampa, Fla., has announced the reorganization of its field operations into three regional groups.

Claims handling and other administrative functions will now be consolidated in regional centers in Chicago; Tampa, Fla.; and Sacramento, Calif. The insurer currently has 42 group sales offices throughout the country; claims were previously handled in 13 of these offices.

New business is being administered according to the new system, with consolidation of existing business expected later this year.

Crown Life says the reduction in operating expenses with the new system will be "reflected in future pricing" of its group insurance products.

Acquisitions

Donald L. Simpson and **R. Donald Barker** have acquired **Cumberland Underwriting Group Inc.**, an excess/surplus lines brokerage based in Nashville, Tenn.

New offices

American Re-Insurance Co. has opened a Kansas City-area office to handle facultative reinsurance. The new office is located at 8717 W. 110th St., Suite 260, Overland Park, Kan. 66210; 913-341-0004.

Benetics Corp. has moved to

markets

new offices at 335 E. Middlefield Road, Mountain View, Calif. 94043; 415-940-6300.

Geo. F. Brown & Sons Inc. has moved its San Francisco branch to 101 California St., 26th Floor, San Francisco, Calif. 94111.

Martin E. Segal Co., New York-based benefits consultant, has opened an office at 10130 103rd St., Edmonton, Alberta T5J 3N9; 403-425-5190.

Swett & Crawford has opened a new Los Angeles-area branch at 18321 Ventura Blvd., Suite 515, Tarzana, California, 91356; 213-881-2801. ■

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OPIC reports best financial results ever

washington

By JERRY GEISEL

WASHINGTON—The Overseas Private Investment Corp. is coming off a record year.

Fiscal 1982 gross revenues for OPIC, which provides political risk insurance to U.S. companies investing in less-developed countries, climbed to about $101 million, up $13.9 million or 16% from 1981, according to the federal agency's annual report.

OPIC also reported that net income hit a new record in 1982: $83.5 million, 9.6% more than the previous high of $76.2 million set in 1981.

In addition, coverages totaling more than $3 billion were provided for 112 projects. OPIC's volume was 100% greater than in 1981.

In 1982, OPIC paid $14,291,696 to settle 15 insurance claims.

A total of $8,544,377 was paid to settle five claims that arose from the expropriation of U.S. investments in Iran and one claim based on the failure to pay an arbitration award in Benin.

In addition, OPIC paid $5,747,319 to settle nine currency inconvertibility claims. These claims arose when governments of host countries prevented U.S. investors from repatriating capital, dividends or royalties.

However, OPIC said that it denied a $1.6 million war and revolution claim and a $287,000 expropriation claim last year.

Construction fatality

The Occupational Safety and Health Administration has referred a construction site fatality to the Justice Department for possible criminal prosecution.

Seventeen-year-old Rhett Surrell, an employee of Amis Construction Co., was killed last year during a sewer-installation project in Shawnee, Okla.

Mr. Surrell was grading crushed rock in a sewer pipe trench when a portion of the trench collapsed, burying him for 15 minutes. He died from suffocation.

Employers that willfully violate an OSHA standard can be fined $10,000 and/or imprisoned for up to six months if that violation leads to the death of a worker.

OSHA said it could not provide any more details on the case until the Justice Department completes its review.

ESOP loans

Trustees of a New Jersey Employee Stock Ownership Plan who made loans to themselves from plan funds must repay the plan more than $900,000 under a consent order obtained by the Labor Department.

The department had charged in a suit that trustees Ben Opatut, Morris Opatut and Joel Opatut made illegal loans from Colonial Foods Inc. Employee Stock Ownership Plan of Freehold, N.J.

The Employee Retirement Income Security Act of 1974 bars trustees from loaning plan money to themselves.

In addition, the department charged that the trustees loaned plan money on unfavorable terms. The department also argued that the Colonial Foods plan trustees failed to demand immediate payment when borrowers defaulted on plan loans.

Aside from paying back more than $900,000 to the plan, the trustees must resign their positions no later than March 18 and apply to the Internal Revenue Service to terminate the plan.

The consent order, issued by the U.S. District Court for the District of New Jersey, also stipulates that the First National State Bank of New Jersey will act as successor trustee until the assets have been distributed to the participants.

Small-business loans

Small employers want to be able to borrow money from their employee pension and profit-sharing plans.

The National Small Business Assn. last month asked the Labor Department to issue a special class exemption that would allow small firms to borrow up to $250,000 from their retirement plans.

Under the request, small businesses could borrow money from their retirement plans to purchase tangible assets, like machinery and plant equipment.

However, a loan would be subject to several conditions. They include:

- The loan would have to be repaid within five years.
- The interest rate would be 2% above the prevailing prime rate.
- The loan would have to be secured with insurance maintained on the collateral.

Currently, the Employee Retirement Income Security Act prohibits employers from borrowing funds from their pension plans.

Fiduciary liability

The Labor Department's Advisory Council on Employee Welfare and Benefit Plans will meet this week to discuss the role of fiduciary liability insurance.

The March 16 public meeting will begin at 9:30 a.m. in Room S-4215 in the Labor Department's main building at 200 Constitution Ave. N.W.

For more information about the meeting, contact Edward Lysczek at 202-523-8753.

Grain inspections

The Occupational Safety and Health Administration is stepping up safety inspections of the nation's grain elevators.

OSHA chief Thorne Auchter said increasing inspections is an interim measure to improve worker protection until the agency issues new standards to reduce the risk of fires and explosions in grain elevators.

Last year, 12 workers were killed and another 35 were injured in grain elevator explosions, according to the Department of Agriculture.

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APRIL 13-14. Dental Insurance seminar in New York, sponsored by American Dental Examiners; $500; $450 for additional registrants from the same company. Milliman & Robertson Inc., 150 Strafford Ave., Wayne, Pa. 19087; 215-687-5644.

APRIL 13-15. Association of Insurance & Risk Managers in Industry & Commerce international conference in Oxford, England; 130 pounds plus value-added tax (approximately $240) for insurance buyers. 1983 AIRMIC International Conference Secretariat, c/o ConEXion, Banda House, Cambridge Grove, Hammersmith, London W6 0LE, England; 01-741-4741; telex 896778.

APRIL 14-16. American Society of Safety Engineers' Western States Development conference in Santa Clara, Calif.; $225 for members; $250 for non-members; $75 for students; non-member reservation received with member reservation from same company will be processed at member rate. Kenneth Geiser, c/o Dinner Levison Co., Box 7669, San Francisco, Calif. 94120; 415-391-5422.

APRIL 15. Workers Compensation & Employers Liability Policy seminar in Chicago, sponsored by the National Council on Compensation Insurance; $25 for members; $30 for non-members. Patricia Lapham, NCCI, 1 Penn Plaza, New York, N.Y. 10119; 212-560-1095.

APRIL 18-20. Insurance Claims and Litigation Supervisors seminar in Nashville, sponsored by the Defense Research Institute; $210 for members; $240 for non-members. Insurance Claims and Litigation Supervisors' Seminar, The Defense Research Institute, 733 N. Van Buren St., Suite 650, Milwaukee, Wis. 53202; 414-272-5995.

APRIL 18-20. Labor-Management Trustees and Administrators institute in Las Vegas, sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

APRIL 18-22. Occupational Respiratory Protection course in San Diego, sponsored by the University of Southern California; $500. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523.

APRIL 18-22. Total Loss-Control Management seminar in Houston, sponsored by the International Safety Academy; $585. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

APRIL 19-21. Industrial Explosion Prevention and Protection workshop in New Orleans, sponsored by Du Pont Co.; $795. Explosion Protection, Du Pont Co., Room X-39700, Wilmington, Del. 19898; 302-999-3699.

APRIL 20. Risk Management Information Systems conference in St. Louis, sponsored by Corporate Systems; $50. Also **April 21** in Kansas City, Mo. Matt Davis, Corporate Systems, Box 31780, Amarillo, Texas 79120; 806-376-4223.

APRIL 24-29. Risk & Insurance Management Society's 21st annual conference in Los Angeles; $520 for members; $620 for non-members. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

APRIL 25-26. Principles of Petroleum Insurance workshop in San Francisco, sponsored by Professional Development Institute; $395. Also **April 28-29** in Los Angeles. PDI Accounting & Insurance Center, Box 13288, NT Station, Denton, Texas 76203; 817-565-3383.

APRIL 25-29. Identification, Sampling and Evaluating Airborne Asbestos Dust in Los Angeles, sponsored by the University of Southern California; $500. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523.

MAY 2-3. Principles of Petroleum Insurance workshop in San Antonio, Texas, sponsored by Professional Development Institute; $395. Also **May 9-10** in Houston, **May 16-17** in New Orleans and **May 26-27** in Dallas. PDI Accounting & Insurance Center, Box 13288, NT Station, Denton, Texas 76203; 817-565-3383.

MAY 2-4. Recognition of Accident Potential in the Workplace Due to Human Factors course in Los Angeles, sponsored by University of Southern California; $300. USC, Office of Extension & In-Service Programs, Institute of Safety & Systems Management, Los Angeles, Calif. 90089; 213-743-6523.

MAY 8-11. Washington Legislative Update seminar, sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

MAY 9. Confined Space Entry Safety workshop in Dallas, sponsored by Loss Prevention Associates; $185. Loss Prevention Associates, P.O. Box 59888, Dallas, Texas 75229; 214-241-0396.

MAY 9-11. 1983 Electrical Safety conference in Madison, Wis., sponsored by the University of Wisconsin; $395. Victor P. Janule, Department of Engineering and Applied Science, University of Wisconsin-Extension, 432 N. Lake St., Madison, Wis. 53706; 608-263-7429.

MAY 9-13. Property Conservation course for property owners, in Long Grove, Ill., sponsored by the Kemper Group; $400. W.P. Thomas Jr., NID (HPR) A-1, Long Grove, Ill. 60049; 312-540-3380.

MAY 10-11. Managing Latent Occupational Disease Liability conference in Arlington, Va., sponsored by The Energy Bureau Inc.; $695. Linda Doren, The Energy Bureau, 41 E. 42nd St., New York, N.Y. 10017; 212-687-3178.

MAY 10-13. Hazardous Materials Safety seminar in Nashville, Tenn., sponsored by the Hazardous Risk Advisory Committee of Nashville; $135 before May 9; $150 thereafter. Hazardous Risk Advisory Committee, Seminar Registration Desk, Metro Civil Defense, 2060 15th Ave. S., Nashville, Tenn. 37212; 615-385-8575.

MAY 11-12. Health Care Cost Containment workshop in New York, sponsored by the Health Research Institute; $395. HRI, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 11-13. Employee Stock Ownership Assn. sixth annual conference in New Orleans; $350 for members; $400 for associate members; $450 for non-members; discounts available for additional participants from the same company. ESOP Assn., 1725 DeSales St. N.W., Suite 400, Washington, D.C. 20036; 202-293-2971.

MAY 11-13. Property Conservation seminar in Wilmington, Del., sponsored by the International Safety Academy; $275. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

MAY 12-13. Evaluation of Structural Failures program in Madison, Wis., sponsored by the University of Wisconsin; $275. Rolf T. Killingstad, University of Wisconsin Extension, 432 N. Lake St., Madison, Wis. 53706; 608-272-3748.

MAY 16-19. Inspector Training seminar in Houston, sponsored by the International Safety Academy; $490. ISA, 10575 Katy Freeway, Box 19600 Houston, Texas 77224; 713-932-9400.

MAY 16-20. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $425. Also **May 25-26** in Chicago. John Garis NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

MAY 18-20. National Safety Management Society annual conference in Arlington, Texas; $230 for members; $275 for non-members; $20 additional for registration after April 1. David M. Wassum, NSMS, P.O. Box 170174, Arlington, Texas 76003; 214-631-6070.

MAY 22-27. American Industrial Hygiene conference in Philadelphia, sponsored by the American Industrial Hygiene Assn. and the American Conference of Governmental Hygienists; $65 for members; $90 for non-members; $15 additional for on-site registration. Stephanie Beidler, AIHA, 475 Wolf Ledges Parkway, Akron, Ohio 44311; 216-762-7294.

MAY 23-25. Employee Benefits symposium in San Francisco, sponsored by the International Society of Certified Employee Benefit Specialists; $420 for members; $495 for non-members. ISCEBS, Box 209, Brookfield, Wisconsin 53005; 414-786-6700.

MAY 23-25. Fundamentals of Industrial Exhaust Ventilation course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $350. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

MAY 23-25. Techniques of Loss Control course in New York City, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Education Department, RIMS, 205 E. 42nd St., New York, N.Y; 212-286-9292.

MAY 23-27. Basic Safety Management seminar in Atlantic City, N.J., sponsored by the International Safety Academy; $570. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

MAY 24-27. Ergonomics seminar in San Jose, Calif., sponsored by the International Safety Academy; $375. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

MAY 25. Insurance Accounting & Statistical Assn. conference in Detroit; $135. International Office, IASA, Mutual Plaza, Durham, N.C. 27701; 919-683-2356.

MAY 26. Employee Health & Fitness: The Corporate View conference in Chicago, sponsored by Campbell Soup Co. and Universal Gym Equipment; $150. Employee Health & Fitness, Box 741, Cedar Rapids, Iowa 52406; 319-365-1663.

MAY 26-28. Litigation in Aviation and Space Law second national institute in Washington, sponsored by the American Bar Assn.; $393 for members; $418 for non-members; $368 for tort and insurance practice lawyers; $343 for young lawyers and government employees; $75 for law students. ABA, Division of Professional Education, 10 W. 35th St., Chicago, Ill. 60616; 312-567-4675.

JUNE 1-3. Fundamentals of Insurance conference in Chicago, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 1-4. Public Risk and Insurance Management Assn. annual conference in St. Paul, Minn.; $220 for members before April 25; $275 for members after April 25; $425 for non-members; $375 for subsequent non-members registrants from the same organization. PRIMA, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

JUNE 2-3. Principles of Petroleum Insurance workshop in Denver, sponsored by Professional Development Institute; $395. Also **June 9-10** in Oklahoma City. PDI Accounting & Insurance Center, Box 13288, NT Station, Denton, Texas 76203; 817-565-3383.

JUNE 7. Health Care Cost Containment briefings in Kansas City, Mo., sponsored by the International Foundation of Employee Benefit Plans; $130 for members; $155 for non-members. Also **June 8** in Milwaukee, **June 28** in Pittsburgh and **June 29** in Tarrytown, N.Y. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

JUNE 7-8. Legal Aspects of Occupational Safety & Health course in Los Angeles, sponsored by the University of Southern California; $250. USC, Institute of Safety & Systems Management; Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523.

JUNE 13-15. Techniques of Risk Management conference in New York City, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 19-22. Collection of Employer Contributions institute in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

JUNE 22-23. Health Care Cost Containment workshop in Boston, sponsored by the Health Research Institute; $395. HRI, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

JULY 21-23. Labor-Management Trustees and Administrators institute in Toronto, sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700. ■

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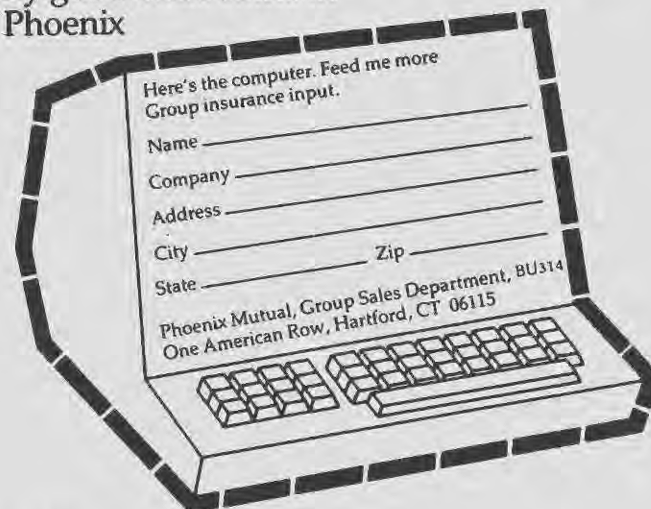

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Howden problems push A&A into red ink

Continued from page 1

These expenses, however, were only the first of many underwriting, investment and other costs A&A was to sustain in 1982, Chief Financial Officer William Farley told reporters. A&A eventually calculated Howden's outstanding liabilties, including the missing assets, at $85 million.

Despite record revenues, the second-largest U.S. brokerage simply could not take up the slack and show a net profit.

A&A's 1982 operating revenues grew 35.4% to $573.3 million from about $423.3 million in 1981, Mr. Farley said.

However, the record revenues, fueled by about $128 million from Howden, were heavily offset by increased expenses, which jumped 49% to $516.4 million from $346.3 million in 1981.

Of the $170.1 million in new expenses, Howden generated approximately $121 million, including legal fees and auditing costs, Mr. Farley noted.

"However, our U.S. business was also negatively affected by the economy and property/casualty insurance market conditions, so it wouldn't be fair to say that all our troubles were caused by Howden," Mr. Farley explained.

Shrinking sales and payrolls at client companies hit by the nation's recession reduced insurance premiums and the resulting brokerage commissions, Mr. Bogardus pointed out. In particular, A&A suffered from the worldwide oil glut when several drilling rig operators who were A&A clients shut down operations and demanded return premium on their coverage.

"When the insurers returned the premium, we paid back the commissions. Some of this business is now returning as the drilling rig companies re-enter operations," Mr. Bogardus says.

Howden, however, further offset the company's $56.9 million pretax operating income with about $13.8 million in underwriting losses and accounting charges due to the amortization of discounts on revalued reserves held by three of its Bermuda underwriting units. They are: Sphere Drake, Trent Insurance Co. and Capitol Reinsurance Co.

After taxes and the third-quarter extraordinary charge of $40 million, income disappeared and was replaced by a net loss of $25 million, down from net income of $57.7 in 1981. The company reported a $1-per-share loss in 1982, compared with earnings per share of $2.91 in 1981.

Although A&A's dismal year-end results pivot on the extraordinary charge taken in the third quarter, fourth-quarter results also ate into earnings.

Fourth-quarter revenues grew 27.3% to $136.8 million from $107.4 million for the same period in 1981, but operating expenses grew 51.8% to $135.6 million from $89.3 million in 1981.

The resulting $1.2 million operating profit was then wiped out by $15.9 million in losses from the Howden underwriting units, including about $9 million in underwriting losses and almost $7 million in accounting charges against reserve revaluations.

After taxes, A&A reported a net loss of $19.9 million for the fourth quarter, down from $15.7 million in net income for the same period in 1981. The company reported a loss per share of 80 cents for the period, compared with earnings per share of 46 cents in the last quarter of 1981.

Any way analysts look at the figures, Howden's portion of the losses was significant.

Although Howden's combined brokerage services, Lloyd's underwriting syndicate management and other underwriting activities produced only a $300,000 net operating loss for the entire year, costs related to the acquisition and the 1981 problems at the Bermuda underwriting subsidiaries produced a $20.7 million carryover loss.

"Howden's brokerage operations, excluding underwriting, still seem to be in relatively good shape and making a profit," Mr. Bogardus pointed out.

"However, we have noticed a slight—less than 10%—reduction in its retail business."

The problems at Howden have also slowed A&A's plans for international expansion, which was the original reason it wanted an overseas subsidiary.

But to help continue worldwide growth despite this setback, the brokerage did make equity investments in brokerages in France, West Germany and the Netherlands, Mr. Bogardus said.

Howden remains a valuable asset and there are no plans to sell any portion of the company, he added, although Howden's Lloyd's of London underwriting agencies must be divested within the next several years to comply with new Lloyd's regulations.

"We anticipate no selling-off of assets in 1983," Mr. Bogardus said. "The fundamentals of the organization are still strong. We have every reason to believe that this is all basically behind us."

A&A says it will continue to try to retrieve missing Howden assets and pursue the lawsuits it has filed against five former Howden directors: Kenneth Grob, Alan Page, Ronald Comery, Jack Carpenter and Ian R. Posgate, Howden's former star underwriter. However, Mr. Bogardus said he does not expect court action until some time in 1984.

Until then, the brokerage is reviewing the possibility of filing suit against accounting firms and investment bankers that served Howden and A&A during the merger negotiations, although none are currently planned.

Mr. Bogardus also foresees no major changes in A&A's management or ownership.

"There have been no shareholder class-action suits filed, nor has there been any pressure for change on the board," he pointed out.

"From time to time, people do approach us about possible acquisition—almost every other week. However, none of these feelers has ever turned into substantive discussions."

Mr. Bogardus specifically denied reports in the Financial Times of London that said A&A was discussing a merger with Sedgwick Group P.L.C., the largest brokerage company in the United Kingdom.

Sedgwick and A&A conducted lengthy merger negotiations several years ago, but both sides said in 1981 that a marriage would be unworkable because of international tax problems. Shortly thereafter, A&A announced that it would acquire Howden. ■

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Morahan gets added role

NEW YORK—Joseph E. Morahan Jr., chairman and chief executive officer of Shand, Morahan & Co. Inc., Alexander & Alexander Services Inc.'s underwriting management subsidiary, will now also manage two of Alexander Howden Group P.L.C.'s underwriting units.

Mr. Morahan, who formed the firm bearing his name in 1970, has been given a mandate by A&A to review the underwriting of Sphere Drake Insurance Co. of Bermuda and Atlanta International Insurance Co. of Atlanta, A&A Chairman John A. Bogardus Jr. said last week.

"This move is part of our developing strategy on the future growth of A&A's underwriting activities. Joe Morahan's demonstrated expertise and track record will be invaluable in focusing and carrying out this undertaking," Mr. Bogardus said, emphasizing that A&A has no plans to sell any of its underwriting subsidiaries.

Mr. Morahan would not comment on Sphere Drake, whose reinsurance agreements are at the center of the troubles at Howden.

A&A discovered after it had acquired Howden last year that Sphere Drake was unlikely to collect on several reinsurance agreements made with companies secretly owned by former Howden directors and that its liabilities were approximately 40% underfunded.

"We'll have to take a look at the management and see exactly how we can make the best use of these companies," he said.

Mr. Morahan will remain based at Shand, Morahan's headquarters in Evanston, Ill.

Iowa liquidates health insurer

Continued from page 2

ever, the company also may have insured METs in other states, according to Mr. Foudree of the Iowa Department of Insurance.

In addition, the Tennessee Department of Insurance reported that last year Iowa State Travelers issued $1.7 million of accident and health insurance policies in that state.

The Tennessee department has canceled certificates of authority to Iowa State Travelers' 500 agents in the state.

"The Iowa court order canceled this company's policies as of Feb. 23, and prohibits it from selling any more policies," said Roy Bess, Tennessee's deputy insurance commissioner.

California, Illinois and Iowa also have issued orders barring Iowa State Travelers from conducting any new business or renewing policies.

"The bottom line is that policyholders with this company no longer have accident and health insurance coverage," said Mr. Bess of the Tennessee Insurance Department.

While the failure of Iowa State Travlers is directly linked to the failure last month of its reinsurer, Lincoln Security Life Insurance Co. of Phoenix, Ariz., underpricing of Iowa State-backed MET health insurance was the underlying reason for the company's collapse, Mr. Foudree said.

"An adequate premium was not set, so the claims could not be paid. It appears that the product was underpriced," he added.

For example, rates charged by National Health Insurance Trust may have been less than half than the rates charged by commercial health insurance companies doing business in Southern California, Iowa and California insurance department officials said.

Multiple employer trusts in the past have failed because administrators charged too little for insurance to lure small employers, paid too much in commissions and reserved too little to pay claims. ■

Coordination-of-benefits rule should be changed, firms say

NEW YORK—When an employee retires and then takes another job, should the first employer still pay for basic medical coverage as required by former National Assn. of Insurance Commissioners' model coordination-of-benefits rules?

Nearly 93 percent, or 175 of 189 Fortune 500 companies, say the 1971 coordination-of-benefits rules should be changed to make active medical coverage take over from retiree coverage, according to a survey by Buck Consultants Inc. conducted in January 1983.

Although the NAIC adopted a change in its model COB rules last December after an NAIC task force recommended the change, legislative action or an insurance commissioner's order may be required for the rule to be changed in some states.

The new NAIC model rule says an employee's current employer should provide primary medical coverage; any coverage an employee might have through retirement or layoff benefits is secondary.

Formerly, the NAIC rule stated that if an employee is covered by two medical plans, the coverage that has been in effect the longest is considered primary.

"With a trend toward people retiring early from one company and taking a job with another, this COB rule could allocate costs unfairly among companies," said Albert Cole, Buck's director of consulting services.

The survey also found that:

• Responding in favor of the rule change, many companies felt retiree medical programs should not have to subsidize the business costs of a retired employee's new employer.

The current employer that is benefiting from the employee's services should be the primary medical coverage provider, the resondents said.

• Making a spouse's active coverage primary over a retired employee's coverage was favored by 61% of the companies responding. Thirty-eight percent of the companies did not favor such a change, and 1% did not respond.

• Fifty-two percent of the companies say they provide the same level of lifetime maximum coverage for retired employees as they do for active employees.

• More than 24% of the companies reported program administration and employee relations problems as a result of the COB rule.

For one company, the rule presented problems in planning divestiture of a unit. Although many employees would be technically retired, they would continue working for the new employer.

As part of the sale agreement, the new employer agreed that its medical plan would be primary coverage for the "retiring" employees. ▪

3 to be sentenced April 1

ALEXANDRIA, Va.—Three men, including a former CIA operative, face sentencing April 1 for their role in trying to arrange the sale of a diesel truck engine assembly line owned by American International Group Inc.

The three had been charged in a multiple-count felony indictment with attempting to arrange the prohibited export of the assembly line from a Detroit-area warehouse to the Soviet Union (*BI*, Feb. 14).

The trio—Stephen G. Carter, a Palatine, Ill., export commodity broker; Paul Sakwa of Washington, the former CIA employee and Amnesty International co-founder; and Jerry F. McCall, a Toronto baker—all pleaded guilty March 1 to reduced charges.

Messrs. Carter and Sakwa each pleaded guilty to single felony counts charging them with knowingly violating a section of U.S. export laws when they "did attempt to arrange sale" of the 800-foot-long, custom-built line knowing that the line's purchaser intended to export it to the Soviets.

Mr. McCall pleaded guilty to a misdemeanor of attempting to misfile documents with the Commerce Department.

Ingersoll-Rand Corp. of Woodcliff Lake, N.J., manufactured the line but was blocked by the Carter administration from exporting it to the Soviets.

The manufacturer then collected between $5 million and $8.6 million from AIG under a political-risk insurance policy. AIG assumed possession of the assembly line. ▪

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Back injury prevention program offered

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Rehabilitation Management Inc. and St. Vincent's Infirmary of Little Rock, Ark., are teaming up to offer a back injury prevention program.

Under the program, Rehabilitation Management personnel first review and analyze back injury data with clients, then check workplace conditions and watch and photograph employees while they are at work.

After a preliminary evaluation, Rehabilitation Management submits its data to the physical therapy department at St. Vincent's Infirmary, a large Little Rock medical center. Specialized staff in the department use the data and the photographs to develop a tailor-made back injury prevention seminar for the company.

Physical therapists then visit the workplace to present a two-hour seminar on back anatomy, physical fitness, body mechanics, preventive techniques and back injuries.

Rehabilitation Management also offers comprehensive consulting. It will train company personnel to conduct ongoing back injury programs, produce slide presentations, filmstrips and videotape cassettes for individual companies.

The basic cost is $785, which includes a consultation session and program presentation. Travel costs are additional.

For more information on the Rehabilitation Management Inc.-St. Vincent's Infirmary back injury program, contact Tom Strickland, Rehabilitation Management Inc., Suite C, 10020 Rodney Parham, Little Rock, Ark. 72202; 501-227-5553.

Movement detector

A safety device that detects sags in mine roofs is available from Conkle Inc.

The Roof Movement Monitor, invented by a former miner, is a reflector that is held flush with the mine roof by a movement-detecting rod. Any movement in the roof trips the reflector, which reflects headlamps of miners entering shafts. The movement-detecting rod can be adjusted to trip from movement ranging from a few thousandths of an inch to several feet.

The movement monitor has been approved by the U.S. Bureau of Mines for use as a mine safety device.

The cost of the basic monitor is $27.50. An electronic model, which includes a digital readout that can be read from a distance of several hundred feet, costs $220. For more information on the Roof Movement Monitor, contact Pat Conkle, P.O. Box 193, Paonia, Colo. 81428; 303-527-4848.

Bank coverage

Baccala & Shoop Insurance Services has developed a complete insurance program for community banks in California.

The program includes seven coverages required by most banks, says Baccala & Shoop President Noel Higgitt. A bank can purchase any or all of these coverage:

- Mortgage impairment.
- Data processing multiperil.
- Broad-form extortion.
- Bankers blanket bond, including all-risk safe deposit, bankers transit and registered and first-class mail coverage.
- Directors and officers liability.
- Corporate fiduciary liability.
- Bankers trust department errors and omissions.

The coverages, with limits of $5 million each, are underwritten through an A-plus rated insurer that is admitted in California.

Several endorsements to the package are also available, including stop-payment legal liability, personal accident extension and automatic teller machine coverage.

Currently the program is available only in California, but Baccala & Shoop hopes to expand it nationwide. The program is geared toward community banks with deposits less than $250 million.

The program is now underwritten through Baccala & Shoop's Memphis office at 3255 Whitebrook Plaza Drive, Whitebrook Office Plaza, Building C, Suite 100, Memphis, Tenn. 38118; 800-367-1111.

Warning system

A fire detection and audio warning system for medium-sized to large buildings has been introduced by ADT.

The 8175 Emergency Communication System uses speakers to provide spoken instructions as well as a warning tone. Paging capabilities can be used in selected areas or on an all-call basis. A tone can be sounded in one area while emergency instructions are given in another. A supervised telephone system allows two-way communication between the control station and firefighters on various floors.

Up to 48 audio speaker and telephone zones can be used on the 8175 system. Standby battery facilities to back up audio amplifiers, a tape player for messages, an electronic VU meter for sound level, a relay panel and a switch panel are included in the system.

Prices for the system vary depending on building size, floor plans and local building codes.

For more information, contact Joe LiCalsi, Product Manager, Fire Protection Systems, ADT, One World Trade Center, New York, N.Y. 10048; 212-558-1100. ■

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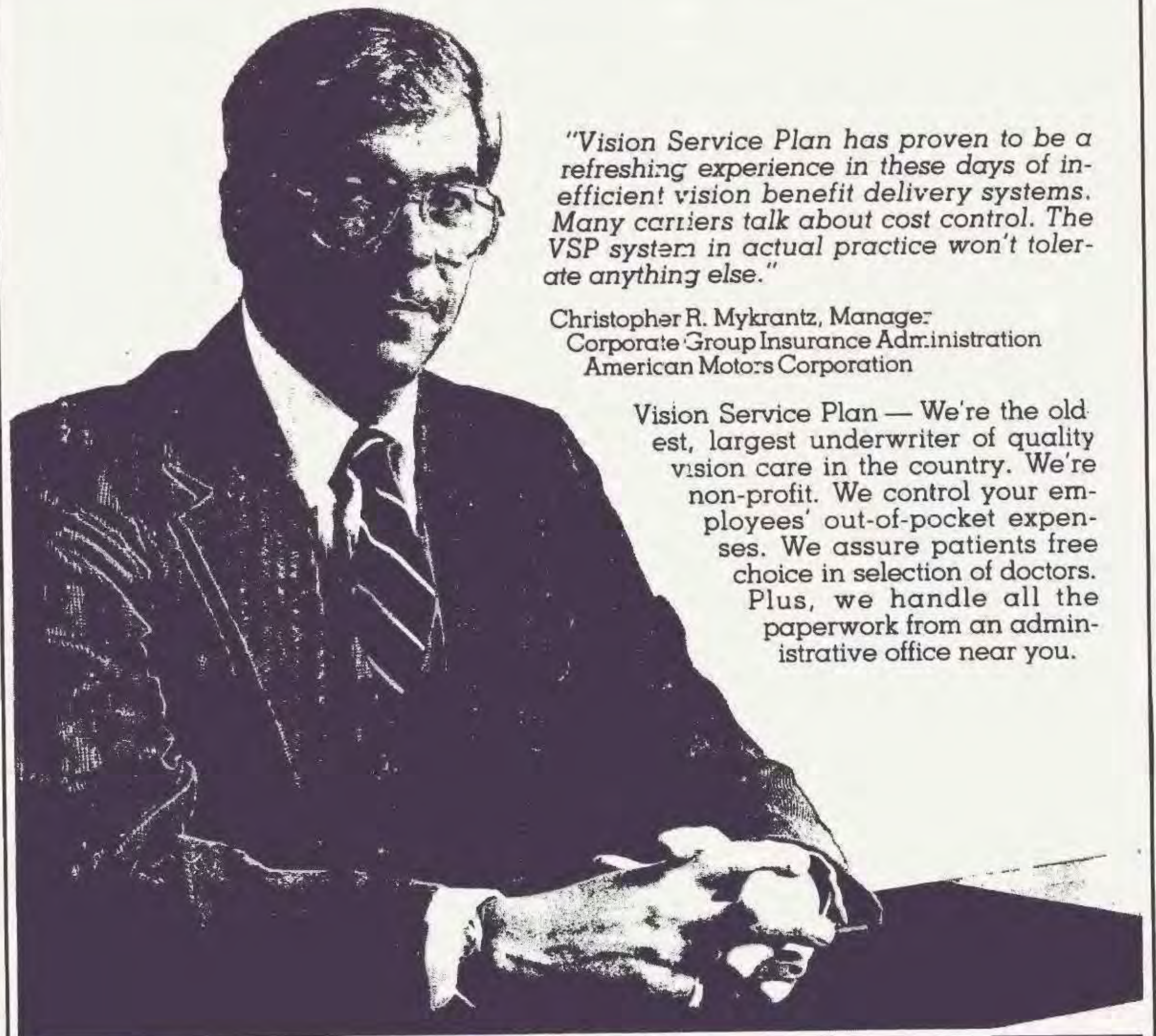

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Tax could tarnish flexible plans

Continued from page 1

creased FICA tax by eliminating any taxable benefit options from flexible plans, said Bob Wallace, a consultant and actuary with Buck Consultants Inc. in New York.

For example, they could just offer tax-free options like health insurance, vision care and dental coverage and not cash.

However, this might reduce the appeal of the plans. The freedom to choose cash in lieu of benefits is especially attractive to young workers who may need the money to meet hefty mortgage payments.

"Flexible benefit plans will survive, but their appeal will be diminished," said William Chip, a Washington attorney with Ivins, Phillips & Barker, which represents the Employers Council on Flexible Compensation.

"Most companies won't offer a cash option," Mr. Chip added.

Benefit experts say there are broad implications in the House's decision to impose new taxes on cafeteria plans.

"Congress is changing its definition on what is taxable compensation," said Jim Waters, a vp with Towers, Perrin, Forster & Crosby in New York. Legislators are now considering benefits—not just salary—as part of the taxable wage base, Mr. Waters adds.

"This is a foot in the benefits taxing door," said Lloyd Kaye, a principal at William M. Mercer Inc. in New York. "Once Congress starts, no one knows where they will stop. That is what is most alarming."

As a matter of fact, the Social Security bill also proposes taxing up to half of Social Security benefits for middle-class and well-to-retirees and would make wages deferred under 401(k) salary reduction plans subject to FICA taxes, too.

However, in contrast to the proposals to tax 401(k) contributions and Social Security benefits, the cafeteria benefits tax never was discussed or analyzed when the House Ways and Means Committee held hearings on the entire Social Security bill. It was added just prior to the committee vote.

"Increasingly, the real legislation is not presented until the hearings are over. This was done behind the scenes," one lobbyist said.

There was little time for employers to do much," said Mr. Chip of the Employers Council on Flexible Compensation, which is now lobbying fiercely against the proposal to subject flexible benefits to the FICA tax.

But the lobbying effort faces tough odds. In the coming months, the attention of legislators and their aides will be focused on other parts of the Social Security bill that affect many more people, like higher payroll taxes and mandatory Social Security coverage for non-profit and new federal employees.

"I would think it (taxing cafeteria benefits) would pass. I doubt if corporate objections will carry the day," predicts Mercer's Mr. Kaye.

In passing the Social Security legislation on a 282-148 vote, Congress also agreed to gradually raise the Social Security retirement age until it reaches 67 by 2027. It is now 65.

Other provisions in the bill include:

- Social Security payroll tax increases for employers and employees would be accelerated. On Jan. 1, 1984, the tax would rise to 7% from 6.7%. Next year's 0.3% increase for employees, however, would be offset by an income tax credit.

In addition, FICA taxes would continue to rise slightly ahead of schedule after 1984. For example, in 1988, the tax would climb to 7.51% instead of the planned 7.15%. The payroll tax would hit 7.65%, as scheduled, in 1990.

- The self-employed, who now pay about three-fourths of the combined employee-employer FICA tax rate of 13.4%, would pay the full rate, which would be 14% in 1984. However, the self-employed could deduct 50% of the combined rate on their federal income taxes as a business expense.
- Non-profit employers, including those that have already withdrawn from Social Security, would have to participate in the program by Jan. 1, 1984. In addition, workers hired by the federal government after Jan. 1, 1984, would be covered under Social Security.
- Local and state governments could not opt out of Social Security after the legislation's effective date. However, public employers that already have withdrawn would not have to return.
- The next hike in cost-of-living benefit increases, now scheduled for July 1, would be delayed until Jan. 1, 1984. All future COLA adjustments would be made on Jan. 1.
- Social Security benefits would be taxed for retirees whose incomes exceed certain levels. The tax would be phased in for individuals whose adjusted gross incomes exceed $25,000; for married couples, the tax trigger would be $32,000. ▪

CIGNA offers grants

NEW YORK—CIGNA Corp. said last week that it has set up a $1 million grant program to help local business coalitions battle soaring health care costs.

Under the program, grants ranging from $5,000 to $50,000 will be awarded to coalitions for specific health care cost-containment projects.

CIGNA said it is especially interested in the creation and use of health cost data bases by business coalitions, so employers can track health care utilization at facilities in their area. ▪

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• A series of booklets on the role of **experience rating in workers compensation insurance** has been published by the National Council on Compensation Insurance. "An In-Depth View of Experience Rating," "ABCs of Experience Rating," "Providing for Future Claim Payment: The Role of Loss Reserves" and "The Wage-Loss Law in Florida: An Update" are available at $2 each by writing the NCCI, Information Office, One Penn Plaza, New York, N.Y. 10119.

• The Labor Department has published "Update No. 15," one in a series of opinion letters that explains the transactions employee benefit plans may engage in under the **Employee Retirement Income Security Act.** The cost is $11.70. Checks should be made payable to LMSA, U.S. Department of Labor, Division of Public Disclosure, Pension and Welfare Benefit Programs, Room N-4677, 200 Constitution Ave. N.W., Washington, D.C. 20216.

• The Labor Department has published a guide for employers that are sponsoring **child care programs.** "Employers and Child Care: Establishing Services Through the Workplace" contains names and addresses of employer-sponsored child care programs operating in the United States. A limited number of single copies are available free from the Women's Bureau, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. The publication also can be purchased for $5.50 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

• A booklet from the loss-control department of the Alliance of American Insurers, "Simplified Water Supply Testing," can help loss-control and municipal water department personnel test **water supplies used for firefighting.** The 48-page booklets is available from the Alliance for $4.25 per copy. To order, write the Alliance of American Insurers, Loss Control Department, 20 N. Wacker Drive, Chicago, Ill. 60606.

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Eagle-Picher presses coverage issue

Continued from page 2

ner, an attorney for Eagle-Picher with the Boston firm of Nutter, McClennen & Fish.

"We're at an end (to litigation) with regard to these particular policies. We know where we stand."

Mr. Kenner explained that Eagle-Picher did not want the high court to review the decision even though it had sought in the court of appeals coverage even broader than that offered under the manifestation theory. It had sought coverage under the triple-trigger theory which says that all insurers on the risk from the time of exposure through manifestation, including the latency period, are liable.

Although that request was refused, Eagle-Picher believed the court of appeals' manifestation ruling provided a breadth of insurance to Eagle-Picher for the claims against it, he said. "It did not want to risk that the result be overturned," Mr. Kenner said, acknowledging the court could have reversed the appellate court and ruled in favor of the exposure theory.

Requesting review by the Supreme Court were a group of Eagle-Picher's London excess insurers that believe in the exposure theory of coverage.

The Eagle-Picher case marks the fourth time the high court has declined to rule on the asbestos coverage issue.

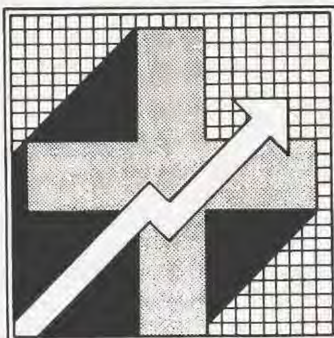
"If one looked to the Supreme Court as one solution, it's obviously been put off for a year or two," one asbestos defendant attorney said.

Some insurers and defendants hoped that the Supreme Court would resolve the issue because of the conflicting decisions that are springing up in more than 30 jurisdictions across the country that are considering coverage disputes.

The defendants in Eagle-Picher's pending suit against its excess insurers include Commercial Union Insurance Co., American International Group, Prudential Re and some London insurers.

The suit was filed in the U.S. District of Columbia District Court where the triple trigger ruling was handed down in Keene vs. INA, but was recently transferred to U.S. District Court in Boston.

Eagle-Picher's aggregate insurance coverage for claims allocable between 1968 and 1978 is estimated at $155 million.



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Asbestos coverage in comp case decided

Continued from page 2

should respond on a proportionate basis.

The company's insurers, however, argued that under the Delaware Workmen's Compensation Act, they were not liable. Since all claims were manifested after 1972 when Champlain became self-insured, they had no obligation to defend or pay claims, the companies contended.

The court agreed with the insurers. Relying on state workers compensation law and the Delaware case of Alloy Surfaces Co. vs. Cicamore, the court said that the "last carrier" on the risk at the time disability arises has the burden of compensation.

Since Champlain was self-insured after 1973, it was the last carrier on suits brought after that year, the court said.

The court further stated that it would not get into the "manifestation vs. exposure" arguments that have been at the core of court decisions such as Keene Corp. vs. INA and Eagle-Picher Industries Inc. vs. Liberty Mutual Insurance Co. that were based on disputes over comprehensive general liability policies.

> 'The court is of the opinion that the essential medical evidence supports the exposure theory.'

It specifically rejected deciding the case in terms of general insurance or contractual considerations, instead relying on the state workers compensation law.

"It should be noted that the 'manifestation vs. exposure' dispute exemplified in Keene and Eagle-Picher arose in the context of products liability insurance coverage, not workmen's compensation coverage and the results there reached were based on contractual interpretation," the court said.

"While the theoretical arguments advanced in support of each approach may prove helpful in analyzing asbestosis claims generally, the question of coverage in workmen's compensation cases is generally dictated by statutory interpretation."

"Indeed, policy provisions must conform with the Workmen's Compensation Act itself."

The Sepco vs. Commercial Union case involved interpretation of comprehensive general liability policies.

In the case, a federal district court in Alabama ruled that the "injurious exposure" rule would apply to insurance policies covering Sepco.

Under the decision, the costs of defense and liability are to be prorated among Sepco's insurers that provided coverage during the exposure period, the court said. Sepco is also deemed to be an insurer for the time it was self-insured, the court said.

The suit, filed by Commercial Union, sought a judicial interpretation of the appropriate coverage theory concerning its policies with Sepco. Sepco later brought in as third parties its other insurers, including Canadian Universal Insurance Co. Ltd., United National Insurance Co., Mission Insurance Co. and Home Insurance Co.

Commercial Union, which insured Sepco from at least 1970 to September 1978 (except for one nine-month period), argued that the manifestation theory should apply.

All of the other insurers sought an exposure interpretation.

Sepco wanted the court to apply the triple-trigger theory of coverage established in the Keene vs. INA case when the U.S. Circuit Court of Appeals for the District of Columbia said all insurers on a risk from the time of exposure to asbestos through manifestation of the related disease must contribute to claims. But Sepco said if the court would not follow the triple-trigger theory, it wanted the exposure theory upheld.

In granting summary judgment for Sepco, Judge J. Foy Guin Jr. said it was bound by the prior asbestos coverage decision of Porter vs. American Optical Corp. In that 1981 decision, the 5th U.S. Circuit Court of Appeals upheld the exposure theory.

He rejected Commercial Union arguments that Porter did not apply and concluded that the terms of Sepco's insurance contracts and the medical evidence both supported the exposure theory.

"The court is of the opinion that the essential medical evidence supports the exposure theory," the court said. "The progressive, cumulative nature of the disease makes the exposure theory the fairest and most practical solution to the insurance coverage question."

The judge noted, however, that he only had to look to the terms of the insurance contracts to come to a decision for exposure.

In addition, because "bodily injury" and "occurrence" were ambiguous terms, they should be construed in favor of the policyholder, the court said.

Originally part of the 5th circuit, the northern district of Alabama became part of the 11th circuit when that new circuit was formed several years ago but is generally bound by the 5th circuit's decisions, an attorney for Sepco said.

Sepco of Pelham, Ala., manufactures and distributes thermal insulation material that in the past included goods containing asbestos. It is currently facing thousands of lawsuits brought by individuals alleging injuries from asbestos-related diseases.

In addition to the declaratory judgment sought, Sepco is also alleging that the insurers breached agreements to insure Sepco and in bad faith refused to defend it.

It seeks $200,000 from Commercial Union for monetary losses due to CU's alleged bad faith and wrongful refusal to defend and $2 million from its insurers for direct monetary loss, punitive damages and the emotional distress suffered by Sepco's employees and executives due to the insurer's bad faith refusal to defend Sepco, according to its amended complaint.

Also in dispute are insurance policies for Sepco dating back to the 1950s.

The Sepco decision brings to at least five the number of state or federal courts that have ruled that coverage is triggered upon a victim's exposure to asbestos, a theory most policyholders want if they can't get a court to apply the broader triple-trigger theory.

There has been only one federal appellate court decision for manifestation in an asbestos case.

Despite the differences-in-coverage theories espoused by the courts, however, all the decisions in coverage cases appear to maximize coverage for the policyholder. ■

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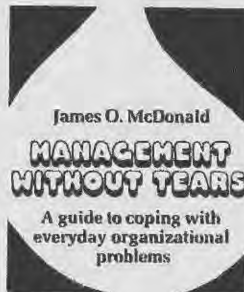

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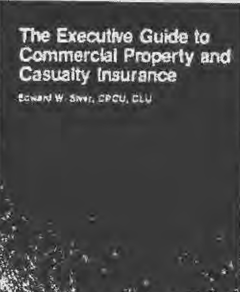

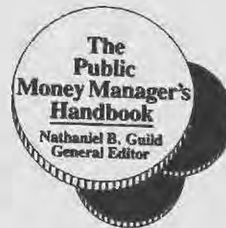

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J&J facing suit

Continued from page 2

media. He added that he could not speculate on how many more suits might eventually be filed by Zomax users.

But further suits are expected, some say.

"It wouldn't surprise me at all. That's what usually happens," said Christopher Smith, a spokesman for the Food and Drug Administration.

The FDA has met with J&J representatives to discuss additional warnings to be placed on the labels of Zomax bottles. J&J is currently considering what measures to take and has not yet yet determined when the product will be returned to the market.

J&J would not comment on its insurance coverage for any judgments that might be awarded to Zomax users.

It also declined comment on whether a claim had been filed with its insurers for the expense of recalling the product.

J&J is currently suing nine of its insurers to recover the more than $110 million in product recall and business interruption losses experienced in the recall of McNeilab's Extra-Strength Tylenol pain reliever last fall (*BI*, Jan. 10).

According to court papers filed in the Tylenol case, J&J has more than $100 million in product liability coverage. Middlesex Assurance Co., one of J&J's two Bermuda captives, underwrites the first $5 million combined single limit for each occurrence, each product and annual aggregate, including defense costs, according to the court papers.

Insurers writing excess umbrella coverage, according to the papers, include North River Insurance Co., a Crum & Forster unit; Employers Insurance of Wausau; Transist Casualty Co.; Aetna Casualty & Surety Co.; American Centennial Insurance Co.; Granite State Insurance Co.; First State Insurance Co.; and Northbrook Excess & Surplus Insurance Co.

However, excess and umbrella liability policies frequently exclude coverage for product recall expenses.

In addition, Affiliated FM Insurance Co. writes $50 million in all-risk property coverage, the suit shows.

J&J would not say if its coverage has changed since it filed suit against its insurers last year.

Of about 15 million people who have used Zomax since its introduction, 1,100 have experienced allergic reactions and five have died, according to J&J.

J&J first reported Zomax's side effects to the FDA and to 200,000 physicians in letters last year. Two of the five deaths were reported in 1982, while the other three victims have died this year.

Zomax's rate of one allergic reaction per 15,000 users is high compared to rates for other products in its class, including Upjohn & Co.'s Motrin, Merck & Co.'s Clindril and Syntex Corp.'s Annaprox, the FDA's Mr. Smith said, adding it's also unusual for fatalities to result from use of such a pain reliever. ■

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Category	Count
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Insurance Management: vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,299
Government, Associations, Unions, Educational Institutions	1,034
Commercial Consumers Sub-total	**22,954**
Insurance Agents & Brokers	9,771
Insurance Cos.	5,217
Financial Institutions	352
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,603
Others allied to the field	937
TOTAL	**41,834**

*Source Business/Occupational breakdown of qualified circulation, November 1, 1982 issue, as submitted to BPA for December 1982, BPA Publisher's Statement.

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Poor '82 insurer results may be repeated

Continued from page 1
year's third- and fourth-quarter renewals. "I'm optimistic that we've seen the worst of it."

However, since there's a lag time between announcing rate increases and reporting the resulting premium gains, most insurers are already predicting that 1983 will be a year filled with further underwriting losses and lower profits. They note that renewals booked at the end of 1982 were made at rates equal to or less than those charged at the end of 1981.

"There's no sign of any rate turnaround," comments insurance stock analyst Michael A. Lewis at E.F. Hutton & Co. in New York.

Leandro S. Galban Jr., a vp of investment banking and research at Donaldson, Lufkin & Jenrette Securities Corp., predicts 1983 will see "a deterioration (in underwriting results) that will leave very little in earnings, even including investment income."

Despite the record underwriting deficits, securities analysts point out the industry is still making a lot more money for its shareholders than in 1975, the lowest point in the last underwriting cycle. However, much of the profit levels the insurers continue to report—despite the huge underwriting losses—are attributed to the huge amounts of investment income they've been raking in.

"The industry profit is still eight times what it was in 1975," says stock analyst Robert V. Brokaw, of Mabon, Nugent & Co. "But you do have companies that never got down to zero income pretax (in 1975) that are down there this time."

Mr. Brokaw says his analysis shows the property/casualty industry as a whole had net earnings of $4.46 billion in 1982, compared with only $605 million in 1974, $493 million in 1975 and $1.9 billion in 1976.

Overall, the aggregate results of the major publicly held insurers surveyed by *Business Insurance* show that aftertax operating income declined 9.6% in 1982, while property/casualty written premium volume rose an anemic 1.6%.

Underwriting losses increased 58% to reach the record level of $4.57 billion. However, investment income, which has been used to offset those deficits, rose only 9.2% to $6.1 billion, compared with a 17% increase in 1981.

The aggregate combined ratio—after policyholder dividends—rose to 111.3% from 106.7% at the end of 1981, easily surpassing the previous record of 107% set in 1975. In layman's terms, that means the industry paid out $1.13 in losses and expenses for every dollar it earned in premium.

The Insurance Information Institute estimated in December that the entire property/casualty industry—including the smaller underwriters not surveyed by *BI*—sustained a $10.4 billion underwriting loss in 1982 and recorded investment income of $14.9 billion, both of which are records.

But, some analysts believe that the industry could be in even worse shape than these number show.

Myron M. Picoult, senior vp at Oppenheimer & Co. Inc. in New York, says he thinks insurers may have overstated their 1982 incomes by not failing to adequately reserve for future losses. He says insurers are attempting to look stronger than they really are on paper to avoid becoming acquisition targets.

"The bottom line is that we may be seeing a facade of false numbers which may further delay a return to more realistic pricing," Mr. Picoult explains. "Hence, the long-awaited recovery may remain in the twilight zone."

A second analyst notes that the recent stock market boom has increased the statutory surplus insurers can report, thus strengthening their balance sheets.

"We are hopeful that there will be some firming in rates this year," says Gerald E. Lewinsohn of Merrill Lynch & Co. Inc. "But given the relatively strong capital positions of many insurers, it is possible that rate increases may not be forthcoming in time to prevent another year of deteriorating underwriting results in 1984."

The prognosis for future years could also depend upon the condition of the economy during 1983, predicts a third analyst.

"A healthy economy is the foundation upon which commercial insurance pricing in 1983 will rest," says Ernest G. Jacob, a senior analyst at stockbroker Alex Brown & Sons in Baltimore. "A strong economy will facilitate insurance price increases that will translate into a solid recovery in earnings in 1984."

Some experts add that the market could finally turn when investment income can no longer support the industry's huge underwriting losses.

Daniel J. McNamara, president of the Insurance Services Office, an industry rate-setting organization, estimates that day will come when the industry reaches a combined ratio of 114%.

"At 114%, broad-based, multiline insurers as a whole have reached the precipice," he says. "Some individual companies will be under severe pressure."

Mr. McNamara adds that the 114% benchmark could be revised downward if investment yields available on Wall Street and elsewhere decline.

Already, more than a handful of insurers are reporting year-end combined ratios exceeding 114%, including Aetna Life & Casualty Co., 114.6%; CNA Financial Corp., 118.2%; The Home Group Inc., 116.1%; CIGNA Corp., 115.9%; Fremont General Corp., 119.8%; Commercial Union Insurance Cos., 120.5%; Liberty Mutual Insurance Cos., 119.2%; Armco Insurance Group Inc., 114.9%; and Employers of Wausau, 115.6%.

For all of these companies, the numbers appear to be moving in the wrong direction.

CIGNA, for example, reported a 53% decline in property/casualty operating income to $126.6 million, a 25.5% decline in aftertax operating income across all lines to $490.1 million and a 5.7% decline in net written property/casualty premiums to $3.7 billion.

CIGNA, which now edges Aetna as the nation's largest stock property/casualty insurer on the basis of net written premiums, labels the underwriting environment as "increasingly difficult."

Aetna, which applied future tax-loss carryforwards to current earnings for the first nine months of 1982, reported the fifth-largest increase in operating earnings with a 6.4% rise to $490.5 million.

However, Aetna acknowledges the carryforwards, which it has

Continued on page 65

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		Price	% Chg	P E	$ Div	% Yld	High	Low	Vol (000)
Aetna Life & Cas Co	NYSE	39.00	-0.6	6.7	2.64	6.8	40.25	39.00	1,117.2
American Bankers Ins Group	OTC	13.75	-2.7	10.7	0.50	3.6	13.88	13.63	176.7
American Gen Ins Co	NYSE	69.00	5.3	9.4	2.20	3.2	70.13*	67.25	355.3
American Indty Finl Corp	OTC	23.25	4.5	23.0	1.12	4.8	23.25	22.50	16.2
American Intl Group Inc	OTC	80.25	2.9	11.4	0.24	0.3	80.50	79.50	859.4
American Natl Ins Co	OTC	17.75	7.6	7.5	0.84	4.7	17.88*	16.63	720.6
American Sts Life Ins Co	OTC	28.50	0.0	8.1	0.88	3.1	28.50	28.50	3.6
Aneco Reins Ltd	OTC	3.13	-13.8	39.1	0.00	0.0	3.50	3.13	27.0
Avemco Corp	AMEX	15.00	0.0	8.7	0.58	3.9	15.00	14.88	9.1
Banks Iowa Inc	OTC	42.50	3.7	11.9	1.52	3.6	42.50	41.00	0.6
Bitco Corp	OTC	36.50	9.0	6.4	2.00	5.5	36.50*	34.00	124.3
Carolina Cas Ins Co	OTC	7.25	5.5	10.7	0.32	4.4	7.25	6.88	2.9
Chubb Corp	OTC	56.00	2.8	9.3	2.92	5.2	56.00	55.13	127.0
Combined Intl Corp	NYSE	32.13	4.5	10.9	2.00	6.2	32.50*	32.00	422.0
Continental Corp	NYSE	31.50	11.0	15.4	2.60	8.3	32.63*	28.13	1,696.5
Crawford & Co	OTC	18.75	0.0	14.0	0.57	3.0	18.75	13.75	9.1
Crown Life Ins Co	OTC	92.00	2.2	6.0	3.10	3.4	92.00*	90.00	0.0
Employers Cas Co	OTC	35.25	2.9	7.4	1.20	3.4	35.25	34.75	10.5
Equifax Inc	NYSE	29.13	0.9	18.6	1.40	4.8	29.13	28.63	42.9
Excelsior Ins Co	OTC	11.50	0.0	0.0	0.70	6.1	11.50	11.50	3.2
Farmers Group Inc	OTC	39.25	-0.3	10.9	1.36	3.5	39.50	39.25	448.4
Foremost Corp Amer	OTC	45.75	8.3	14.5	1.24	2.7	45.75*	44.75	37.0
Fremont Gen Corp	OTC	19.75	17.0	36.6	0.48	2.4	21.00*	17.00	1,434.3
Great West Life Assurn Co	OTC	189.00	0.0	15.4	10.00	5.3	189.00	189.00	0.0
Hanover Ins Co	OTC	41.75	1.8	6.1	0.88	2.1	44.00*	41.75	48.1
Hartford Steam Boiler Insptn	OTC	49.00	7.7	10.8	2.80	5.7	49.00*	45.50	14.8
Jefferson Natl Life Ins Co	OTC	43.50	-1.1	11.2	0.76	1.7	44.00	43.50	2.6
Kemper Corp	OTC	42.13	5.3	7.9	1.80	4.3	42.13	40.25	150.3
Lincoln Natl Corp Ind	NYSE	50.00	-0.5	8.9	3.00	6.0	52.13*	50.00	115.4
Mission Ins Group Inc	NYSE	36.25	1.4	9.0	1.00	2.8	38.25*	36.25	197.6
Nationwide Corp Ohio	OTC	41.50	1.2	14.8	0.70	1.7	41.50*	41.00	1.1
Northwestern Natl Life Ins	OTC	30.38	1.7	21.2	1.50	4.9	30.50	30.13	108.5
Ohio Cas Corp	OTC	51.00	4.9	10.4	2.52	4.9	51.38*	49.38	170.5
Old Rep Intl Corp	OTC	28.63	2.2	7.0	0.92	3.2	29.13*	28.50	221.6
Orion Cap Corp	NYSE	20.63	7.1	12.0	0.66	3.2	21.00*	19.25	131.1
Preferred Risk Life Ins Co	OTC	29.50	18.0	8.7	0.92	3.1	29.50*	26.50	30.5
Provident Life & Acc Ins Co	OTC	57.00	0.9	8.0	2.60	4.6	57.00*	56.50	21.1
St Paul Cos Inc	OTC	65.38	0.6	6.7	2.30	4.3	65.50*	65.13	476.9
Safeco Corp	OTC	54.88	2.1	9.6	2.40	4.4	55.38*	54.25	267.6
Sri Corp	OTC	43.50	-1.1	8.8	1.12	2.6	44.00	43.50	67.2
Seibels Bruce Group Inc	OTC	26.75	5.4	13.2	0.80	3.0	26.75	25.50	205.6
Statesman Group Inc	OTC	6.88	-3.5	6.1	0.15	2.2	6.88	6.75	10.3
Tokio Marine & Fire Ins Co	OTC	103.75	-1.2	16.6	0.92	0.9	105.25	103.25	9.8
Travelers Corp	NYSE	27.88	3.7	7.6	1.80	6.5	29.25*	27.88	1,242.1
United Fire & Cas Co	OTC	30.50	0.0	8.2	0.88	2.9	30.50	30.50	1.2
United States Fid & Gty Co	NYSE	50.88	7.7	12.8	3.84	7.5	51.50*	49.75	416.1
United Svcs Life Ins Co	OTC	20.75	-1.8	6.2	1.00	4.8	21.38*	20.75	29.5
Uslife Corp	NYSE	23.63	-1.0	6.4	0.88	3.7	24.38	23.63	252.3
Washington Natl Corp	NYSE	23.00	-2.6	11.1	1.08	4.7	23.88	23.00	81.3
Zenith Natl Ins Corp	OTC	18.75	1.4	9.4	0.80	4.3	18.75	18.50	13.0
INSURANCE COMPANIES	AVERAGE			9.9		4.0			

Agents/Brokers

		Price	% Chg	P E	$ Div	% Yld	High	Low	Vol (000)
Alexander & Alexander Svcs	NYSE	23.33	-5.6	13.5	1.00	4.3	24.75	23.25	677.8
Baldwin & Lyons Inc	OTC	40.50	0.0	7.3	0.80	2.0	40.50	40.00	0.7
Corroon & Black Corp	NYSE	28.88	-2.1	13.8	1.80	6.2	31.38	28.88	47.5
Crump E H Cos Inc	OTC	10.15	1.2	14.5	0.40	4.0	10.13	10.00	46.0
Emett & Chandler Cos Inc	OTC	11.15	1.1	0.0	0.00	0.0	11.13*	11.00	17.2
Hall Frank B & Co Inc	NYSE	32.50	7.4	15.7	1.70	5.2	32.50	30.63	456.3
Integrated Res Inc	AMEX	43.13	15.4	13.0	0.00	0.0	43.13*	37.75	249.9
Marsh & Mclennan Cos Inc	NYSE	44.00	1.7	13.1	2.20	5.0	44.50*	43.75	190.5
Poe & Assoc Inc	OTC	10.00	0.0	62.5	0.60	6.0	10.00	10.00	3.0
Reed Stenhouse Cos Ltd	OTC	14.88	-7.0	14.2	0.60	4.0	16.00	14.88	81.8
AGENTS/BROKERS	AVERAGE			12.6		3.5			

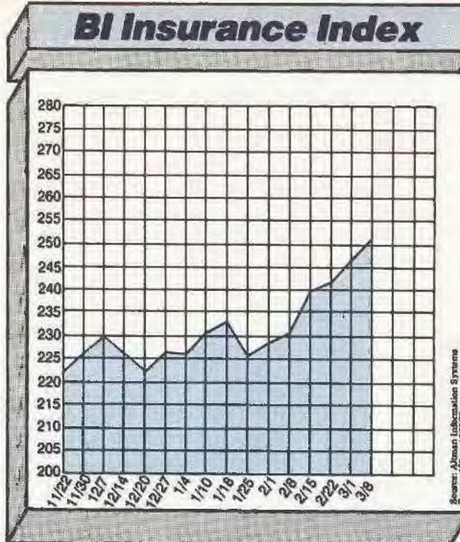
Conglomerates/Holding Cos.

		Price	% Chg	P E	$ Div	% Yld	High	Low	Vol (000)
American Express(Fireman's Fd)	NYSE	55.88	-5.5	12.3	1.80	3.2	58.88	55.88	1,836.0
Anderson Clayton(Ranger/PanAm)	NYSE	28.13	8.7	11.6	1.32	4.7	28.13	26.00	297.4
Armco Inc	NYSE	19.13	5.5	0.0	0.80	4.2	19.75	18.13	1,244.3
City Investing Co. (Home Ins.)	NYSE	31.25	8.7	8.6	1.70	5.4	32.25*	29.25	1,062.2
CNA Finl Corp (CNA)	NYSE	18.13	-2.3	7.5	0.00	0.0	18.75	18.00	50.8
Control Data (Comml. Credit)	NYSE	47.38	-6.2	11.5	0.60	1.3	49.88	47.38	894.5
General Re Corp	NYSE	67.75	6.4	14.5	1.28	1.9	67.88*	64.25	326.3
Gulf Utd Corp	NYSE	29.13	8.9	9.4	1.32	4.5	29.13	26.88	459.8
Cigna Corp	NYSE	43.75	-2.5	6.5	2.48	5.7	45.00	43.75	1,116.4
ITT (Hartford Group)	NYSE	35.75	7.[illegible]	8.1	2.76	7.7	36.25*	33.75	2,886.4
Optimum Hldg Corp	OTC	9.38	4.2	9.0	0.00	0.0	9.38	9.00	9.1
Sears Roebuck & Co. (Allstate)	NYSE	34.00	[illegible]	[illegible]3.8	1.52	4.5	35.00*	34.00	3,475.1
Baldwin Utd Corp	NYSE	36.00	-[illegible].0	7.0	0.88	2.4	37.63	36.00	360.5
Teledyne Inc (Argonaut)	NYSE	156.00	0.3	[illegible]2.4	0.00	0.0	158.00*	152.75	697.3
Transamerica Corp (Occidental & Fred S. James)	NYSE	26.25	12.3	9.2	1.50	5.7	26.50*	24.13	1,100.3
CONGLOMERATES/HOLDING COS.	AVERAGE			10.8		2.8			

*Record high/low since Jan. 1, 1983

System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* stock index again set a record high, closing at 253.0 for the week ending March 8, up 5.9 points from the record of 247.1 set on March 1. Thirty-nine stocks gained, eight were unchanged and 17 declined. The leading gainers were Preferred Risk Life Insurance Co., 18.0%; Fremont General Corp., 17.0%; Integrated Resources Inc., 15.4%; Continental Corp., 11.0%; and Gulf United Corp., 8.9%. The leading losses were posted by Aneco Reinsurance Co. Ltd., 13.8%; Reed Stenhouse Cos. Ltd., 8.9%; Alexander & Alexander Services Inc., 5.6%; Statesman Group Inc., 3.5%; and CNA Financial Corp., 3.3%. The *BI* index increase of 2.4% outperformed the New York Stock Exchange composite index.

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Zurich-American's income falls

SCHAUMBURG, Ill.—Zurich-American Insurance Cos. reports that statutory net income for its casualty operations declined 56% in 1982 to $12.5 million from $28.4 million in 1981.

However, fourth-quarter income rose 72.9% to $16.6 million in 1982 from $9.6 million in the last quarter of 1981.

Net written premiums for Zurich-American's casualty group rose 12.3% for the entire year to a record $458 million from $408 million. However, it reported an underwriting loss of $74.3 million for a combined ratio—after policyholder dividends—of 114.9% in 1982, up from 105.3% a year earlier.

Net written premiums for the fourth quarter of 1982 increased marginally to $115.2 million from $113 million in the final quarter of the previous year. ■

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Summary of major property/casualty insurer 1982 results

(all figures in thousands of dollars)

(ranked by change in operating income)

Rank 1982	Corporate: Consolidated revenues 1982	Aftertax[1] operating income 1982	Aftertax[1] operating income 1981	Percent change 1981-1982	Property/casualty operations: Combined[1] ratio 1982	Combined[1] ratio 1981	Net premiums written 1982	Percent change 1981-1982	Pretax underwriting income (loss) 1982	Percent change 1981-1982	Pretax net investment income 1982	Percent change 1981-1982
1 American General Corp.[3]	2,913,200	202,700	169,000	19.9	105.1	106.4	811,800	18.9	(62,900)	20.3	119,000	0.3
2 American International Group	3,563,172	412,650	345,327	19.5	98.2	96.2	2,263,156	9.7	33,890	(52.3)	302,309	19.4
3 General Re Corp.	1,497,780	206,647	177,475	16.4	101.8	99.1	827,369	6.1	(15,821)	—	170,672	4.8
4 The St. Paul Cos.	2,158,951	195,690	176,335	11.0	105.7	104.1	1,572,772	4.2	(93,324)	69.9	262,257	16.7
5 Aetna L&C Co.	14,164,400	521,900	490,500	6.1	114.6	112.1	3,547,400	(7.6)	(514,600)	11.4	515,400	5.9
6 Fireman's Fund Ins. Cos.	3,356,329	244,076	230,884	5.7	104.5	103.2	2,637,633	6.5	(116,944)	50.2	327,451	5.6
7 Mission Ins. Group Inc.	427,776	47,816	45,676	4.7	100.8	100.4	326,451	(5.2)	(2,655)	85.7	47,520	12.4
8 Old Republic Int'l. Corp.	N/A	42,798	41,298	3.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9 CNA Financial Corp.	3,157,466	127,108	126,442	0.5	118.2	113.6	1,570,400	1.5	(309,300)	47.9	363,800	7.7
10 SAFECO Corp.	1,488,459	107,558	109,835	(2.1)	101.6	98.9	831,616	0.3	(13,211)	—	96,543	8.0
11 The Home Group Inc.	2,277,445	107,431	110,440	(2.7)	116.0	113.7	1,686,475	(3.3)	(260,030)	9.1	288,560	16.9
12 Kemper Corp. (incl. life)	1,985,097	74,982	80,028	(6.3)	109.4	105.7	933,340	13.7	(86,890)	84.4	77,187	5.4
13 The Hartford Ins. Group	5,081,538	236,717	268,079	(11.7)	111.6	109.3	2,978,791	(3.7)	(342,182)	23.8	470,611	0.6
14 The Travelers Corp. & subs.	11,380,665	309,866	359,378	(13.8)	111.2	109.0	2,959,310	(5.4)	(351,990)	34.8	245,128	5.1
15 CIGNA Corp. (pro forma)	11,786,900	490,100	658,000	(25.5)	115.9	107.3	3,699,900	(5.7)	(556,800)	104.0	570,800	7.9
16 Ohio Casualty Corp.	830,908	57,020	77,744	(26.7)	105.3	99.6	798,055	1.4	(43,332)	—	83,760	9.0
17 The Chubb Corp.	1,508,637	74,234	103,549	(28.3)	110.3	102.4	1,107,257	3.2	(113,084)	392.0	121,194	6.6
18 USF&G Corp.	2,305,973	114,134	164,493	(30.6)	112.4	106.3	1,976,692	(1.9)	(264,600)	127.1	275,251	6.0
19 Reliance Ins. Co. & subs.	1,193,910	67,532	100,864	(33.1)	105.7	102.8	1,070,773	12.9	(46,120)	83.3	171,017	19.4
20 The Continental Corp.	3,505,788	105,210	203,465	(48.3)	112.8	110.1	2,604,661	4.2	(354,712)	32.5	304,800	7.6
21 Hartford Steam Boiler	212,970	5,029	14,609	(65.6)	99.0	93.2	147,094	(1.4)	1,532	(84.6)	16,226	5.7
22 Armco Ins. Group Inc.	674,678	8,692	34,693	(75.0)	114.9	108.1	578,871	9.4	(84,201)	104.5	69,190	2.8
23 Fremont General Corp.	456,832	5,572	23,949	(76.7)	119.8	103.6	253,846	(6.6)	(52,356)	434.7	38,895	14.8
24 Royal Group (U.S. subs.)[2]	N/A	10,600	65,900	(83.9)	111.1	104.0	1,200,000	12.4	(142,200)	119.4	163,300	11.2
— Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	N/A	120.5	108.1	1,475,000	7.6	(305,900)	123.8	176,700	15.5
— Employers of Wausau[2]	N/A	N/A	N/A	N/A	115.6	112.8	911,011	4.1	(62,767)	65.5	186,486	9.0
— Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	N/A	119.2	117.2	2,827,300	0.0	(338,581)	25.1	484,800	19.3
— Sentry Ins. Cos.[2]	434,572	11,432	12,235	(6.6)	109.9	106.5	721,941	5.1	(74,563)	59.5	101,975	9.1
Cumulative	76,363,446	3,787,494	4,190,198	(9.6)	111.3	107.4	42,319,014	1.6	(4,573,641)	(58.0)	6,050,832	9.2

[1]After dividends [2] Statutory [3]1981 results as reported prior to merger with NLT Corp. N/A—Company did not provide data

Insurers post record underwriting losses

Continued from page 63

ceased using after they were questioned by the Securities and Exchange Commission, added $203 million to its 1982 income (*BI*, Feb. 21). Without the use of the carryforwards, the insurer's operating income would have declined about 35% to $319 million, which would have ranked it 19th on the list.

Besides suffering underwriting and profit losses, some of the largest insurers also reported reduced premium volume. For example, Aetna's written premiums fell 7.6% to $3.55 billion to rank behind CIGNA.

However, CIGNA also reported a 5.7% written premium decline, based upon a pro forma combination of the 1981 results of INA Corp. and Connecticut General Corp.

The Travelers Corp. reported a 5.4% decline in premiums written by its property/casualty subsidiaries to $2.96 billion. Other major insurers reporting declines in property/casualty written premiums were Fremont General, down 6.6%; Mission Insurance Group Inc., down 5.2%; The Hartford Insurance Group, down 3.7%; The Home Group Inc., down 3.3%; USF&G Corp., down 1.9%; and Hartford Steam Boiler Inspection & Insurance Co., down 1.4%.

The company reporting the largest gain in premium volume was Houston-based American General, whose property/casualty written premium climbed 18.9% to $811.8 million. However, much of that gain is attributable to its failure to include the property/casualty results of NLT Corp., which it merged with last year.

Other big premium gains were recorded by Kemper Corp., up 13.7%; Reliance Insurance Co. and subsidiaries, up 12.9%; Royal Group Inc. (the U.S. subsidiaries of Royal Insurance P.L.C.), up 12.4%; American International Group, up 9.7%; and Armco, up 9.4%.

The largest jump in combined ratio was posted by Fremont General, a mid-size, West Coast-based workers compensation specialist. Fremont's combined ratio zoomed 16.2 percentage points to 119.8%, ranking it just behind Commercial Union Insurance Cos.' 120.5%, the highest of the surveyed companies.

CU's combined ratio is interesting because the company has been tagged by industry observers as a fierce competitor willing to cut rates in order to write new business. That fact is reflected by CU's above-average premium growth of 7.5%, accompanied by a 123.8% increase in underwriting losses, more than double the industry average.

It's not known how well CU's strategy works on the bottom line, however, since its British parent does not report profit figures for its U.S. operations.

However, CU's huge underwriting loss increase was surpassed by two other major insurers, Chubb and Fremont General.

Three others reported underwriting red ink in 1982 compared with profits in 1981: General Re Corp., SAFECO Corp. and Ohio Casualty Corp.

AIG and Hartford Steam Boiler were the only two surveyed insurers to turn an underwriting profit. However, AIG's underwriting profits declined 52.3% to $33.9 million, while Hartford Steam Boiler's dipped 84.6% to $1.5 million.

Among the largest dozen or so insurers, General Re, Travelers, Hartford, Fireman's Fund, SAFECO, The Home, Reliance, Continental and Employers of Wausau reported lower rises in combined ratio than the industry average.

For five of those companies, however, poor 1981 performances still left them with 1982 combined ratios above the aggregate. They were The Home at 116.0%; Travelers at 111.2%; Continental at 112.8%; Wausau at 115.6%; and Hartford at 111.6%.

Not surprisingly, insurance company executives expressed a wide range of opinions about the direction of rates in 1983 when informing their shareholders of the 1982 results.

For example, several corporate officers were pessimistic about any change in the competitive pricing picture.

"Property and casualty results continue to be adversely affected by a highly competitive pricing environment which shows few signs of near-term improvement," Henry U. Harder, Chubb's president and chairman, told shareholders in a quarterly report.

Chubb blamed much of its $113 million in underwriting losses on its previously announced decision to add an estimated $60 million to medical malpractice reserves after an examination by the New York Insurance Department.

The insurer said that its 145.9% combined ratio on its casualty business would have been reduced to 107.5% had medical malpractice business not been included. Overall, Chubb reported a combined ratio of 110.3% after policyholder dividends, up from 102.4% at the end of 1981.

At Hartford Steam Boiler, President Wilson Wilde attributed a 1.9% decline in year-end revenues on general economic conditions and the competitive environment. He said a relatively sharp decline in interest rates in recent months "has not yet affected aggressive price cutting in the marketplace for property and liability insurance."

However, executives at at least two major insurers appear to have less-pessimistic views.

For example, CU states that losses in 1982 were substantially impacted by weather-related claims and by additions to reserves to reflect the severe impact of the economy upon workers' compensation and liability claims.

CU's British parent, Commercial Union Assurance P.L.C., also said it was adding an additional $137 million to the capital of its U.S. subsidiary, "reflecting confidence in the developing turnaround for Commercial Union in the U.S. markets."

The likelihood that the market will turn was also cited by AIG President Maurice R. Greenberg in a statement accompanying the insurer's generally favorable year-end results.

Last year's figures have discredited the "cash-flow" underwriting theory "and it would seem clear that a return to more professional underwriting practices and reasonable pricing levels is now likely," Mr. Greenberg explained.

Others seem to be just wishful about the future, without predicting when the good news will finally be heard.

"We expect our national property/casualty operation to benefit from an eventual tightening in the insurance marketplace," the management at Kemper told its shareholders in its year-end report, which included the news that property/casualty operating earnings declined 51.3% to $19.2 million while overall earnings—including life operations—dropped 6.3% to $75 million.

"We feel we are well-positioned now to take full advantage of the expected recovery in our industry when it occurs," added John P. Mascotte, chairman and chief executive of Continental Corp., which announced a 48.3% slide in operating earnings.

Interestingly enough, two of the insurers reporting large earnings gains last year suffered large underwriting losses, too.

For example, St. Paul, which ranked fourth on the survey with an 11% rise in operating income, attributed its good results to a tripling in the earnings generated by its investment banking subsidiary. Without this gain, St. Paul, which reported a 69.9% increase in underwriting losses, would have slipped several positions.

Likewise, Fireman's Fund, which ranked sixth on the list with a 5.7% earnings increase, suffered a 50.2% increase in underwriting losses.

Fireman's Fund attributed its strong profit advance to a decision made in 1981. At that time, it decided to invest heavily in long-term municipal bonds to lock in then-high interest yields.

As a result, the insurer netted almost a 15% aftertax increase in its investment income, which helped offset the deterioration in underwriting. ■

Leonard M. Wilson's column on the insurance brokerage industry, which usually appears in *Business Insurance* the second Monday of every month, will be appear next week.

How The Hartford improves cash flow for groups of 100 or more.

"If you're still paying standard premiums, you're losing money."

Ray Drury, Vice President, Group Sales, tells benefit plan managers how The Hartford's full range of cash flow options can cut insurance costs.

Q. How did your Minimum Funding Group Life Insurance slash premium payments by almost 90% for a large Southwestern city?

A. By replacing the standard monthly premium that would have been due on the city's half-billion dollars of Group Life with a two-part premium—one part fixed and based on expenses and the premium for pooled coverages, the other part variable and tied to actual claims.

Thanks to this arrangement, the city's fixed monthly premium was reduced from $135,000—the estimated standard premium that would have been due—to less than $15,000. And the city has the use of the funds without any dilution of coverage or insurance safeguards.

Q. If losses become higher than normal, will the city pay more than the standard premium?

A. Absolutely not. Our Minimum Funding plan caps total monthly premiums—fixed and variable combined—so that they never exceed what would be due under a standard-premium plan.

Q. Can cash flow advantages be realized by small groups?

A. Definitely. While our Minimum Funding Group Life and cash flow LTD plans are designed for larger groups, we also have a full spectrum of options for groups of 100 or more. They include Minimum Premium Plan, Administrative Services Only, and Excess Risk Insurance.

With these options, you retain all or part of the risk and responsibility relating to claim payments. In doing so, you also retain all or part of the funds you'd ordinarily pay the insurance company for assuming that risk and responsibility. The cash flow advantages stem from having the use of those funds. If you hold reserves, you can also realize cash flow advantages from interest income generated by that money.

Q. How great a cash flow improvement can a small group realize by self-funding?

A. The improvement can be dramatic. For example, a West Coast electrical equipment manufacturer with 300 employees completely self-funded its medical benefits, while The Hartford provided Stop Loss coverage. As a result, the company reduced its fixed monthly cost from over $100 per family in standard premiums to under $10 per family—including third-party administration.

Q. What ways do you have to improve cash flow with your fully insured plans? And what kind of impact can they have?

A. We have Deferred Premium plans and Retrospective Rating Agreements which are available with our full range of group Life/Health coverages. Using both those options, a Midwest food processor with some 4,000 employees improved its cash flow by more than $1 million in a conventionally insured Hartford group plan. And that's not an isolated example.

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