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MARCH 18, 1985

business insurance®

Reporting weekly for corporate risk, employee benefit and financial executives/$1.50 a copy; $52 a year

update

Bendectin did not cause birth defects, jury rules

CINCINNATI—The anti-nausea drug Bendectin did not cause birth defects in children whose mothers took the drug during pregnancy, a U.S. District Court jury says.

As a result, Merrell Dow Pharmaceuticals Inc., which marketed the drug, is not liable for their injuries, the jury ruled last week.

The decision involved 892 cases and about 1,100 plaintiffs, said Merrell

Continued on next page

Year-end 1984 broker results
(In thousands of dollars)

	Gross revenues	% change	Net income	% change
Marsh & McLennan	$1,101,374	14.7%	$58,676	-37.5%
Frank B. Hall	372,841	5.3	1,538	-87.7
Corroon & Black	199,094	20.8	-6,977	N/M
Crump Cos. Inc.	69,621	26.5	4,945	65.6
Arthur J. Gallagher	64,179	20.3	6,296	47.5
Poe & Associates	22,818	10.4	-642	N/M

N/M-Not meaningful

Brokers very optimistic about profit upturn in '85

By LINDA J. COLLINS

The publicly held insurance brokers are poised for a profit upturn in 1985, report brokerage officials and securities analysts who follow brokerage stocks.

After watching the competitive commercial insurance market eat into their profits for several years, the brokers are optimistic that the suddenly tightening market will improve their fortunes.

"We generally do not make predictions, but we feel very optimistic about our general operating environment for the next 2½ to three years," explains a spokesman for Marsh & McLennan Cos. Inc., the largest of the publicly held brokers. "Now we are in a phase of the cycle that will be very good, not just for Marsh & McLennan, but for the brokerage industry as a whole."

"As far as brokers are concerned, our income will grow faster than our expenses," adds James M. Power, president and chief operating officer at The Crump Cos. Inc., which *Business Insurance* ranked as the ninth-largest U.S. broker based on 1983 revenues.

"This will be a good situation for brokers, unlike the last several years," he adds.

Analysts who follow the brokers' fortunes agree.

"Brokers are picking up market share due to their expertise," says Thomas G. Rosencrants, director of research and general partner at Conning & Co. in Hartford, Conn.

"The odds favor more possible earnings surprises. We are very bullish on insurance brokerage stocks. . . .It's 'Happy days are here again,'" according to Mr. Rosencrants.

The brokerage climate for 1985 is indeed positive, agrees Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg & Towbin in New York.

"Rates have begun to go up and are going up substantially. . . .The industry is moving into a very beneficial environment," Mr. Wilson says.

"I feel that the broker environment is very positive relative to the fact that commercial rates are increasing, and I feel that these rate

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Courts take opposing views on pollution exclusion clause
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NEWSPAPER

MGM Grand coverage trial expected to open today

By STEPHEN TARNOFF

LAS VEGAS, Nev.—MGM Grand Hotels Inc., its broker and more than 30 insurers are expected to begin their battle today over $170 million back dated liability insurance coverage intended to cover losses from the November 1980 fire at the MGM hotel in Las Vegas.

However, as of late last week, parties in the litigation were still involved in settlement negotiations.

"The situation is definitely not static," said one attorney, who added some settlements were still possible before the trial opens today.

At issue is who is liable for a $75 million settlement MGM made in January 1983 with 450 victims of the fire that killed 85 persons and injured more than 700.

The litigation began in March 1983 when MGM filed suit against Frank B. Hall & Co. Inc., the broker that placed the much-ballyhooed retroactive coverage; Union International Insurance Co., a Hall subsidiary that wrote the first $35 million of retroactive coverage above MGM's existing $30 million; and about 20 other insurers on the first, second and third excess layers.

The suit, which was filed after Union International stopped paying claims stemming from the fire, asks the court to rule on the extent of coverage provided by the back dated policies and charges the insurers with bad faith for not indemnifying MGM promptly.

Later 19 insurers on the fourth layer were added to the suit.

In June 1983, Hall and Union International countered by asking the Nevada state court to declare null and void the first $35 million of the coverage, charging that MGM intended to use the retroactive liability insurance to cover punitive damages as well as compensatory damages in violation of the policies.

Hall and Union International, plus other insurers, say it is apparent that the $75 million settlement, which they consider excessive, included punitive damages.

A month later, Hall and Union International filed suit against Del E. Webb Corp., a general contractor for MGM, its insurers and MGM to force Webb's insurers to pay the MGM losses. Hall and Union International contend the retroactive coverage is excess of the coverage provided by Webb's insurers.

MGM's and Webb's insurers also are fighting over who will pick up the $14.1 million in legal costs that MGM has paid out in the fire litigation.

Finally, in early 1984, the third-layer excess insurers on MGM's retroactive coverage filed a cross-complaint against the second-layer excess insurers, charging that they should have accepted a settlement with the fire victims that would have capped insurers' losses at $50 million.

If they had done so, the fire-related claims and related costs and legal expenses would have been capped in the second layer and the third-layer insurers would not have been tapped.

All of these issues will be heard by Judge Paul S.

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Fidelity insurance capacity for large banks dwindling

By STACY SHAPIRO

LONDON—The withdrawal of U.S. and London underwriters from the fidelity insurance market is forcing large U.S. banks and other financial institutions to pay sharply higher rates and settle for reduced limits, insurers say.

In London, capacity for financial institutions' fidelity risks has been cut in half in the past six months, says Stephen Burnhope, a director of Merrett Underwriting Management at Lloyd's of London and a leading fidelity bond underwriter.

. . . MARKET ALERT . . .

Among the London insurers that have stopped writing North American financial institution risks is Guardian Royal Exchange Assurance P.L.C., a spokeswoman for the insurer confirmed.

In the United States, several large markets have stopped writing financial institution fidelity risks, including Fireman's Fund Insurance Cos., Crum & Forster's U.S. Insurance Group and underwriting manager Shand, Morahan & Co.

As a result of the market contraction, financial institutions are facing a variety of coverage problems including:

- Rate hikes of up to 300%.
- Sharply lower limits. Large banks may be able to find only $100 million in limits, compared with $200 million to $300 million last year.
- Increases in deductibles and retentions of up to 500%. Large banks may now be required to assume deductibles as high as $25 million, compared with $5 million a year ago.

"Fidelity bond" is a generic term for different types of all-risk theft coverages purchased by banks, insurance companies, savings and loans and other financial institutions. The most common type of fidelity bond is the bankers blanket bond, which covers theft from both internal and external sources.

Some fear the sudden changes in the financial institution fidelity bond market could cause the market to collapse.

"There is a fear that there might not even be a market for underwriting the bonds of the major U.S. banks," said Walter S. Tomenson Jr., chairman of the financial and professional services division of Marsh &

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update

Bendectin not to blame: Jury

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Dow attorney Frank Woodside III of the Cincinnati firm of Dinsmore & Shohl. The decision came in the first stage of a trial to determine whether Bendectin caused the injuries. If the jury had ruled Bendectin injured the children, it would then have decided whether Merrell Dow was liable for the injuries and the amount of damages the company would have had to pay.

Plaintiffs' attorneys indicate they will appeal the decision.

Merrell Dow faces about an additional 450 Bendectin cases in courts across the country, Mr. Woodside said.

Last year, Merrell Dow agreed to pay $120 million to settle cases involving more than 700 plaintiffs who alleged injuries from Bendectin (*BI*, July 23, 1984). However, that class-action settlement was subsequently overturned by an appellate court.

Merrell Dow made an initial $40 million payment on the settlement and that money, plus $3.5 million in interest, was ordered returned to Merrell Dow by U.S. District Court Judge Carl Rubin, who presided over the trial.

Bendectin production was stopped in 1983. It is estimated that the drug was used in more than 33 million pregnancies.

Plaintiffs' attorneys last year estimated that as much as $2 billion in insurance coverage was available to pay Bendectin claims.

Asbestos producers win case

KNOXVILLE, Tenn.—A U.S. District Court jury ruled last week that National Gypsum Co. and U.S. Gypsum Co. are not liable for the costs of removing asbestos and repairing walls and ceilings in two local school buildings.

The ruling was the first court decision in litigation filed by school districts and local governments against asbestos producers to recover the cost of inspecting buildings for asbestos material and the cost of encapsulating or removing the material (*BI*, Feb. 18).

"We are pleased with the decision," a spokesman for U.S. Gypsum said, though he noted "it is one case and we intend to vigorously defend all the other cases."

An attorney for plaintiff Anderson County, Tenn., said it is seriously considering appealing the ruling.

Delta America Insurance sale

HAMILTON, Bermuda—Delta Holdings Inc. late last week was working out sale of Delta America Insurance Co. of New Hampshire to Swiss Reinsurance Co., according to Alan E. Chilvers. group vp of International Risk Management Ltd., a Bermuda-based unit of The Reiss Organization that manages Delta America Insurance.

Delta America Insurance is a subsidiary of Delta America Reinsurance Co. of Louisville, Ky., which recently suspended underwriting after a regular Kentucky Insurance Department examination (*BI*, March 4).

The Reiss Organization has long-standing ties with Swiss Re, which has reinsured various risk-sharing pools managed by Reiss.

India hires law firm

NEW YORK—The government of India has hired a Minneapolis-based law firm to represent the victims of the toxic gas leak at the Union Carbide Corp. chemical plant in Bhopal, India.

The 131-lawyer firm of Robins, Zelle, Larson & Kaplan is experienced in disaster litigation, in which it has primarily represented insurers. These cases include the MGM Grand Hotel litigation (see story, page 1) and the litigation over the Alberta Gas Chemicals Inc. plant explosion and fire in Duluth, Minn. (*BI*, Aug. 8, 1983).

However, the firm also represents plaintiffs and recently settled 198 lawsuits for an estimated $38 million with A.H. Robins Co., manufacturer of the Dalkon Shield (*BI*, Nov. 19, 1984).

Robins, Zelle was appointed after an Indian official interviewed several U.S. law firms. The Indian government passed legislation Feb. 20 endorsing government efforts to obtain compensation for the more than 2,000 persons killed and approximately 150,000 injured as a result of the Dec. 3 accident.

Questions have been raised about the impact of the firm's selection on the lawsuits filed already on behalf of the disaster victims by approximately 50 other plaintiffs' attorneys. Those cases were ordered consolidated last month in U.S. District Court for the Southern District of New York by the Judicial Panel on Multidistrict Litigation (*BI*, Feb. 11). A pretrial hearing in the litigation will be held April 16.

The Indian government's action should not affect lawsuits that have already been filed, said Deepak Vorah, press attache with the Indian Embassy in Washington.

The lawsuits filed so far seek billions of dollars in compensatory and punitive damages solely against Union Carbide Corp., said

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Vol. 19, No. 10—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 Rush St., Chicago, Ill. 60611. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, circulation department, 740 Rush St., Chicago, Ill., 60611; 312-649-5221.

Bethlehem Steel settles with retirees over benefits

By JUDY GREENWALD

BUFFALO, N.Y.—Health insurance premiums paid by non-union workers who retired from Bethlehem Steel Corp. before April 1984 are capped for life under an agreement reached between the steelmaker and the retirees.

However, the agreement, which settles a class-action suit brought by the retirees, makes the retirees responsible for copayments and deductibles.

The deductibles can be increased annually, along with the total amount of medical expenses that the retirees will be responsible for under the plan's stop-loss provisions.

U.S. District Judge John T. Elfvin gave his tentative approval to the settlement agreement last week. Copies of the agreement, which also guarantees a continuation of retirees' life insurance benefits, have been mailed to about 20,000 former salaried Bethlehem Steel employees. They have until April 15 to comment on the plan.

The judge is expected to give his final approval to the plan after a hearing on April 29, and it will take effect either May 1 or June 1.

The non-union retirees sued Bethlehem Steel after it introduced a new health care plan last April for non-union retirees that incorporated employee premium contributions, copayments and deductibles for the first time (*BI*, Oct. 1, 1984).

The company also reserved the right to make annual changes to the plan.

According to a source, the company had hoped to save about $6 million with the new Comprehensive Medical Plan, which replaced a retiree health care plan implemented in 1981. The case has been closely followed by other employers who have considered cutting their retiree health care benefits (see story, page 34).

The retirees won the first round in the legal battle in September when Judge Elfvin ruled Bethlehem Steel did not have the right to modify the retirees' health benefits because retirees were clearly told they were entitled to the benefits for life.

And, the judge said, although the company maintained that its plan documents said Bethlehem reserved the right to change the plan, many of the benefit booklets given to retirees and oral presentations did not make that point.

The judge also noted in his decision that in any case the language of the plan documents themselves was ambiguous on the issue of whether the benefits were guaranteed for life.

Judge Elfvin subsequently ruled that Bethlehem could continue to apply the provisions of the Comprehensive Medical Plan until the case was heard by an appellate court, but that the company must reimburse any premiums paid by the retirees under the plan and could not collect any future premiums until an appeal was heard (*BI*, Oct. 22).

Bethlehem appealed the decision to the U.S. Circuit Court of Appeals in New York in November.

The agreement between Bethlehem Steel and its retirees combines elements of the 1981 and April 1984 plans. Under terms of the settlement, plan participants will pay $11 a month for health care premiums if they are under 65 and $6 a month if they are 65 or over 65. Bethlehem may not increase this premium contribution at any time.

Under the April 1984 plan, the amount of premiums

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Mission gets $75 million in new capital

By STEVE TARAVELLA

LOS ANGELES—Mission Insurance Group Inc., which last month said it would seek additional capital, will receive a $75 million infusion from its major shareholder, American Financial Corp., to support underwriting this year.

Salomon Bros. Inc., the New York-based investment banking firm, assisted Mission in obtaining the funds from Cincinnati-based American Financial, which owns 49.9% of Los Angeles-based Mission.

The $75 million injection will increase Mission's unaudited policyholders surplus to $118 million from $43 million, officials say.

Mission will receive the $75 million in additional capital and surplus in two transactions.

First, an American Financial subsidiary in Cincinnati will assume approximately half of Mis-

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Courts take opposing views of pollution exclusion clause

By STEPHEN TARNOFF

Two recent court decisions further muddy the issue of insurance coverage for pollution incidents under liability policies.

The two state appellate court decisions take opposing views on whether the pollution exclusion clause in a liability policy bars coverage for defense costs in pollution liability lawsuits.

The pollution exclusion clause in comprehensive general liability and other types of liability policies denies coverage in pollution liability claims unless the pollution is "sudden and accidental".

In *Techalloy Co. Inc. vs. Reliance Insurance Co.*, the Superior Court of Pennsylvania said the company's dumping of tricholoretheline was not "sudden and accidental," and that as a result Techalloy was not entitled to more than $64,000 in defense costs.

However, in Waste Management of Carolinas Inc. vs. Peerless Insurance Co., the North Carolina Court of Appeals ruled that the operator of a waste collection and transportation service that allegedly deposited hazardous chemical waste was entitled to defense costs from its insurers.

The decisions are part of an ongoing battle between insurers and policyholders over the effect of the pollution exclusion clause in liability policies.

In the Techalloy case, a class action was filed against the company, which is in the business of cutting and stripping steel. The suit alleged that Techalloy recklessly dumped or stored TCE, contaminating water.

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Enforcement of VEBA rule delayed

By JERRY GEISEL

WASHINGTON—Employers that fund long-term disability benefits for non-union workers through tax-exempt trusts will have more time before they must comply with one congressional restriction affecting the trusts.

According to a conference report accompanying last year's tax bill, companies that fund LTD benefits through Voluntary Employee Beneficiary Assns. cannot offset the benefits paid to disabled non-union workers with Social Security disability benefits if they also fully offset pension benefits with Social Security.

This restriction on integrating LTD benefits funded through VEBAs, also known as 501(c)(9) trusts, was to go into effect Jan. 1 (*BI*, Oct. 29, 1984).

Since that deadline for compliance has come and gone, employers affected by the provision are confused about what to do, consultants say.

Now, according to a "blue book" recently issued by the congressional Joint Committee on Taxation, the VEBA provision will not go into effect until the Treasury Department publishes rules governing the provision.

"The Congress did not intend these new rules for integrating disability benefits to go into effect until the Treasury provides guidance as to their application," according to the blue book, which is the committee's detailed explanation of the 1984 tax law known as the Deficit Reduction Act.

Treasury Department rules on LTD integration and other VEBA-related issues are not expected to be published for several months, a government attorney said.

The delay in the compliance deadline is good news for employers who fund LTD benefits through VEBAs and haven't been sure—in the absence of definitive Treasury rules—exactly what changes they might have to make.

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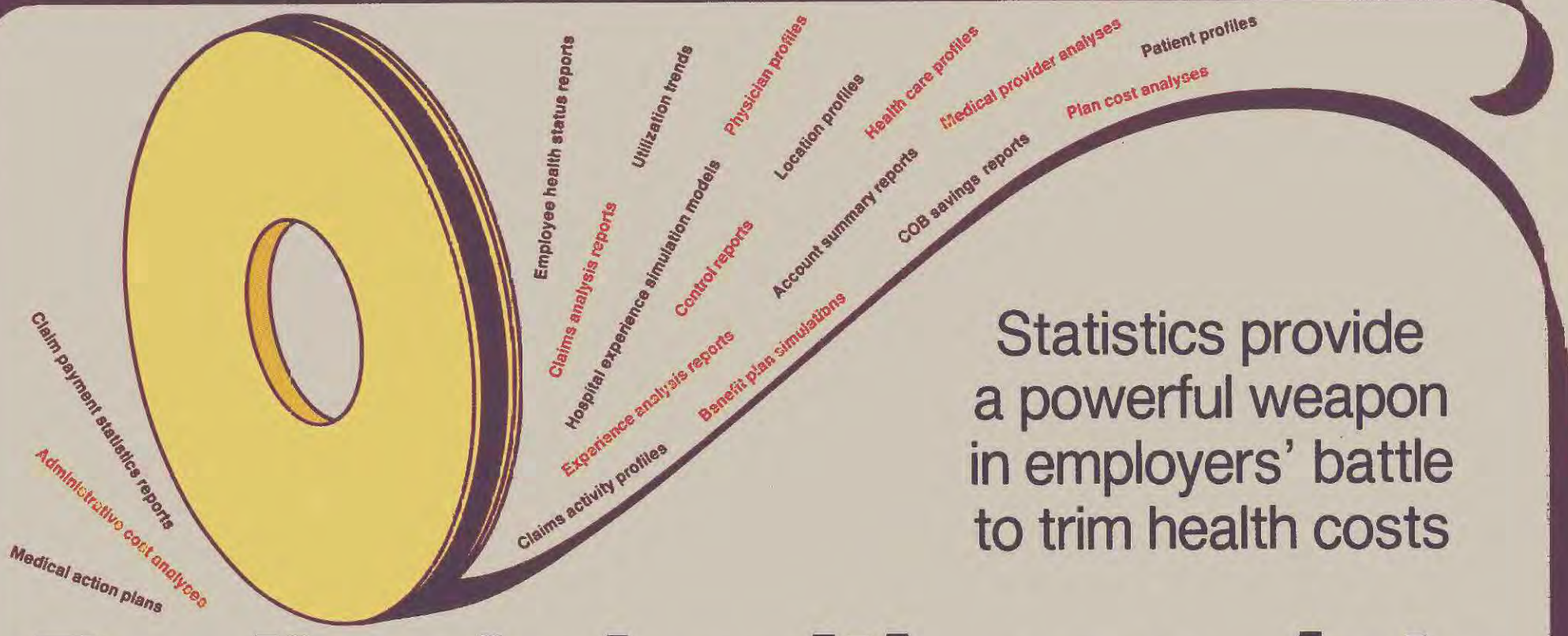
To our subscribers

Many readers have recently complained they now receive *Business Insurance* several days after the publication date.

The delay in delivery is the result of a change in procedures instituted by the U.S. Postal Service. *Business Insurance* is working with the Postal Service to identify and resolve the problems that are leading to late deliveries.

Business Insurance regrets any inconvenience caused by the delivery problems.



Statistics provide a powerful weapon in employers' battle to trim health costs

Reeling in health care data

By DIANE LYNN KASTIEL

Employers—hungering to control health benefit costs—are scrambling to get a full plate of health care data.

"What employers are doing is moving toward purchasing health care the way they purchase any other product for their company," said Susan Gunderson, a member of the planning section of the health care studies unit of the Mayo Clinic in Rochester, Minn.

They are asking, "What exactly does it cost and what exactly are we getting for our money?" she said.

In fact, their insatiable appetite for this information has spurred the development of a whole new industry of "health care data consultants"—companies that specialize in health care data collection and analysis (see story, page 16).

And, employers are paying anywhere from several thousand dollars to as much as $100,000 annually for these services, depending on the company's size and the extent of the analysis.

"In one year, we had an 11-fold increase in revenues and about a sixfold increase in employees covered (by the health plans analyzed)," said Ernest Ludy, president of Medstat Systems Inc., a health care data consulting firm in Ann Arbor, Mich.

Medstat reported 1984 revenues of $1.013 million generated from 16 clients that provide health care for more than 1 million employees and their dependents.

"Last year, we were turning down business," said Rob Chernow, president of Corporate Health Strategies Inc., a subsidiary of Metropolitan Life Insurance Co. that provides data analysis to clients of Metropolitan and other insurers.

"We couldn't handle what was coming through the door."

Currently, CHS has 100 clients that provide health care coverage for 750,000 employees and dependents, compared with only 25 clients representing 187,500 covered lives at the end of 1983.

In response to this growth, CHS added 12 employees to its staff of 24—a 50% increase.

Insurers, third-party administrators, benefit consultants, universities, government entities, employer health care coalitions and trade associations also are helping employers get their hands on data about their health care costs.

For example, CIGNA Corp. reports that as many as 35% of its clients use its data analysis services, "and the demand is increasing at an annual pace of 25% to 30%," said Chip Sharkey, vp of marketing.

Seven states are currently considering proposals to create statewide data bases (see story, page 24).

And, half of the 135 employer health care coalitions in the United States are doing some kind of data analysis, a 20% to 30% increase from the number involved in data analysis two years ago (see adjacent story).

In most cases, the raw data needed to analyze an employer's health care costs comes from its group health insurer's or third-party administrator's claims reports. This information is put on magnetic tapes and fed into a computer, and then the data consultant manipulates this information electronically to produce statistical reports on almost any facet of the employers' health care costs.

Employers can find out which providers are the most expensive, which medical procedures are performed most frequently and which employees are ringing up the largest bills.

They can identify procedures performed on a hospital inpatient basis that should be performed on an outpatient basis. They can pinpoint areas of abuse by providers. And, they can detect inefficient cost-containment programs.

The statistics the data consultant culls are then usually compared with "normative data" to see how the employer's experience stacks up with others.

If an insurer is doing the analysis, the claims information from its entire book of group health insurance often is the benchmark for comparison. Or, an employer's experience might be compared with data collected by state agencies or with the National Hospital Discharge Survey, a statistical sampling of 400 to 500 hospitals nationwide that provides national and regional information on patients, diagnoses, lengths of stay, etc. The survey is compiled by the National Center for Health Statistics, a division of the U.S. Depart-

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Coalitions supply the necessary clout

By DIANE LYNN KASTIEL

In the quest for health care data collection and analysis, business coalitions are among the most active explorers.

Of the 135 employer health care coalitions in the United States, more than half are doing some kind of data collection or analysis, says Rick Lee, director of public policy issues for the Washington Business Group on Health. He says that number represents an increase of 20% to 30% compared with two years ago.

The coalitions' power lies in their ability to get health care data from providers and insurers that may be reluctant to provide such information to a single employer, explained James Mortimer, president of the Midwest Business Group on Health, based in Chicago. It a classic example of the power in numbers, he explains.

"We've found that if as few as three or four (companies) approach an insurance company together, there's almost nothing they can't get," he said.

Most often, coalitions serve as liaisons between their members and "data consultants"—companies that specialize in health care data collection and analysis—rather than doing data collection and analysis themselves.

The coalition's members supply information on their health care costs and utilization, but the actual analysis is done by a data consultant. Then, the coalition prepares reports for its members and makes recommendations on the basis of the analyst's findings.

The Utah Health Cost Management Foundation, a Salt Lake City employer coalition, will begin this year

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Unions willing to talk about cost control

Labor unions approaching the bargaining table this year say they are willing to discuss health care "cost management" alternatives, but most are adamant about not accepting any contract that merely shifts more of the costs of health care to their members. See Associate Editor Michael Bradford's report on page 28 on how far the unions are willing to bend.

Hospital bill audits add up to big savings

Old-fashioned auditing of computerized hospital bills is turning up lots of mistakes, and that adds up to a lot of money saved for a growing number of employers that hire the auditors. Free-lance reporter Margaret LeRoux explains how—and how much—on page 54.

It can be risky to cut retirees' benefits

Employers seeking to cut the costs of their retirees' medical benefits are taking a big risk of ending up in court. But, careful planning and communicating—especially before cuts are made—can raise the odds of success. Associate Editor Judy Greenwald reports on page 34.

Health care savings are hard to document

While many group health insurers and claims administrators are boasting about the savings they are generating for their clients through the implementation of cost-containment measures, they all caution that quantifying these savings is not an exact science and buyers should not try to compare or contrast results. See Associate Editor Carol Cain's report on page 39.

Employers clamor for health care data

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ment of Health and Human Services.

In this way, employers can find out how their health care costs compare to those of other employers in their industry, to employers with similar employee populations or to employers in their geographical area.

"Employers are asking, 'What's the next level we can go to in health care cost management?,'" said Thomas E. Wood, a partner at Hewitt Associates in Lincolnshire, Ill.

"And the answer is to dig in and get these numbers and see what else they can do."

"They've been through the 'I-want-to-buy-a-cost-containment-program' phenomenon, and a lot of benefit administrators and trust fund administrators really got burned," added James Studnicki, associate professor in the department of health policy management at Johns Hopkins University's School of Hygiene and Public Health in Baltimore.

"They got a lot of promises, and and at the end of the cost-containment program they looked at their bottom line and, low and behold, there wasn't any impact," Mr. Studnicki said.

David B. Walker, consulting principal at A.S. Hansen in Deerfield, Ill., said that employers "did not understand the depth and complexity of the (health care) problem. They put in a quick fix and thought it would work. They thought it was something they could fix easily with Band-Aids."

But employers say the data they needed wasn't available when they began their cost-containment programs.

"Initially, when we got into this health care cost containment, we had to shoot from the hip," said Donald Flagg, vp of human resources for the Stouffer Corp. in Solon, Ohio. "We had no data to go on."

Now, Stouffer is pooling its health care data with that of about 20 other Ohio employers, including General Electric Corp., the Standard Oil Co. (Ohio) and Sherwin-Williams, as part of the Cleveland Community Data Collection Project.

The project is sponsored by the Health Action Council of Northeastern Ohio and administered by United Medical Resources Inc., a health care data analysis company in Cincinnati.

The Big Three automakers also are turning their attention to data collection.

The Ford Motor Co. began gathering health care data last year, using the services of Medstat.

Although its data is still being collected from its health insurers, eventually Ford will be able to access detailed health care utilization and cost information on an in-house computer terminal that will be connected to Medstat's databank.

"We're hoping to identify areas of our program that should be modified because they're not cost-beneficial," said Jack Shelton, manager of Ford's employee insurance department.

"We're hoping to identify providers that are not providing care in concert with proper norms so that we can talk to them."

Chrysler Corp. recently hired Health Data Institute Inc. in Boston to conduct a comprehensive, detailed analysis of hospital claims filed by its employees in southeast Michigan. The study compared local hospitals on factors like length of stay, and number of admissions per diagnosis. It uncovered that Chrysler was paying for unnecessary employee admissions for lower-back pain and longer-than-necessary lengths of stay for maternity patients (*BI*, Dec. 24, 1984).

Armed with this data, Chrysler and its insurer, Blue Cross & Blue Shield of Michigan, convinced the hospitals to adopt certain guidelines for admissions and lengths of stay before related charges could be justified.

Last October, General Motors Corp. bought Electronic Data Systems, a Dallas-based data processing services company, which will establish a computer system that will allow GM to tap into the claims files of its health care insurers and analyze this data in almost unlimited ways. GM hopes to cut its $2.2 billion health care bill by 10% with this system (see story, page 14).

Others just beginning to concentrate on accessing health care data include The American Electronics Assn., whose 3,000 member companies make it the largest electronic trade association in the United States. It is working with consultants Data Resources Inc., a subisidiary of McGraw-Hill Inc. in New York, to develop an industry-wide health care data base.

"There are some unique aspects of this industry," said Wanda Kownacki, the association's health care program manager. "For instance, the industry employs a lot of young employees, which would affect health care costs."

The association's pilot project is focusing on claims information from 10 member companies that together provide coverage for 70,000 lives, including dependents. A report on the findings of the pilot project is due in May, and then the association hopes to expand the data base to include more members.

Similarly, Sheet Metal Workers Local 100 in Suitland, Md., which has a self-funded, self-administered health care program, just began collecting and analyzing data on its health care costs and utilization in the past year.

Using a computer system developed by Honeywell Inc. in Minneapolis, the union can compare hospital charges from month to month and break expenses into categories such as room and board, doctors' fees and ancillary charges.

A contrast to these newcomers is Deere & Co. in Moline, Ill., which installed a computer system in 1979 to collect health care utiliztion and cost data, as well as pay claims for its self-insured, self-administered health benefits program.

Deere developed its own software to keep track of the more than 1 million claims it receives each year.

The system tells Deere exactly where its health care dollars are being spent, how much they're rising and in which areas.

Once employers begin collecting data, they often find the results so beneficial that they expand their efforts.

"We expanded what we were originally looking for—information on the hospitals—to every aspect of our health care expenditures, including doctors' visits and prescription drugs," said Warren Billings, director of benefit admin-

Continued on page 6

The Government stopped us from offering some of our Flexible Spending Programs.

Flexible Spending Accounts are a good idea for employers and employees.

Unfortunately, the IRS doesn't agree. In recent rulings, they eliminated some of the many advantages offered by FSAs.

But despite the changes, Flexible Spending Accounts are too important of an idea to die. Not only do they provide employers with a method for controlling benefit costs, but they help employees cover medical costs with non-taxable income.

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Title_____

Company_____

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City_____

State_____ Zip_____

BI-3

NWNL GROUP

A division of Northwestern National Life Insurance Company
Home Office: Minneapolis, Minnesota

So we've reconstructed them.

Health care data

Continued from page 4
istration for AT&T Technologies in New York.

"Just about any way you cut it, we look at it in a broad way. And when we see an aberrant situation, we focus on it more closely," he said.

AT&T uses normative data from the National Center for Health Statistics to compare against its data base, which contains information on 430,000 employees.

AT&T's original software was developed with the help of its benefits consultant, Johnson & Higgins. AT&T currently uses the services of Corporate Health Strategies.

Boise Cascade Corp. in Boise, Idaho, also has increased its requests for data since 1981, when it first asked its health insurance companies to prepare basic claims reports for it.

"We started working with them, asking for additional reports and additional information," said Dick Harding, director of benefits.

"And that has evolved to the point where we take their tapes and hook them up to our system and make our own evaluation," Mr. Harding said.

Boise Cascade accesses this data through a terminal that is on-line with Medstat's data base.

Once employers have health care data in their hands, they can use it in endless ways, they say.

One key use is to help employers understand and redesign their existing health care plans.

This often is done through a technique called benefit modeling, in which a computer simulates modifications in a health care plan it has analyzed to see what effect they would have on the cost of the plan. The modifications could be cost-shifting measures, cost-containment programs, or a complete restructuring of the health care plan.

"Our system actually goes back and 're-pays' all last year's claims under a different set of assumptions and plan design characteristics," explained Andy Knapp, senior consultant in the corporate cost-containment division of the Prudential Insurance Co. of America, which offers benefit modeling as part of its data analysis services.

"We can look at that employer's experience and predict the financial impact of any (plan design) change."

Corporate Health Strategies also offers benefit modeling.

"You can sit there and play to your heart's content," said Mr. Chernow.

"You can devise any scheme you want and see if it saves you money. It's like an economic model. Corporations can see which plan design will save them the most money and then politically see which one works best for them and implement it."

Data analysis also can help employers track the success of plan design changes once they are implemented.

"The key is to use your data to track the effectiveness of your action program," noted Paul M. Gertman, chairman and chief scientist of Health Data Institute.

"While you need to look periodically to see what new problems have sprung up, what you need to use your data analysis for is to answer the question, 'Have we made a difference with our cost-containment efforts?'"

Data analysis also can help employers use employee assistance programs more efficiently, added Prudential's Mr. Knapp.

"For example, if your stress-related diagnoses are only occurring in your employee population between age 50 and 55, you would

Continued on facing page

Experts give tips on data collection

For the benefit manager who wants to get into data collection, here's some advice from the experts:

- First, and perhaps most importantly, know your company. A good background study is crucial, experts unanimously advised.

"If you don't have a foundation, you can't build a house," said David B. Walker, consulting principal in the Deerfield, Ill., office of A.S. Hansen.

"The right way to analyze what is going on with a company is to go back at least two years."

- Don't expect a "quick fix." Be willing to invest some time and money if you want the data analysis to produce results.

"What some companies fail to do is to use this data for long-term planning," said William E. Hembree, director of the Health Research Institute in Walnut Creek, Calif. "They get fixated with the short-term solutions. Data is much more useful in solving long-term problems than in achieving a quick fix."

- Keep abreast of what others are doing. Get ideas from them and learn from their mistakes.
- Be prepared to implement the health care plan changes that your data analysis indicates are needed. "A lot of people ask for health care data and once they get it, they don't use it," said Dick Harding, director of benefits for Boise Cascade Corp. in Boise, Idaho. "So (the data analysis) becomes wasteful."
- Get as much data from your insurer as possible—it saves money."Tell them, 'Look, we're in business with you,'" Mr. Walker said. "We give you X hundreds of thousands of dollars worth of business a year, and we want data in a format that we can understand. And we want you to show us where our problems are."
- Join a coalition. "An excellent way to do (data analysis) and the cheapest," Mr. Walker said.
- Be sure your analyst adjusts your health care utilization and cost data demographically—or do a demographic analysis yourself.

"What we've seen is a lot of people are doing this health data analysis without looking at the characteristics of the employer population," said Susan Gunderson, a member of the planning section of the health care studies unit of the Mayo Clinic in Rochester, Minn. "And we feel that without that, you can't get the whole picture."

"It's unbelievable," agreed Jerry Kaple, director of health cost management for Data Resouces, Inc. in Bethesda, Md. "Employers don't know whether their utilization is high or low if they don't know the demographics of their population. Figure out a way to have access to the demographics of your population. It's worth it."

- And, realize that data analysis is only one step in controlling these costs and your efforts should not stop with the analysis. "Data never, ever solves problems," Mr. Hembree said.

"It just identifies the problems. And once we've identified the problem, it's the selection of the solution that's important," Mr. Hembree emphasized.

Health care data is new field

Continued from facing page
want to target your (stress management) EAP to that group, rather than your whole employee population."

Because data analysis provides information on providers' patterns of service as well as on employees' health care usage, it also can be used in negotiations with health care providers.

"It turns out in almost all cases, that when we show (providers) the facts and tell them why we think these things are inappropriate, we get a lot of cooperation," said Robert Reveley, vp of health care affairs for Blue Cross/Blue Shield of Michigan.

"They initially respond with some amount of resistance because they look at it as someone outside the medical profession questioning their institution. They have suggested to us that we're more concerned about cost than quality. And we say, 'Yes, we're concerned about quality of care, but we're also concerned about costs,'" Mr. Reveley explained.

"As this dialogue goes on, the providers realize that we do know what we're doing and we're not just picking on them."

According to Mr. Reveley, Blue Cross/Blue Shield of Michigan has used the data developed through its EXAM and ASSURE programs to persuade several Detroit hospitals to implement their own pre-certification programs.

And Blue Cross/Blue Shield of Michigan intends to use this data in the future to identify providers that it wants to include in the preferred provider organizations that it sponsors.

Having access to good cost data allows an employer to take a more aggressive stance in negotiating with providers.

"Typically, what's happened is PPOs approach employers and say, 'We'll give you a 10% or so discount if you encourage your employee to come to us,'" according to Mr. Chernow.

"They may be offering you a 10% discount, but if their prices are 20% higher than other hospitals, you're not going to save any money at all.

"Data allows you to approach the providers from a proactive standpoint and say, 'This is what I want.'"

Mr. Chernow said clients of Corporate Health Strategies "have gotten as much as a 20% and 30% discount in some areas" by using information gathered through data analysis in negotiating with providers.

Hansen's Mr. Walker agreed that providers do cooperate more when they know that the employer or its consultant is armed with health care data.

"When this thing first started, they looked on us as absolute vigilantes," he said.

"Now, hospitals are coming to us for help with their marketing programs."

Data also can help employers focus their cost-containment programs on those providers that have the most fat in their health care delivery systems, according to Mr. Reveley.

"Many of the plan design cost-containment programs are what I would characterize as 'shotgun programs,'" he said.

"And that's not as cost-effective as being selective and identifying those providers that are the costly ones.

"Data analysis can help sharpen the targets for cost containment, and you can start using a rifle instead of a shotgun," Mr. Reveley added. ■

Data shows trends

Even though their efforts are relatively new, data analysts say they are learning a lot already from scrutinizing health care costs.

For one thing, all the analysts agree, employers are definitely spending more on health care than necessary.

"The biggest trend we see is that employers are paying 20% to 25% more, on the average, than they should have to pay to get the same services," said Dr. Gary McIlroy, president of Health Risk Management in Minneapolis.

"There's certainly a lot of waste in the hospital field," said Paul M. Gertman, chairman of the board and chief scientist for Health Data Institute Inc. in Newton, Mass.

"Our estimates show from 20% to 30% of all hospital admissions are unnecessary."

A recent data analysis for a large company showed "potential excess costs of 24%—a savings of over $3 million," said David Glueck, vp of benefits consultant of Towers, Perrin, Forster & Crosby in Chicago.

"It would be an unusual study that didn't reveal 20% savings, just by eliminating overutilization," he said. "There is indeed an overuse of treatment, surgery and hospital confinement."

Data analysts also are finding that most cost-containment programs, on the whole, are not saving as much money as they could because they do not fit the needs of the company that implements them.

For example, some companies automatically implemented costly pre-certification and second surgical opinion programs, unaware that their health plan had a very low rate of hospital admissions, said Jerry Kaple, director of health cost management for Data Resources Inc. in Bethesda, Md.

"What we are finding and what employers have realized by implementing these strategies and by looking at the cost of them is that you don't want to use every program for every employer," Ms. Kaple said. "What you want to do is target your cost-containment efforts."

"You have to identify those factors that affect hospital utilization rates and incorporate that kind of information into the data base," added James Studnicki, associate professor in the department of health policy management at Johns Hopkins University in Baltimore.

"The principal objective (of a data base) is to allow purchasers of care to evaluate their health benefits utilization and cost experience and then, on the basis of that information, make decisions about programs that affect their plans."

Data analysts also are finding that providers often negate the savings achieved through cost-containment programs by "padding" employers' health care bills in other areas.

"Hospitals and doctors have numerous ways of adapting and responding to cost-containment programs, and employers will have to maintain eternal vigilance," said Mr. Studnicki.

"You have to maintain the ability to systematically track and evaluate your expenses over time—you can't ever turn away from it."

opinions

Employers must speak up

THE MEEK MAY WELL inherit the earth, but they'll be powerless to hold down health care costs.

The message repeated again and again in this week's Spotlight Report on health care cost containment is that benefits managers must speak up loud and clear if they want to keep the upper hand in the ongoing battle against rising health costs.

For example, benefit consultants are warning companies that want to implement cost-control measures in post-retirement health benefit plans that unless they clearly communicate up front that such benefits are subject to change, they could well end up in court at the hands of disgruntled retirees who believe promises made to them have been broken.

Employers cannot on the one hand want to have control over the cost of retirees' health benefits and on the other hand be too timid to stand up and make it clear to employees from day one that post-retirement benefits are not untouchable. In the end, that timidity could be costly.

Likewise, employers cannot afford to be meek at the bargaining table when they negotiate new labor contracts this year. Although unions are apparently more open-minded to health care cost control now than in other years, to keep tight reins on health costs employers still must state a strong case for cost containment and know what issues they can bend on and where they must stand strong.

In the same vein, the success of employers' quest to get their hands on the data they need to scrutinize exactly where their health care dollars are going and who is abusing the system largely depends on their willingness to fight to get that information.

Although a whole new industry of health care data consultants is springing up to cull and manipulate statistics on things like hospital admissions, coordination of benefits and administrative costs, their hands are tied if they cannot, in the first place, get the facts about the employers' health expenses.

And, for most employers, the key to that vital information is a group health insurer or third-party claims administrator.

If an insurer is reluctant to release information on the employer's claims experience, it is the employer's task to pressure the insurer to do so. It is also the employer's responsibility to tell its insurer or administrator exactly what information it wants and then insist that the data is "clean."

If the data is incomplete or inaccurate, the employer must tell the insurer or administrator about it—and demand improvement. Some data analysts say that currently 50% of the data they receive from insurers and administrators is so inaccurate that it cannot be included in the data base.

If no one stands up and demands better statistics, the quality of the data bases on which employers rely to make health benefits decisions will never improve—and the decisions made could well reflect the poor quality of the data on which they were based.

Employers are also finding that banding together in health care coalitions is increasing the roar when they do speak up.

An insurer or administrator that might be tempted to ignore one employer's request for clean health care data might think twice about snubbing an army's demand.

Indeed, being meek does have its rewards; unfortunately, lower health care costs is not one of them.

letters

Computer users must determine their own needs

To the editor: We were amazed to find that in the flurry of articles on personal computers (*BI*, Feb. 18), very little was said about the operational implications of maintaining a stand-alone system.

Vendors who rely solely on micro-based systems will have to convince their users to accept full responsibility for data control and integrity. In turn, users will have to accept this responsibility or pay the price of inaccurate information.

Operational issues have very little to do with the size or cost of the microcomputer. Operational complexities depend on the amount of data being maintained. Even small users can accumulate a lot of data over time. Items that need to be considered are:

- Data entry, validation and correction procedures.
- Control of claims management activities (e.g., claim diary, payment and excess claim control, etc.).
- Data base quality control (i.e., ongoing data integrity).
- Data recovery after hardware or software failures.
- Telecommunications for multilocation operations. (This is not only a mainframe issue.)
- Coordination of data and information among various providers (e.g., excess carriers, claims adjusters, banks, etc.).

We encourage potential users to carefully consider operational issues, and we hope that the consultants will speak more about these issues in the future. There is bound to be a lot of initial interest in these stand-alone systems. However, we suspect that most users will not be willing to incur the costs and headaches of maintaining their own data in the long run. We are convinced that most users want more direct access to accurate risk management information and the ability to easily manipulate it. Information is the organized byproduct of data. Information management can be successfully separated from data maintenance.

Information management and decision support (not data maintenance) are the two areas where micros should have the greatest payback in the near future. Service providers should not rush out and replace their mainframes with micros, but rather look to layered-system architectures consisting of micros and mainframe products working together to meet user needs.

At the present time, we are not rushing to build a stand-alone version of our RISX-FACS, SELEX-FACS and MICRO-FACS products. However, we do offer some of these products on a unbundled basis. When we unbundle our integrated products and services (i.e., claims management, property values management, loss control, brokering and information), we make sure that our users end up with an effective system.

There is a distinct difference between unbundling and unraveling. Pushing operational data maintenance costs, responsibilities and associated problems to the user will not always address their decision support needs.

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Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

BI editorials win awards

Business Insurance has won two awards for editorials it published last year.

Editor Kathryn J. McIntyre won second-place honors in the 1984 awards competition sponsored by the Chicago Chapter of the American Society of Business Press Editors for her editorial, "Asbestos agreement is best option."

The editorial, published Aug. 27, 1984, urges asbestos producers, insurers and reinsurers to join the Wellington asbestos claims facility, despite its shortcomings. The editorial recognizes that the agreement incorporates compromises on the part of all parties in the asbestos litigation, but points out that not joining the facility will prolong litigation and not necessarily guarantee more favorable final results.

Deputy Editor Lorrie Gibson received an honorable mention in the same competition for her editorial, "Belts vs. bags debate is overblown."

That editorial, published Sept. 17, 1984, urges risk managers not to join in the unending debate over mandatory passenger restraints in cars, but rather to recognize that not only is it a must that their employees wear seat belts, but it also is prudent to have airbags installed in company cars to offer added protection to employees.

The competition sponsored by the Chicago chapter of ASBPE attracted 400 entries in a variety of categories. *Advertising Age* and *Crain's Chicago Business*, two sister publications of *BI* published by Crain Communications Inc., also won awards in the competition.

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Published by Crain Communications Inc., Chicago
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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 25-4248, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 604207 CRAIN COM NYK; Suite 814, National Press Building, Washington, D.C. 20045; 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 20-22 Bedford Row, London WC1R 4EB, England. $1.50 a copy. $52 a year in U.S. Canada and all other foreign add $16 for surface mail. Europe and Middle East only add $45 for air delivery. First-class mail to U. S. and Canada only, add $48. Bermuda only, $97 per year expedited delivery. WILLIAM STRONG, vp-circulation. ROBERT FIORITO, *circulation manager*. ROGER DiGREGORIO, *fulfillment director*. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 740 Rush St., Chicago, Ill. 60611, or phone 312-649-5221. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229.

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Health care data often inaccurate: Analysts

By DIANE LYNN KASTIEL

"Dirty" health care data—information full of inaccuracies and omissions—is the biggest obstacle to developing reliable statistics that employers can tap to control health care costs.

Data analysts complain the information they can get only from group health insurers is so inaccurate that they often can't even use half of it.

"The state of data in the United States needs to be improved considerably," said William E. Hembree, director of the Health Research Institute in Walnut Creek, Calif. "Probably the chief difficulty (in data analysis) is relying on reports that are based on inaccurate data.

"We're tossing out 50% to 60% of the data just because it's so inaccurate. The technology to be able to produce and analyze reports is light years ahead of the data on which they're based," he said.

Mr. Hembree said one of the HRI data base's most important functions is the editing of claims information received from participating employers' group health insurers.

This edited information is the basis for what he calls "input edit reports."

These provide the user with a copy of the data available, he said.

"If this data base was simply used to edit data, we'd feel it served a pretty important purpose. Because the input reports this computer generates not only tell the user what information he has but also what is missing, that enables the user to sit down with its insurer and say, 'This is what kind of information we need.'

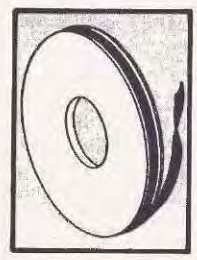
"I hope that the other companies that are analyzing data are finding the data as dirty as we are and are throwing that dirty data away," he said. "And, I hope they're telling employers their analysis is based on only 40% to 50% of the data."

"On the average, 50% of the data we get is not useful," agrees Dr. Gary McIlroy, president of Health Risk Management in Minneapolis. "The size of the insurer has no relation to the quality of the data."

U.S. Corporate Health Management in Santa Monica, Calif., whose clients include BankAmerica Corp., Lockheed Corp. and Mattel Inc., faces similar problems.

"Certainly, inaccuracy and incompleteness (of data) are two major problems we face," said Vp Dick Brown.

The main problem is that the data from the insurers is improperly or insufficiently coded, Mr. Brown explained. And, different insurers use different coding systems, which further complicates analysis.



"But, the interest in health care data that's being generated by employers has forced the carriers to clean up the data, and they're making great strides," Mr. Brown said.

When asked about the problem with dirty data, the insurers interviewed said they have not had a problem with inaccurate data. One insurer pointed out that insurers also want their information to be accurate.

"We rate our claims inputters on accuracy of claims," said Thomas Raffio, director of management reports for John Hancock Mutual Life Insurance Co. "Our claims payment system is designed to capture many more statistics than we need to pay claims. And we do that because we know that down the road, we'll have to use that information for (their analysis program). So it's in our best interest to capture information accurately and fully."

But, even if the data supplied were accurate, data analyses still would have some shortcomings.

Because data analysts have their own collection and analysis methods, there's a limit to how much they can be compared or used interactively.

"Right now, if you ask five different people to evaluate a cost-containment program, you're likely to get five different methods of analysis and five different conclusions on the effectiveness of the cost-containment program," said James Studnicki, associate professor of health policy and management at Johns Hopkins University School of Hygiene and Public Health.

Johns Hopkins in Baltimore is working with the International Foundation of Employee Benefit Plans in Brookfield, Wis., to build a national health care utilization data base for use by employers.

"This (data base) is going to be set up with the principle objective to allow purchasers of care to evaluate their own health benefit utilization and cost experience and then, on the basis of that information, to make decisions about programs that affect their plan expenditures," Mr. Studnicki said.

The pilot project will involve 12 to 36 IFEBP member trust funds and corporations that operate employee health care benefit plans. It is scheduled to cover 18 months and then will be broadened.

Another limiting factor in data collection is the lack of information on outpatient hospital care.

According to Ernest Ludy, president of Medstat Systems Inc., between 40% and 45% of health care services are performed on an outpatient basis, and that should increase to more than 50% by 1990.

Medstat will have its outpatient data base operating within six months. It is one of the few firms that has an outpatient data base. ■

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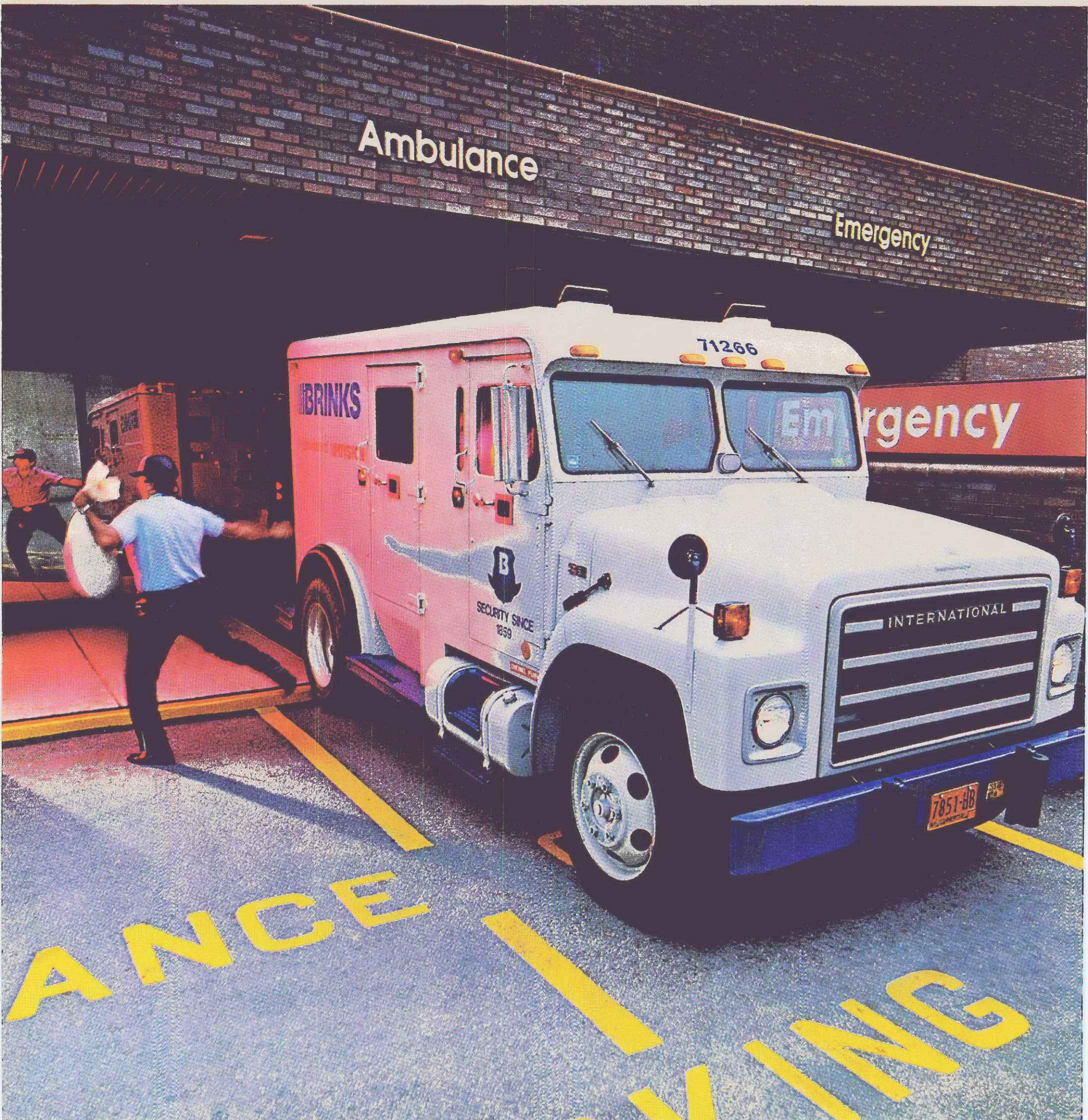

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CIGNA companies also have helped save their clients $8.50 for every $1 spent by instituting second opinion surgery programs. In addition, there are benefit plans that reward the use of same day surgery and care at home.

Prepaid health care is another important approach to cost containment. By its very nature prepaid health care puts the burden of containing costs where it should be—on the provider. And CIGNA companies are not only keeping costs down, but keeping the quality of care up at the same time.

To back up our belief that everyone has to pitch in to help keep medical costs down, CIGNA has just finished awarding nearly $1 million in grants. These grants enable local coalitions of businesses, civic leaders, and health care providers to pursue solutions to health cost problems.

If you want to know more about what CIGNA companies can do to contain your costs, please write to CIGNA Corporation, Dept. R1, One Logan Square, Philadelphia, PA 19103.

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CIGNA

Data system may help GM cut health costs

By DIANE LYNN KASTIEL

DETROIT—General Motors Corp. plans to slash 10% off its $2.2 billion annual health benefits bill by scrutinizing data on its employees' health care habits.

Last October, the automaker purchased Electronic Data Systems, a Dallas-based data processing services company for, ironically, $2.2 billion. Now, this subsidiary is working on the enormous project of establishing an "interactive" health care data system for GM—one that will allow the automaker to tap into the claims files of all its health insurers and manipulate the information in a variety of ways to find out just about anything on its health care costs and employee utilization patterns.

EDS expects the project, which should be up and running in 18 to 24 months, will save its new parent at least $220,000 in health care costs the first year.

"We think there is a conservative 10% savings to be achieved," said Dean Linderman, corporate vp of EDS' insurance group. "Nobody really knows what the art of the possible is, (but) we think that is a realistic target."

The system will do three basic things. First, it will maintain complete records on the health care eligibility of GM's 770,000 active and retired employees, who must sign up by April 1 for either GM's traditional health care plan, a health maintenance organization or a preferred provider organization. Secondly, it will process all health care claims, which hopefully will be entered on the EDS system by GM's health care insurers.

And, most importantly, the new system will allow the company to manipulate its claims data with use of a computer, to answer a variety of questions on its health care costs and utilization.

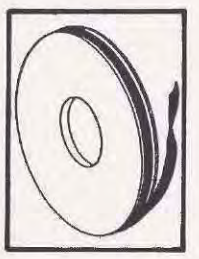
GM is negotiating with its health care insurers to have them input GM's claims information into EDS' computer, using terminals that EDS will install in the insurers' offices, Mr. Linderman said.

The system will produce three types of reports: activity reports, financial reports and cost containment/utilization review reports.

The activity reports simply monitor use of health care, providing statistics such as number of claims processed and number of claims paid per insurer.

The financial reports will detail the cost of GM's various health care programs, broken down by several factors, including insurer, plant and geographic region.

The cost containment/utilization review reports are what Mr. Linderman calls "the medical science analysis side of things," and what GM is most interested in.



"The information will be used to refine the benefits and find the most cost-effective programs," he said.

"There's a massive amount of information you can retrieve from the system," according to Mr. Linderman. However, what GM pulls from the system and how it manipulates that information will be up to the company.

"GM ought to be able to manage its benefit program the same way it manages the manufacture of its cars," Mr. Linderman said. "In this day and age, it's ridiculous not to have management control over a program like this."

According to Mr. Linderman, the system will provide almost infinite information on the health care plans themselves, the providers and the insurers.

In the health care plan area, GM will be able to find out what its various health care plans cost, which one is most efficient and which one is used most. All of this information can be broken down geographically, demographically and by company division. For example, in addition to determining if GM's preferred provider organization program is saving money, the system will show how much money is saved in which geograhic areas and among which group of employees.

The informational category on insurers will provide statistics on which insurers are receiving the most claims, how much individual insurers are paying in claims and what the average claim costs. Again, this information can be broken down by geographic, demographic and plan design specifications.

For example, GM can find out which divisions file the most claims and which employees in that division file the most costly claims.

In the provider category, GM can pinpoint the costliest providers, identify patterns of care among providers and determine how frequently various procedures are performed. Information also can be analyzed by geographic, demographic and plan design variables.

In addition to analyzing these three areas independently, GM also can do cross-analysis. It is this type of analysis that will provide specific answers to just about any question GM has about its health care costs.

"If I want to know the experience of a given provider in a certain part of the country for a certain diagnosis of a particular age group of employees of a particular sex—I would be able to find it," Mr. Linderman said. "The art to doing that type of analysis is completely possible today and that's where we're taking GM." ■

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Companies meet growing demand for data services

By DIANE LYNN KASTIEL

Responding to burgeoning demands from employers, many different groups—from special consulting firms to insurers—are providing data collection and analysis services

The range and extent of these services vary, however, as do their price tags.

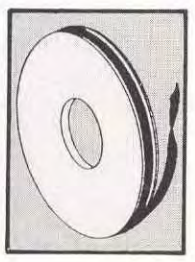
The following is a sampling of some of these companies and the services they offer. It is not intended as a complete guide, but only a representative sampling.

The most specialized providers in this field are being dubbed "health care data consultants" and they are springing up into a whole new industry.

Data Resources Inc., in Bethesda, Md., a division of McGraw-Hill Inc., has worked with companies such as Owens—Corning Fiberglas Corp. and North American Phillips.

DRI compares clients' health care data, which it receives from the clients' insurers or third-party administrators, to a data base developed from statistics from state data bases (see story, page 24) and the National Hospital Discharge Survey.

(The National Hospital Discharge Survey is a statistical sampling of between 400 and 500 hospitals throughout the country and comprises approximately 225,000 hospital admissions. It provides national and regional information on patients, diagnoses, lengths of stay, and sources of bill payment.



The survey is conducted annually by the National Center for Health Statistics, a division of the U.S. Department of Health and Human Services. It is available to anyone for $140.)

Once DRI has analyzed the data it recieves, clients are given information on their health care plans through periodic, written reports or through access to computers that are "on line" with DRI's computer system.

This "interactive" computer system allows clients to access information on their health care plan on an on-going basis.

"(The clients' computer) talks to our mainframe computer and they can do their own analysis," said Jerry Kaple, director of health cost management at DRI. "You don't need to know any programming to do this analysis."

The user-friendly software provides clients with a "menu" from which the client can select the information he or she wants.

"You can design your own reports," she said. "You can subset your data all the way down to a specific employee record."

Using this system, an employer can track information on the number of hospital admissions involving its employees in a given year, which diagnoses they included, the average length of a hospital stay, the average bill and hospital charges by diagnosis.

In addition, the employer can spot patterns of care among providers, including identifying procedures done on an inpatient basis which could have been done on an outpatient basis, and cost variations among providers.

The traditional, "hard copy" reports provide clients with the same information, but the on-going access to information that is possible through the computer link-up is eliminated. The hard-copy reports are supplied at whatever frequency the employer requests; most employers request quarterly reports, Ms. Kaple said.

In addition to collecting and analyzing data, DRI will recommend

Continued on page 18

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AND AFFILIATED COMPANIES

Data services

Continued from page 16
plan design modifications and even negotiate rates with providers. Usually, however, DRI works in conjunction with benefits consultants who handle these follow-up steps, Ms. Kaple said.

The cost of DRI's services is based on client size. An employer with 5,000 employees that only wants periodic reports, forgoing the computerized access system, could expect to spend $10,000 annually, Ms. Kaple said. A larger employer, such as a Fortune 500 company that has interactive computerized access, could spend up to $100,000 a year.

Health Data Institute Inc., in Newton, Mass., also collects information on employers' health care costs and utilization through insurers' or third-party administrators' claims reports.

The company's clients include Boise Cascade, Chase Manhattan Bank and Johnson & Johnson. HDI also acts as a "subcontractor" for insurers such as Allstate Life Insurance Co., John Hancock Mutual Life Insurance Co. and various Blue Cross plans, providing data analysis services for these insurers' policyholders.

HDI's data base consists of information supplied by corporations and insurers as well as statistics from state data bases. Altogether, the data base has information on about 50 million lives; however, all patient identifiers are coded and scrambled and proprietary information supplied employers and insurers is kept confidential

HDI's analysis begins with its MedLogic program, a series of computer programs that enable HDI to screen the data submitted by insurers, identifying faulty information that could distort the analysis.

Once the data is "cleansed," HDI's MedUse program analyzes it for cost and utilization patterns. Then, MedReports provides such things as trend analyses of health care costs and utilization, comparative analyses that highlight differences between the client's cost and utilization patterns and those of a comparable employee population and interpretative analyses that identify causes of wasteful utilization or inflated costs.

HDI's MedDisability, Appropriateness Evaluation Protocol (AEP) and Ancillary Services Review programs are optional additions to the MedUse program.

MedDisability incorporates disability claims information with health care data to provide a more complete picture of health-related costs and utilization. The Appropriateness Evaluation Protocol audits hospital charts to identify inappropriate admissions and care. The Ancillary Services Review program identifies inappropriate or unnecessary ancillary services.

HDI's MedBenefit program provides "benefit modeling" services, which use computers to simulate changes in a company's benefits program to see what effect the changes would have on the program's cost and utilization.

The costs of HDI's services range from $1 to $2.50 per employee, per year, depending on extent and range of services.

Health Research Institute in Walnut Creek, Calif., is a non-profit organization that offers data collection and analysis services. The institute uses its National Statistical Data Base, which it began building in 1981 and was up and running in late 1982, to compare employers' health care costs and utilization to national and regional norms.

The institute's data base is made up of cumulative informat.on from its more than 50 clients' claims data, which is gathered from the clients' insurers. These clients include Owens-Illinois Inc. and Hammermill Papers Group.

The institute supplies employers with both "input" reports and "output" reports. The input reports are generated after a computer "filters" the information from the employer's insurer and deletes inaccurate or incomplete information. These reports let an employer know what the final analysis will be based on, explained William E. Hembree, HRI director.

The output reports provide information on and analysis of the employers' health care costs and utilization. These 23 reports fall into five categories: benefits costs analyses, utilization analyses, administrative costs analyses, provider analyses and an executive summary.

The benefit costs analyses track the cost of the health care benefits themselves, including cost per em-

Continued on facing page

Firm offering COB program

A New Jersey company plans to help employers and insurers identify duplicate health care claims through a computer system that allows insurers to communicate with each other on suspect claims.

International Data Processing, a data processing and consulting company in Murray Hill, N.J., has developed a data base that computerizes coordination of benefits information.

According to Dominic Celentano, marketing communications vp, American businesses lost $32 billion in 1982 because of duplicate payments of health care claims. Insurers that subscribe to IDP's data base will be able to get COB information on any claim, using a terminal in the insurer's office.

So far, eight insurers have signed letters of intent to participate in the system. Mr. Celentano said he could not name these insurers, but added they are among the 15 largest group health insurers.

"(The network) will give them information not only on if there's a duplicate claim, but will also supply information on the claimants themselves—a claimant may have had a history of making duplicate claims," he said.

But the network preserves insurers' proprietary information on other aspects of their business, he added.

"(Insurers) can get information only on what they ask, not on the whole file. And they can only ask questions on duplicate coverage," he said.

Currently, insurers communicate with each other on coordination of benefits by mail. But, this method is slow.

"It takes, on the average, 63 days to settle a (duplicate) claim inquiry," Mr. Celentano said. "And with our system, it takes no more than six days."

IDP's system also will get information from non-subscribing insurers, by sending a subscribing insurer's inquiry to an electronic mailhouse. This mailhouse will send the inquiries to the non-subscribers, and information included in the non-subscriber's reply will be added to the data base.

Continued from facing page
ployee, cost per hospital confinement, cost per hospital day, etc.

The utilization analyses provide information on the average length of hospital stay, total hospital days used and number of employees admitted to the hospital.

Administrative costs analyses provide data on the administration of the plan. These reports could tell an employer if the cost of administering a cost-containment program is worth the savings the program realizes. It could also tell an employer if administrative costs are too high and how they compare with other plans' costs.

The provider analyses give specific information on provider practices and can tell the employer which providers are the most costly, which are most frequently used by employees and which procedures each provider performs most frequently.

The cost of the institute's services varies according to several factors, including the number of employees an organization has, the complexity of its data, whether the institute has had previous experience with the employers' insurers and the amount of time that must be spent on the project.

Based on these factors, an employer with 5,000 employees and a fairly uncomplicated project could expect to spend between $10,000 and $15,000 a year for the institute's services, Mr. Hembree said.

Health Systems International in New Haven, Conn., a computer software manufacturer specializing in health care, offers a Medical Claims Monitoring System (MCMS) that evaluates claims and determines what would be a fair amount to pay.

This determination is based on several factors, including the hospital's cost of labor and location; patient factors, such as age and diagnosis; and procedural factors, including a determination of necessity of procedures.

"The only time you have leverage is before you pay the bill," said Richard Averill, vice chairman. "So we developed a system that would answer the employers' question: 'What is this bill for? Should I pay it? What should I pay?'

"Most importantly, it enables the employer to say, 'This is what I'll pay you.' And when all is said and done, that's the only thing that will save money. That's what the Medicare system does. It determines what it's going to pay (through the use of diagnostic-related groups). And it's worked. And the corporate sector should follow that lead," he said.

HSI is able to determine equitable payment using data from the National Hospital Discharge Survey data base collected by the National Center for Health Statistics, revenue data from the American Hospital Assn. and government statistics on Medicare costs and usage.

Employers are connected to the claims monitoring system through computer terminals placed in their offices. To use the system, the employer enters a variety of information into the computer, including hospital charges, diagnosis, length of stay and procedures performed.

The computer responds with the amount the employer should pay on the claim and alerts the employer to any problems with the claim, such as a bill for a procedure that probably was not administered, considering the diagnosis.

Other programs employers can purchase include the Interactive Database Query software, which allows employers to get statistical profiles of claims. Using this program, an employer can ask the computer for the number of times a specific procedure was performed in a specific time period by a specific provider and what the average bill for this procedure was.

HSI's Standard Reports software provides employers with a series of reports that compare their utilization data on a particular hospital, physician or employee to that of a similar patient population.

HSI's MCMS, including supplementary reports, costs about $1 per year per employee.

Medstat Systems Inc. in Ann Arbor, Mich., whose clients include Federal Express Corp., the Ford Motor Co. and Levi Strauss & Co., offers data collection and analysis of both inpatient and outpatient services through an interactive computer system.

Medstat compares employers' utilization data to national norms using statistics from the National Hospital Discharge Survey and the collective claim experience of its clients.

Medstat specializes in providing on-line information to employers through computer terminals at the client's site. However, it also provides "off-line," or traditional, reports on health care costs and utilization.

Its Cost Management software tracks trends in an employer's health care costs and utilization, volume and costs of hospital services by diagnostic-related groups, provider practices and the health care costs and utilization for different geographic locations.

This software allows the user to manipulate his or her health care data to access an almost unlimited amount of statistical information. Benefit modeling also can be performed on the computer using this software.

In addition to accessing this information on-line, employers receive a quarterly package of control reports, which monitor important cost and utilization indicators and highlight problems that need investigation through the on-line system, and an account summary, a comprehensive analysis and review of the company's medical expenditures that identifies savings opportunities and makes recommendations for achieving those savings.

Medstat provides technical training to clients when they are tapped into the computer system and provides phone-in consulting services to help employers with technical problems as well as data interpretation and analysis.

The company also sponsors periodic user conferences which allow employers to communicate with each other and provide feedback to MedStat.

"The reason we have to have the regional user group every four months is the system is very dy-

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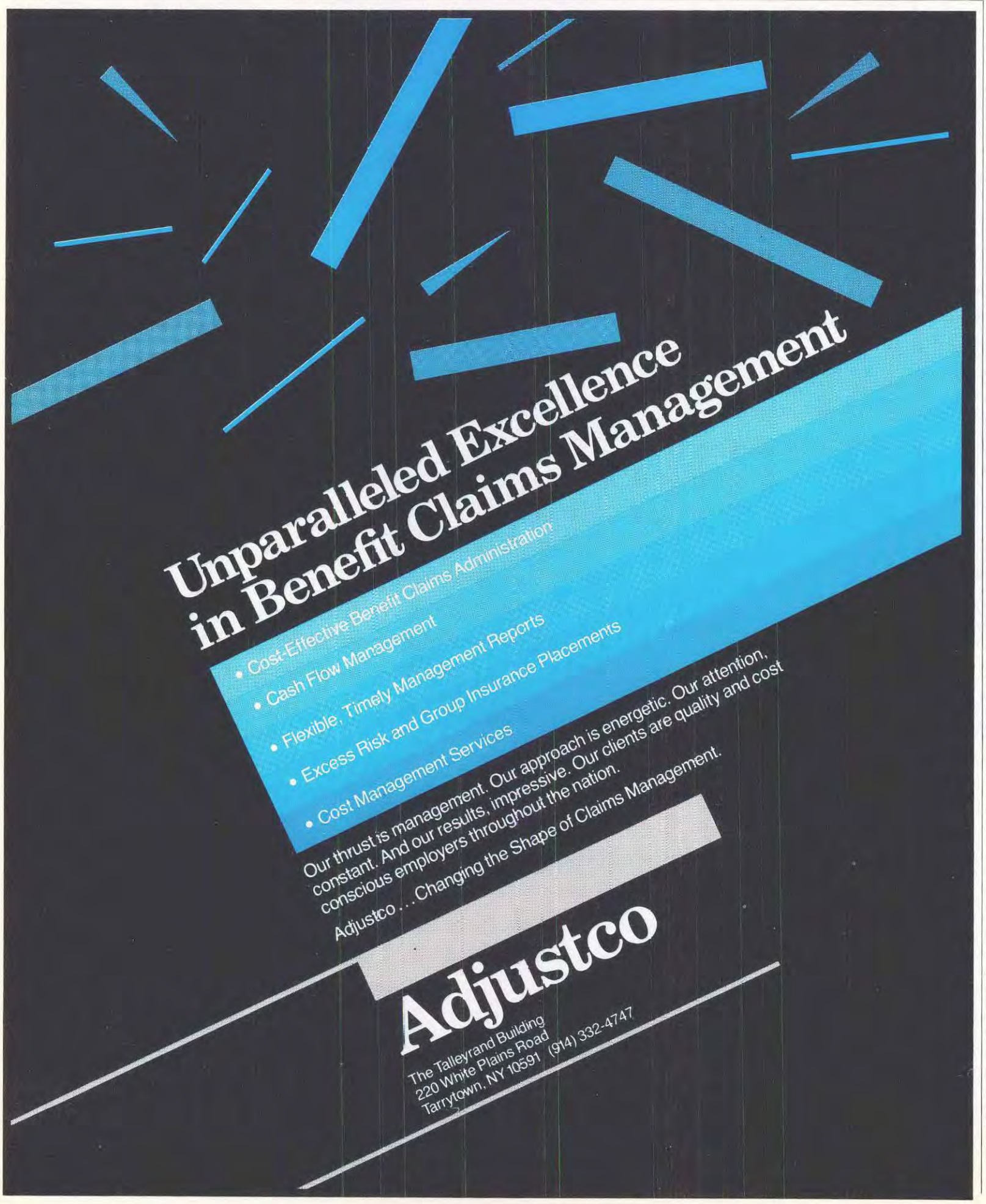

Data services

Continued from preceding page
namic," said Ernest Ludy, president. "We're on the fifth version of software since our prototype was built (in 198_)."

Many insurers and third-party administrators also offer data collection and analysis services to their clients. Some do this by "subcontracting" a health care data analysis specialty firm; others have developed their own programs.

Metropolitan Life Insurance Co. acquired Corporate Health Strategies Inc. in November 1983 as an independent subsidiary to provide health care data collection and analysis to its clients.

CHS compares employers' claims data to normative data from the National Center for Health Care Statistics and claims data from Metropolitan's book of business, which comprises 50 million health care claims and 1 million hospital admissions per year.

CHS uses this data base to compare things such as rates of hospital admissions, lengths of stay and charges for a particular patient group to the standard or norm for such a group. To make broad comparisons of these variables between hospitals, doctors or regional areas, CHS can make adjustments for patient mixes.

For example, in comparing frequency and efficiency of heart surgery among hospitals, CHS will make adjustments for hospitals that have a high number of heart surgery patients, perhaps because they are well known for successful heart surgeries.

Once these analyses and evaluations are made, Metropolitan's Medical Action Plan (MAP) program helps employers solve any problems that might have been uncovered. This involves community assessment and provider intervention.

The community assessment program looks at the breakdown of clinical specialists in an area; various characteristics of the local hospitals, such as bed capacity and occupancy rates; alternative health care facilities; and community efforts in the areas of utilization and cost containment.

MAP's intervention program involves direct discussion with health care providers. Metropolitan has a staff of health care professionals who conduct these discussions, which are aimed at achieving more efficient medical practices and lower costs.

Metropolitan also provides benefit plan consulting and will recommend plan design changes. And, through the use of benefit modeling, the insurer can show an employer the effect on costs and utilization of any proposed changes to its health care plan.

CIGNA Corp. has offered its Medical Management Information (MMI) program to its group clients since 1982. Like other insurers offering data analysis services, CIGNA's data base is the claims information from its health insurance business.

The program supplies Plan Cost Reports at no additional cost to CIGNA clients. These reports "identify where (the employers') money went," according to Chip Sharkey, vp of marketing. Specifically, the reports break down costs by diagnostic group and services rendered, such as office visits, lab tests, X-rays and emergency room treatment.

CIGNA provides additional analytical reports for a fee of $2,000 to $3,000 a year, depending on the size of the group and the number of reports requested. These supplemental reports come in a variety of formats.

Plan Costs Analysis reports tell the employer what portion of the total health care expenses employees are sharing through deductibles and coinsurance, how much is spent on inpatient services compared with outpatient services, and how the employer's health care expenses compare to what other companies spend and to regional and national norms.

Employee Health Status reports tell the employer which illnesses occur most frequently among employees, which illnesses are the most expensive to treat, if the conditions for which employees are being hospitalized really warrant confinement and how these variables compare with national and regional norms.

Provider Utilization Analysis reports tell the employer which facilities confine patients for longer or shorter periods than usual for specific diagnoses, which facilities provide a high or low number of ancillary services, which facilities admit patients earlier than necessary and how all these factors compare with regional and national norms. ■

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Coalitions' role

Continued from page 3

to put together a data base of information on health care costs and utilization in the state.

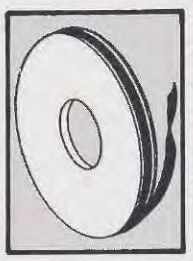
Currently, it's helping employers work with their insurers to get the necessary information.

"The insurers' data is woefully lacking in many elements," said Evan Schelin, assistant director of the coalition. "We're working with our members and the third-party payers they work with to get them to capture the necessary information on the claims forms."

"The employer has to act like a prudent buyer and right now employers have very litte information about the product they buy," said Mr. Schelin. "They don't have a good idea of how their employees use health care in response to community norms."

Because Utah uses health care conservatively, employers in the state need to compare their health care information to "localized" information rather than national norms, Mr. Schelin said.

"The reports will give the employer not only the pattern of use of his employees, but the pattern of practice of the providers his employees use," Mr. Schelin said.



Many coalitions are working directly with providers to put together price lists for their members and the local community.

The Kansas Employer Coalition on Health Inc. in Topeka, working with three local hospitals, published a price list in December that contains charges for the 25 most common diagnostic-related groups. It will be updated about every six months, said Werner Gliebe, the coalition's managing consultant.

Since the original list was published, another hospital has agreed to release prices to the coalition; those prices were published in the coalition's February newsletter.

Also, two other hospitals have made verbal commitments to provide pricing information and the coalition is negotiating similar agreements with eight others.

"Once it became apparent that other hospitals in the community were willing to do it, the domino theory took over," Mr. Gliebe said. He explained that the nonparticipating hospitals felt they would look bad if all the other hospitals did release prices to the coalition.

The Kansas coalition has found working directly with providers to be more beneficial than working through their members' insurers.

"The data is more accurate for the simple reason that the hospitals have to generate the data for the purpose of payment," Mr. Gliebe said, adding that Blue Cross and Blue Shield of Kansas pays hospitals prospectively through a DRG system.

It cost the coalition almost nothing to collect data from the providers. "The hospitals have given us the data voluntarily," Mr. Gliebe said. "It just costs us for printing and distribution and that's about it."

In July, Ohio's Coalition for Cost Effective Health Services in Columbus published a price comparison guide for 24 common diagnoses at 10 local hospitals. The guide, compiled with the cooperation of the hospitals and Blue Cross of Central Ohio, lists median charges based on actual billings, according to Charles A. Turner III, executive director of the coalition.

The coalition hopes to expand the list to include information on 50 Ohio hospitals, Mr. Turner said, adding that he expects hospitals will cooperate in helping the coalition reach its goal. "When you're being chased, it's sometimes wise to look like you're leading," he said.

Since the comparison guide was published in July, three hospitals have begun publishing guaranteed prices for some procedures, Mr. Turner added. Riverside Methodist Hospital in Columbus recently created a hotline that people could call to get average charges for a variety of diagnoses. "That number, I've been told, is very busy."

The Midwest Business Group on Health is encouraging its 150 member companies to press their health care insurers for reports on their health care costs and utilization.

"It takes a lot of time to really understand data and to analyze data," Mr. Mortimer said. "And getting that commitment of time on the part of the insurance carrier and the company is certainly one of the biggest challenges."

The Midwest coalition also is working with the Mayo Clinic in Rochester, Minn., to establish a data base for Olmsted County, Minn., employers. In its role as project facilitator, the coalition advises the clinic on the kinds of data employers should have access to and serves as a liaison between the clinic and participating employers, which include Honeywell Inc. in Minneapolis, Minn., and Deere & Co. in Moline, Ill.

The Minnesota Coalition on Health Care Costs is working with Health Data Institute in Newton, Mass., on a project to compare and analyze hospital costs throughout the state. Using data collected by the Foundation for Health Care Evaluation, a peer review organization, the coalition compared hospital costs for 30 companies with over 25,000 hospital admissions, according to Joan Pearson, chairman of the coalition's health care management information subcommittee.

The Minnesota coalition is planning to sponsor a seminar by the end of April, which will be open to the public, to discuss the findings of the project and its first report. The coalition also will distribute a hospital cost guide at the seminar, which will include information on quality and accessibility of care among providers.

The New Jersey Business Group on Health has been collecting health care data for over a year, trying to find out if the state's DRG-based hospital reimbursement system is saving employers money. According to Alison Alkire, coalition president, the first report is due by the end of the summer.

"We want it to contain information that will enable us to sit down with the hospital associations and insurers and discuss problems from a well-informed position," Ms. Alkire said. "Right now, we don't know enough about the system to say, 'Look, this is a problem,' and work with them on solutions. It's of some value to have a price list, but it's of more value if you can get some information on what kind of costs might come up in the future."

The coalition is gathering its information from insurers in the state, including Aetna Life Insurance Co., the Prudential Insurance Co. of America, the Travelers Insurance Co. and CIGNA Corp. and Blue Cross of New Jersey.

The New Jersey coalition hopes its "system specific" approach—looking at a health care delivery system rather than the experience of an individual company—will ultimately benefit any company by providing information on the system with which it must work.

"If you want to look at the cost of health care from a responsible corporate position, you can't just look at your own bottom line," Ms. Alkire said.

"Because the shift is going to happen somewhere. The system will make up your savings by shifting it to other employers." ■

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States developing data bases to track health care patterns

By JULIE TRUCK

More and more states are developing health care data bases to monitor health care costs and utilization patterns.

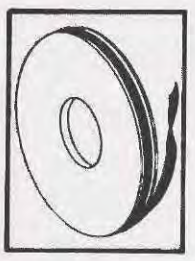
While data bases have existed for several years in states that regulate hospital prices, at least seven states are currently taking steps to develop data bases with an eye more toward cost containment than regulation.

Giving employers and individuals access to health care utilization information could spur competition among providers, resulting in lower costs, data base developers say.

And, the data bases also allow employers to compare themselves with similar companies around the state and determine where health care budgets can be trimmed, they add.

"There's always been a handful of states that have had it (a data base)," said Joseph Davis, health care consultant to Ohio Gov. Richard Celeste.

"States are beginning to respond to the community, (by legislatively mandating the data bases)," Mr. Davis said. However, "whether this will work or not remains to be seen," he added.



In Colorado, H.B. 1034 was introduced in January to create a Health Data Commission within the state's Department of Health.

The commission would compile and distribute health care cost data collected from state agencies, health care providers and third-party payers, such as insurers, said the bill's sponsor, Rep. Ronald Strahle, D-Fort Collins.

The bill, if passed, would also mandate a uniform billing system by third-party payers, hospitals and physicians by July 1, 1986, Rep. Strahle added.

Patient diagnoses, care, and cost information contained in the data bases would be available to employers, as well as members of the general public, he added.

In North Carolina, members of the Medical Cost Containment Commission have developed a draft proposal that will hopefully be introduced in the Legislature within a month, said Sandra Greene, senior director of health, economic research of Blue Cross, Blue Shield of North Carolina.

The draft calls for creation of a data base commission composed of state-appointed members, with "the primary focus to provide utilization and cost data to employers," she added.

Data for in patient admissions, including utilization patterns and cost data, would be collected on a uniform billing form, Ms. Greene said.

Data on out patient admissions, emergency centers and physician data would be collected next, she added.

The creation of a state-wide data base also will be considered by the Ohio Legislature this year.

A draft proposal will be introduced within the month, said an aide to Rep. Ray Miller, D-Columbus, the bill's sponsor.

If passed, the bill will mandate a standard billing form to be used for collecting hospital discharge data, she added.

Cost information for basic hospital services and procedures would also be available to the public and employers, she said. "Our idea was to provide (a service) for those without insurance so they would have an idea of their costs before going into the hospital," she said.

In Nebraska, legislation S.B. 382 would mandate the use of a uniform billing form by Jan. 1, 1987, and the collection of the resulting

Continued on page 26

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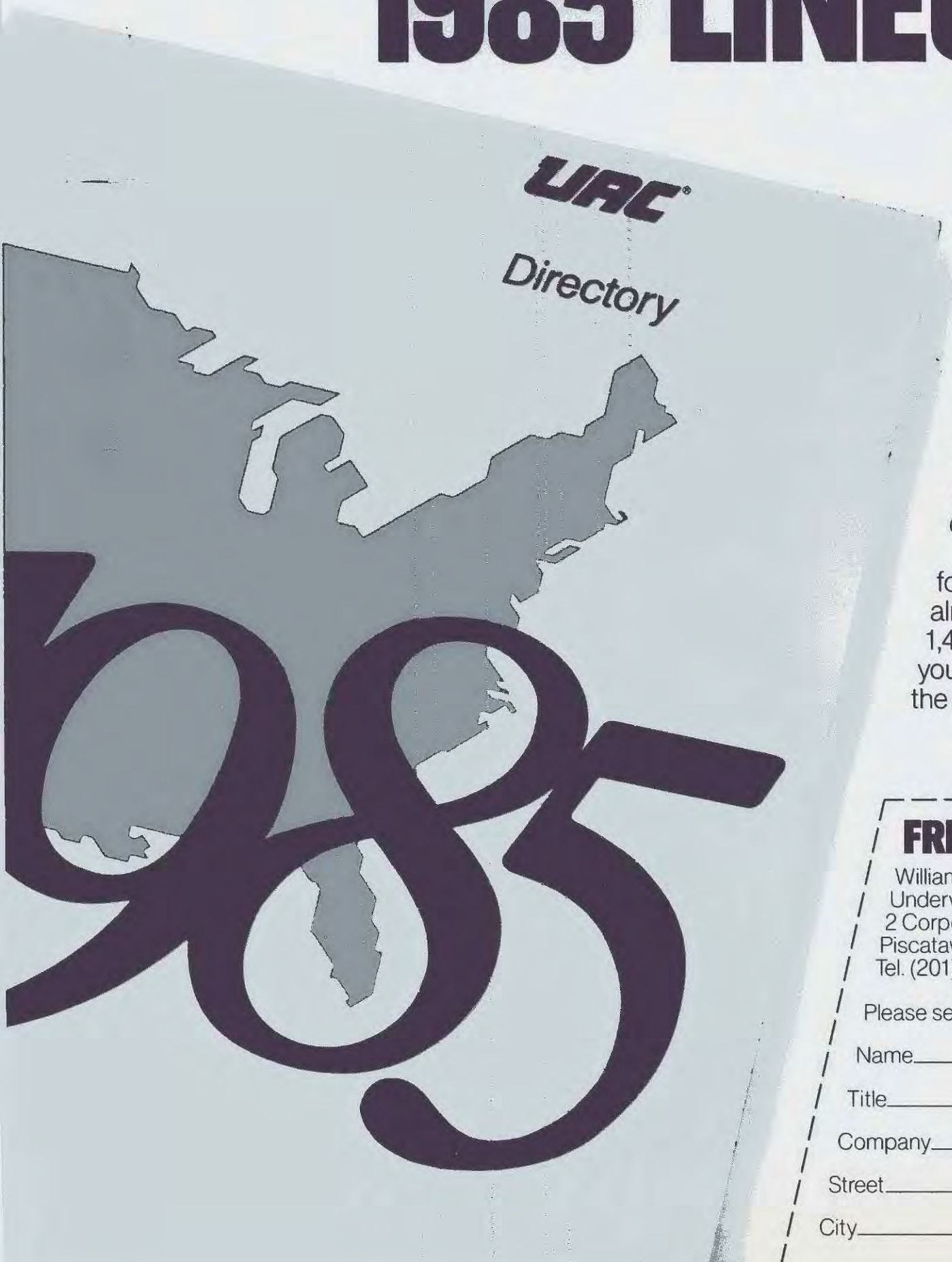

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State data bases

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data from all hospitals with more than 100 licensed beds, said Dennis Martin, counsel for the Public Health and Welfare Committee for the Nebraska State Senate.

Provisions in the bill also call for the collection of information to develop charge and utilization data for provider comparison.

)The state's Department of Health would oversee the data base and have authority to enforce use of the standard billing form and hospital release of data, he said.

In New Hampshire, H.B. 476 calls for a state-wide data base to gather information from acute care hospitals and nursing homes by using a uniform billing form to be determined by the commissioner of Health and Human Services, said Rep. Sara Townsend, R-Sullivan, the bill's sponsor.

Data collected will include hospitals' financial information, such as operating costs, liabilities, number of hourly and salaried workers, and patient information on diagnoses, lengths of stay, operative procedures, age and sex.

The information would be available to employers, as well as members of the general public, for a fee yet to be determined, she said.

The Virginia General Assembly has enacted a law commissioning a special study by the state's Department of Health in conjunction with three other state agencies.

The study would address the feasibility of creating a statewide data base along with an examination of the possible organizational structures of the data base; the methods of governance; its scope of service; means for revenue or expenses; patient confidentiality and the means of compiling the data.

This study is designed to supplement information contained in an earlier, less definitive study by the Department of Health, said Samuel Clement, director of the Division of Health Planning in the Virginia Department of Health.

The report will be issued to the Legislature by June, he added.

In Wyoming, the governor this month signed S.B. 92, which creates the Health Care Data Authority within the agency of Health Planning and Development.

Scheduled to begin operations in May, the authority will collect data from health care facilities, such as hospitals, health maintenance organizations and nursing homes, insurers or other appropriate sources, said Lawrence Cohen, administrator, Division of Health and Medical Services, Department of Health and Social Services.

The law requires the authority to present an annual report to the state Legislature on utilization patterns, new medical services, comparative information on average charge for service, including length of stay, number of discharges and charges for ancillary services—which include blood tests, X-rays, or transfusions.

Hospital financial disclosures of assets, liabilities, employee wage and salary information, rates, charges and medical malpractice claims and costs will also be available, he said. Reports will be available to employers and the public.

A common tool used by the states to gather health care data is the UB-82 form, a uniform hospital billing form developed for national use in 1982 by the U.S. Health Care Financing Administration under the guidance of the National Uniform Billing Committee.

The committee consisted of representatives of HCFA, Blue Cross/Blue Shield Assn., Health Insurance Assn. of America, Office of Civilian Health and Medical Programs of the Uniformed Services, Federation of American Hospitals, American Hospital Assn. and various state hospital associations.

The form includes data on patient characteristics and conditions, diagnoses, operative procedure and discharge status.

The form also provides a financial services section listing total charges and a breakdown of each service to the patient and its cost.

In 1984, the Illinois Legislature enacted a law establishing the Illinois Health Care Cost Containment Council consisting of 11 representatives from the health care, consumer, insurer and employer communities.

Under that law, Illinois hospitals were required to convert to the UB-82 by Jan. 1 of this year, said Steven King, vice president of provider affairs for the Midwest Business Group on Health, a regional coalition of business and public employers based in Chicago.

The council also has been given the authority by the Legislature to enforce the ruling, he said.

By using hospital in-patient data on a patient's age, sex, diagnoses, length of stay and procedure provided by the billing form..."we can create a profile of any given hospital in the area," he noted.

A free, quarterly report will be issued by the council beginning in October that will detail cost analyses and trends in Illinois' some 250 acute-care hospitals, he said.

For example, financial information on the hospital's charges, patient diagnoses and procedures for a given hospital could be compared and contrasted with other area hospitals, he said.

Special reports for businesses or health care organizations could also be compiled for a fee, he added.

Iowa's Health Data Commission, established by the Iowa Legislature in 1983, was created to provide information on physician and hospital costs to the public and employers, said Michael Reagen, chairman of the commission and state commissioner of human services.

Hospitals and insurers must release the information contained on the UB-82 form to the commission for compilation, he said.

"With detailed information, people...will become more cost conscious, providers more cost conscious in looking at different practices and payers more thoughtful in putting (health insurance) plans together," he said.

Previous reports focused on health care costs, but the commission is looking at generating utilization information, Mr. Reagen said.

Hospital and physician pricing data will be available to compare local areas, he added.

Reports which are published about every three months, are free.

While some states are just in the

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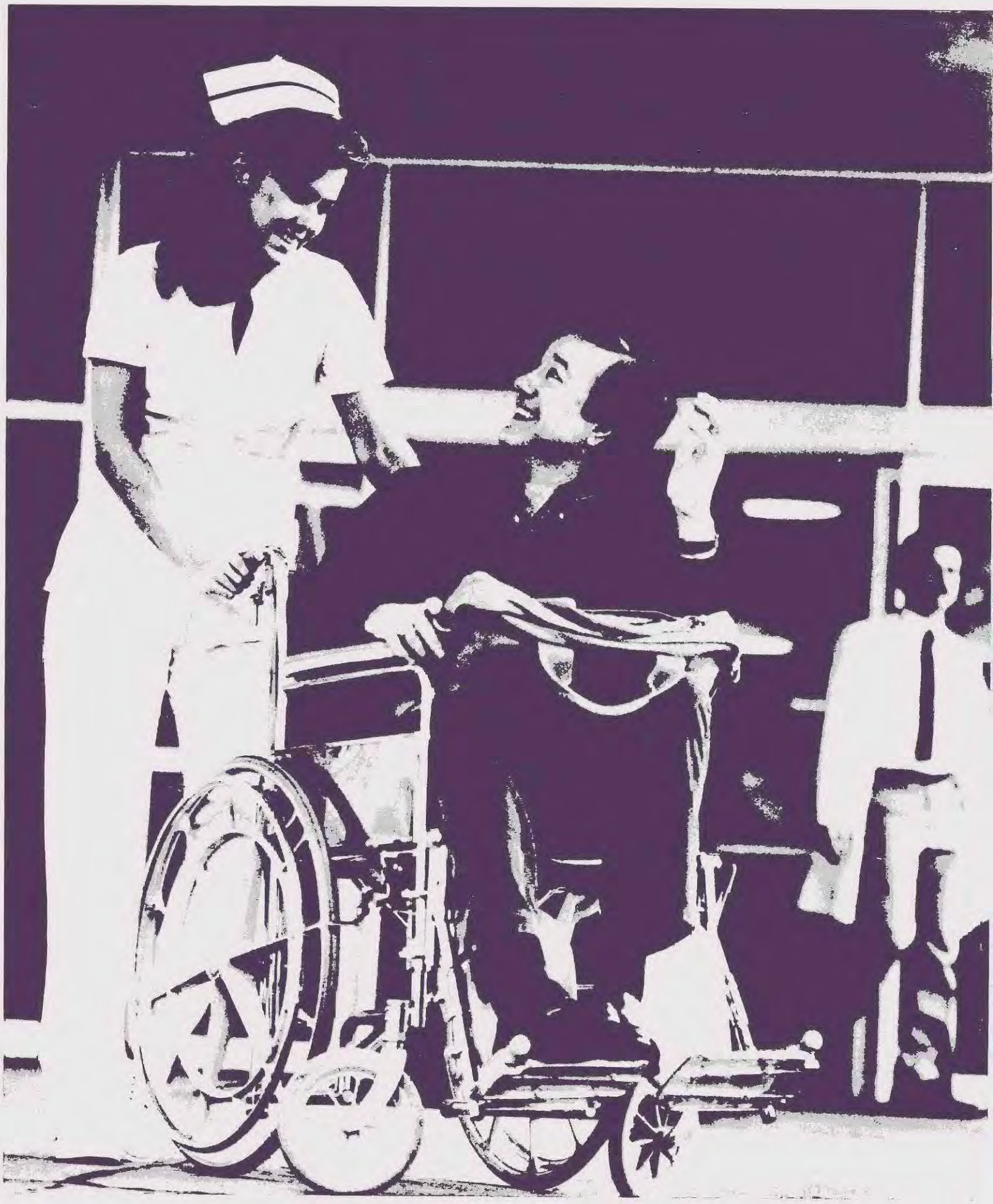

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process of establishing data bases, others—mainly those that regulate hospital prices—have had data bases in place for several years.

Since its inception in 1973, the mission of the California Health Facility Commission, an independent data collection agency, has been to develop uniform reporting systems for financial and utilization statistics from California's 553 hospitals, said Lucy Johns, an independent consultant for health care planning and policy.

Financial data, detailing gross and net hospital revenues, total hospital costs and costs by departments, are obtained from a uniform data collection form. Cost per discharge and per patient also are available.

Hospitals are required to report to the commission both quarterly and annually, and the data is compiled into reports that are available for a nominal charge, Ms. Johns said. However, California does not regulate hospital prices.

In 1984, the sunset provision under which the commission was formed expired. But, its duties will be assumed by the Office of State Wide Health Planning and Development.

The Florida Hospital Cost Containment Board, established in 1979, was given the authority in 1984 by the state Legislature to function as a hospital rate-setting and review board.

The commission collects and reports on financial data of hospitals, including gross and net revenues, expenses, wage and salary information and other hospital expenses collected from some 250 state and acute-care hospitals, said Lester Abberger, deputy director.

Using the UB-82, the commission also collects and reports on patient information taken from the form.

Comparative charge reports list the costs for 11 hospital services, Mr. Abberger said.

Maine's Health Information Center, formed in 1976 as a non-profit data collection center, is directed by a board drawn from state health care agencies and providers, said President Alice Russell.

In 1979, the Legislature required all hospitals to report patient discharge data to the group, she said. All such data is available to the public, if it does not identify the patient, she noted.

Data compiled by the association is released to the Health Care Finance Commission, the hospital regulating board, she said.

In compiling the hospital's data, the center can analyze length of stay, diagnoses, procedure, ancillary services and doctors' fees.

Association reports are available on a fee-for-service basis.

Maryland's Health Services Cost Review Commission has required hospitals to submit specified data on discharge patients since 1977, said Arlene Stephenson, research statistician for the commission.

Using a billing format similar to the UB-82, the data is compiled from the state's 55 hospitals and is comprised of both financial information detailing a hospital's cost categories and patient information.

The data base produces both standard and specialized reports for sale to hospitals, business coalitions or other interested parties, she said.

Massachusetts' Health Data Consortium, a private non-profit association formed in July 1978, collects patient discharge data from about 115 state-regulated acute-care hospitals, said Deborah D'Arpa, research associate for the consortium.

Using a form similar to the UB-82, information collected is also submitted to the Massachusetts Rate Setting Commission, the hospital regulating state agency.

Hospital financial data, plus patient discharge data, is compiled.

Reports are generated from each hospital's fiscal year data and can be used to issue reports on a hospital's market share, patient diagnoses, patient origin and demographics or length of stay.

In New York, the state's Department of Health established the Statewide Planning And Research Cooperative System (SPARCS) in 1979 to collect hospital inpatient data from insurers and the 285 hospitals, which are state-regulated, said James O'Meara, director of the SPARCS bureau.

Cost information from the uniform billing form used by SPARCS and a common discharge data abstract generate the information used in preparing the SPARCS reports, available to employers and the public at a nominal price, he said.

Reports could be categorized by hospital or region and would include average ancillary charges, length of stay, amount billed, patient diagnoses and procedures.

In 1976, the Washington State Hospital Commission, the state hospital regulating agency, began compiling a financial data base of hospital operating budgets and costs by department from the UB-82, said Mary Bensen, deputy director.

The commission is creating a data base of patient data it began collecting in July 1984. Included in the data will be patient diagnoses, discharge information and procedures, she said. Patient information reports should be available by July.

In addition, the commission publishes a price report detailing the average cost of acute care, an hour of operating room time for each of the hospitals, the average cost per stay and the average cost per in-patient stay, she said.

Copies of the reports are available for the cost of the computer processing time, she added. ■

Unions open to cost control, but most reject cost shifting

By MICHAEL BRADFORD

Labor unions approaching the bargaining table this year say they won't accept contract provisions that shift health costs to their members, but they are prepared to accept health care "cost-management" alternatives.

In their efforts to block cost-shifting measures like higher health plan deductibles and larger copayments, unions are negotiating health benefit packages that call for increased access to health maintenance organizations and preferred provider organizations and a host of cost-containment techniques like pre-admission certification and mandatory second surgical opinions.

"To control rising costs without reducing hard-won benefits or endangering jobs, unions are modifying negotiations," explains a spokesman for the AFL-CIO in Washington. "We are seeking benefit plans that reduce costs without eroding benefits.

"Our highest priority is to keep quality medical care that workers can afford," the spokesman says. "Because health care costs are going up, if the boss says, 'You have to pay more (through co-payments or deductibles),' that is an income loss."

The AFL-CIO—the nation's largest labor organization—has issued a formal statement opposing cost shifting and urging its state and local chapters and 96 union affiliates to incorporate cost-containment programs to help control rising health care costs.

The statement asks the affiliates to seek health care programs that require mandatory second surgical opinions, outpatient testing, pre-admission hospital reviews and other "cost-effective utilization techniques."

Observers agree that unions will enter negotiations during 1985 armed with more studies, proposals and an open attitude toward programs that control health care costs while offering workers affordable quality benefits.

"For the first time, unions are starting to talk about controlling health care costs," says Kathleen Daley, assistant director of marketing at CIGNA Corp.

"They are finally in the same ball park as management. The economic realities are facing the unions as well as everyone else and the unions are finally making sounds about cost containment," she says.

"Unions can't walk in and demand first-dollar coverage anymore," adds Dick Seiden, a senior vp for Frank B. Hall Consulting Co. in Hawthorne, N.Y. "They can't argue that health care benefits aren't costing the employer anything anymore."

Mr. Seiden explains "there is a general softening among the unions on health care issues because the general public is more aware that health care costs are out of control," although he admits "it varies from union to union and industry to industry.

"Unions are more receptive to bargaining with their first-dollar coverage," he adds.

Declining union strength and membership has also put labor leaders in weaker bargaining positions, Mr. Seiden says.

Anthony Gajda, a consultant with William M. Mercer-Meidinger Inc. in New York, adds: "Most firms have become aware of the need to address rising costs. How they go about it varies. Some will try to implement straight cost-shifting, others cost-management and some will try a combination of the two.

"But it's difficult to bargain cost-shifting," Mr. Gajda notes. "If cost-management is available, that's the way the union is going to go."

Benefit consultants and others who monitor negotiations between unions and management also point to trends that could affect the way health care benefits are structured during this year's bargaining. Those trends include:

- Unions doing more homework on health care issues. Labor leaders are becoming more educated about the cost of health care benefits, and this increased awareness of employers' costs has spurred them to design their own alternatives to employers cost-shifting proposals well before they begin formal contract talks.

In fact, a spokesman for the International Brotherhood of Electrical Workers in Washington said the union even likes to do some "pre-negotiation" negotiating. "We're usually more successful if we can get to them before we sit down at the bargaining table."

- Higher deductibles and larger copayments remaining unpopular among unions and only being accepted by labor when other cost-management techniques cannot be

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Union contracts

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implemented.

"They would still like to keep the first-dollar coverages," says CIGNA's Ms. Daley. "And what they view worse than copayments is a deductible."

- Labor and management forming more joint committees to identify and control areas that contribute to high health care costs.

For example, Ford Motor Co. and the United Auto Workers have formed a committee that monitors employees' medical, surgical and laboratory procedures.

- Labor accepting programs that were developed for salaried and non-union employees rather than the traditional development of benefit programs for union members that are later given to other workers.

"It used to be that unions ran benefit programs," says Ms. Daley. "Now it seems changes are made in programs for salaried workers and the unions follow."

Hall's Mr. Seiden notes: "The corporate environment has moved significantly away from first-dollar coverage for non-union members. It is going to be a natural evolution to turn to the same thing for union employees."

Recent negotiations between the nation's two largest automakers and the United Auto Workers union are good examples of how labor is helping to institute benefit cost management ideas without accepting health cost shifting.

Later this year, for instance, Ford—which negotiated a new contract with the UAW last fall—will for the first time begin offering preferred provider organizations to its hourly workers. Salaried workers were given the option of using preferred providers on March 1.

While it was rumored last year the Dearborn, Mich.-based automaker would go to the bargaining table to seek higher health care deductibles and copayments for workers, a spokeswoman at the company's Detroit office said the agreements with the union "maintained or improved all current benefits."

Only the deductible for prescription drugs was raised, from $3 to $5, she said.

There's good reason why Ford is working hard to control its health care costs. The company's total health care bill rose to $742 million in 1983, an increase from $550 million in 1980.

Ford estimates health care costs added $300 to the cost of producing a vehicle in 1984, compared with $292 per vehicle in 1983 and only $119 per vehicle in 1975.

Ford has offered some cost-containment programs to salaried workers—like HMO options—for several years, the company spokeswoman says, but now the No. 2 automaker is launching other "pilot programs" aimed at reducing health care costs.

A rehabilitation program for cardiac patients will be evaluated and continued if it proves to be effective in cutting costs, she noted. Mandatory second surgical opinions for non-emergency surgery are now required of hourly workers in all Ford locations, and hospice programs are being introduced in some areas.

Female employees at Ford who take time off from their jobs to have children will find a reduction in maternity days allowed this year.

Ford is also sponsoring educational programs that will explain the benefits of using HMOs and PPOs and outline changes that pertain to payment of Medicare benefits.

"The UAW has been very involved in its efforts to contain health care costs," said another Ford official. "They've been helpful in developing these pilot programs."

In addition to these program, Ford also is using the the services of Medstat, an Ann Arbor, Mich., firm that gathers data to identify trends in health care costs. The information will provide management with an idea of how health care providers perform and whether some procedures, tests, prescriptions or other services might be unneccesary or overpriced.

The largest of the Big Three automakers, General Motors Corp. in Detroit, and the UAW jointly established a goal during last fall's contract negotiations to reduce the company's annual health care bill of $2.2 billion by 10%.

The plan is now in the "implementation stage" according to a GM spokesman, and although results won't be noticeable until at-

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Union contracts

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least a year from now, union and labor officials are optimistic that the cost-cutting measures will be effective.

Union workers at GM have the option of choosing to participate in a health maintenance organization, preferred provider organization or a traditional insurance plan that includes utilization review and precertification features.

The company offers more than 100 HMOs to its 350,000 UAW members, and about 55,000 workers and dependents are enrolled in the plans. Using HMOs saved the automaker an estimated $20 million in 1983, GM has reported (*BI*, Aug. 27, 1984).

Officials at Chrysler Corp., whose contract with the UAW expires in October, would not elaborate on the company's health care benefits except to say that workers are offered HMO alternatives and indemnity coverage is available through Blue Cross/Blue Shield.

Besides the UAW, other unions also say they are willing to work with employers to help contain health costs.

A spokesman for the International Brotherhood of Electrical Workers, which will negotiate contracts later this year with RCA Corp., General Electric Co., Westinghouse Electric Corp. and American Telephone & Telegraph Co., said the union "actively supports cost-containment measures and actively opposes cost-shifting measures."

"Cost-shifting doesn't get at the problem of escalating costs," the spokesman says.

"If you shift costs now and costs continue to go up, you just have to shift them again.

"Cost containment gives better quality health care by eliminating things like a lot of unnecessary surgery and cutting down on the number of days patients spend in the hospital."

The IBEW notes that it already has joined forces with some employers to keep the lid on health costs.

The IBEW helped form the Health Care Cost Control Committee with AT&T management two years ago to research ideas for containing costs, said the union spokesman. The group has been active since the January 1984 divestiture of the communications giant.

Although figures aren't available to measure the progress of the committee, the IBEW indicated "progress is being made in controlling costs."

Doug Kuhn, associate director of research for the International Assn. of Machinists and Aerospace Workers in Washington, said his union is encouraging employers to utilize PPOs.

"A lot of employers are big enough to do that at the drop of a hat," he said, although he admits the concept of PPOs is meeting resistance from workers.

"A lot of people have the notion that if they are going to have an operation, they feel more confident with their own doctor." And, many mothers balk at PPOs because of the relationships their children have developed with family physicians, said Mr. Kuhn.

Part of the Machinists union's three-year agreement reached last summer with Cessna Aircraft Co. of Wichita, Kan., allows the company to investigate the use of PPO plans for its 8,800 employees nationwide.

Before the new labor agreement was signed, Cessna offered workers an indemnity health plan underwritten by Aetna Life & Casualty Co. or the option of enrolling in an HMO.

The new contract contains a number of other cost-containment provisions aimed at keeping Cessna's health care costs lower than last year's $13.5 million expenditure and employees' contributions to health care under the indemnity plan to no more than the current $4.75 per month for individuals and $10 for workers with dependents.

Fred Bright, Cessna's manager of management resources, said that because of the company's poor performance last year, workers were not granted wage increases in the new agreement. But for the next two years, employees are eligible for annual bonuses of 1.5% of each year's base pay.

In exchange, the aircraft manufacturer agreed to some changes and expansions in health care benefits for workers, Mr. Bright explained.

One unique addition to the Cessna plan is an incentive for employees to audit their own hospital bills.

Mr. Bright explained that if an employee finds overcharges in the bill, Cessna will share 50% of the savings with the worker. An employee may receive as much as $500 under the plan.

Cessna's indemnity plan includes a $100 annual deductible per family member or $200 for an entire family. Workers pay 20% of medical costs until out-of-pocket expenses reach $1,000. At that point, expenses are fully covered up to the $250,000 lifetime limit.

The Cessna agreement also contains several "conditional benefits," he said.

For example, the company pays the cost of second surgical opinions, and if non-emergency surgery is performed without a second opinion, only 50% of cost will be reimbursed by the health plan.

The Cessna plan will also pay only half of hospital services performed when there is no pre-admission testing, and if an operation is performed in a hospital when it could have been done on an outpatient basis, the coverage will pick up only 25% of the cost of the procedure.

Because of employee abuse in the use of emergency room services, a $25 payment is required of Cessna workers when they use such services. The fee is not required in injury cases or if the employee is admitted into the hospital for treatment after the emergency room visit.

Negotiations with unions on health care issues are becoming easier, said Mr. Bright, because "union leadership in general is realizing the country has a serious health care cost problem."

The 350,000-member American Federation of State, County and Municipal Employees is also focusing on benefit issues even though "uncertainty is the name of the game right now," says Linda Lampkin, the union's research director.

"It is difficult to negotiate wage increases because the federal budget will impact state budgets," she explains. "No one knows yet what money will be there."

The union did reach an agreement with the state of Iowa in late February that calls for the state to pick up any increases in health care costs over the next two years.

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Workers were also granted a modest pay increase of 1% for the first year of the agreement and 4% for the following year.

Two years ago, Iowa AFSCME members agreed to a wage freeze in exchange for a promise that no employee contributions toward the workers' health plan would be required for individual coverage and that they'd remain at $60 per month for family coverage.

The state's health insurance plan is self-insured and administered by Blue Cross/Blue Shield of Iowa.

AFSCME's agreement with Iowa employers also calls for cost-containment measures like mandatory pre-admission testing, restrictions on weekend admissions for surgery to be performed the following week, utilization reviews and hospice coverages.

When negotiating cost-containment measures, AFSCME considers the needs of workers in each location, according to Ms. Lampkin. For example, "Because much of Iowa is rural, HMOs are not very popular," she explains. "But the majority of our members in Minnesota and Wisconsin use HMOs. In those areas, we make sure competition exists between the HMOs so rates will stay low."

AFSCME has also established joint cost-containment committees with employer agencies in Pennsylvania and Michigan, and is preparing to set up others in Indiana and the District of Columbia.

"We're trying to show employers that shifting costs doesn't help, it's only a short-term solution. We are concentrating on showing them plan redesign."

The Pennsylvania AFL-CIO is preparing to submit a proposal to state legislators that would ensure that the state's health care providers emphasize prevention, early detection and the development of preferred provider networks.

The Pennsylvania AFL-CIO Health Care Cost Containment Program encourages the development of programs such as ambulatory surgery, home health care, nursing home care and hospice care. The proposal seeks legislation to require hospitals to offer "a full range of outpatient services."

If the program is instituted, the state AFL-CIO predicts health insurance premiums for workers in Pennsylvania could be lowered 26.9%.

"Instead of cost shifting, let's find the leaks and fix them," said Robert T. McIntyre, executive vp of the Pennsylvania AFL-CIO. "Once the proposal is introduced, we'll find out where the opposition is. There's something in there that cuts at everybody, but a lot of people are going to have to sacrifice to stop the hemorrhage."

One union, the Amalgamated Clothing and Textile Workers Union, is taking cost-containment one step further than many other labor organizations. The union's department of occupational health and safety is attempting to shift some of the cost of employee health care onto the workers compensation system.

Eric Fromme, the department's director, said his group's efforts focus on identifying work-related illnesses and injuries among clothing and textile workers that have traditionally not been recognized as work-related.

"Once some of these serious illnesses are recognized under the workers comp system that transfers some of the cost from health care to workers comp," Mr. Fromme said. "And it also aids in prevention."

The union has identified certain disorders like tendonitis and muscular ailments as work-related, he said, and workers are being trained to avoid them by changing work habits. Preventing the disorders from occurring produces further health care cost savings, he adds.

The union's occupational health and safety department also provides cancer-screening services that has saved employers "phenomenal amounts of money," Mr. Fromme said.

The ACTWU will be negotiating new contracts for 60,000 members of the Clothing Manufacturers Assn. of the USA in May and 12,000 workers belonging to the Men's and Boys' Outerwear Manufacturers will reach the bargaining table in October. ■

Cutting retirees' health benefits is risky

By JUDY GREENWALD

Employers that want to clamp down on the cost of their retirees' health care benefits are finding it can be a risky endeavor. And, how successful they are might well hinge on how good they are as communicators.

If medical benefits were promised to retirees over the course of their employment, employers may not be able to take them away now, no matter how expensive they are.

And, if the employers try, they may well be sued by disgruntled retirees.

Despite this threat, some employers with large numbers of retirees with lucrative post-retirement benefit plans are still forging ahead with cost-containment plans. And, consultants are helping them carefully plot their moves.

Other employers, however, are accepting the fact that they can't break the promises they made to current retirees, either verbally or in plan documents, and are focusing instead on getting costs under control now for future retirees.

The issue of controlling retirees' benefits costs—and the role that communication of benefits can play in it—were brought home last year when a dispute between Bethlehem Steel Corp. and 18,000 non-union retirees over benefit reductions was decided in the retirees' favor.

In that case, U.S. District Court Judge John T. Elfvin ruled in September that Bethlehem did not have a right to reduce retirees' benefits because the steel company had not reserved the right to do so (*BI*, Oct. 1, 1984).

Regardless of what company plan documents said, retiring employees were clearly told that they were entitled to their benefits for life, and many of the booklets distributed to them did not indicate otherwise, the judge said.

'I don't think there's any magic elixir' to help avoid a court battle over cuts in benefits for employees, says Albert Cole Jr., director of group consulting at Buck Consultants Inc., headquartered in New York.

And, the language of the plan documents themselves was ambiguous and subject to different interpretations, he added.

As a result, Judge Elfvin ordered Bethlehem to restore first-dollar medicalcoverage for the retirees, canceling the premium contributions, deductibles and co-insurance provisions the steelmaker had introduced.

Bethlehem appealed the decision and ultimately reached a settlement with the retirees. It had hoped to save about $6 million by cutting the benefits, one source said.

Employers' concerns that their hands could well be tied when it comes to cutting retirees' health care benefits were further heightened when another U.S. District Court judge ruled that employees have a *vested* right to continued medical coverage—despite how well a company might communicate its right to cutback or terminate those plans (*BI*, Oct. 29, 1984).

In the decision involving White Farm Equipment Co. and 700 non-union employees, Judge Ann Aldrich ruled that the Employee Retirement Income Security Act, which protects workers' and retirees' pension benefits, also gives courts the authority to fashion common law to protect retirees' welfare benefits.

White Farm, which had filed for bankruptcy, stopped all retiree medical, life and prescription drug coverage, but Judge Aldrich ruled the retirees had earned those benefits in the same manner they had earned or vested in their pension benefits.

White Farm is appealing Judge Aldrich's order that benefits be restored retroactively, despite the fact that the company had reserved the right to change or discontinue benefits in a 1978 benefit booklet.

Although some consultants believe the White Farm decision is an aberration because welfare benefits are specifically excluded by ERISA, they don't mitigate the problem employers face in controlling retirees' health care costs.

"The truth is, many companies

Continued on page 35

New rules affect retiree benefits

Besides contending with court decisions guaranteeing retirees' health care benefits, employers also must deal with a new rule on how they must account for their liability for retirees' health care costs, plus a new tax law governing the funding of these liabilities.

Together, the three developments are making employers focus more attention than ever on the wisdom of offering post-retirement health care benefits.

Last November, the Financial Accounting Standards Board ruled employers must include information on post-retirement health care benefits in financial statements.

This is considered a preliminary step to requiring these benefits to be pre-funded, says Betsy Cropsey, FASB project manager. She anticipates the board will issue a pre-funding proposal for discussion next year.

Most employers now pay for retirees' health benefits on a "pay-as-you-go" basis, say consultants.

But, the Deficit Reduction Act of 1984 reduces the tax advantages of pre-funding health benefits (*BI*, July 16, 1984). The act provides that effective Jan. 1, 1986, investment income earned by reserves held by 501(c)(9) trusts, or Voluntary Employee Beneficiary Assns., and experience-rated plans to fund retirees' health benefits will be subjected to the business income tax, which can be as much as 46%. Under current law, reserves earn interest tax-free.

This puts employers in the uncomfortable position of knowing they have a problem, but being able to do little about it.

"There's a real tug and pull in different directions," says Tom Nelson, a consulting actuary at Milliman & Robertson in Chicago. "It's clear that something has to give."

Before employers and consultants jump in and make changes in the way they have been handling retiree benefits, they are waiting for the results of a study on the need for federal standards for post-retirement benefits, which is being prepared by the Department of Labor and the Treasury.

The report, which was due Feb. 1 but now is not expected to be completed until this summer, is widely expected to recommend a program parallel to 1974's Employee Retirement Income Security Act, which required pre-funding for pension plans.

"It wouldn't surprise me if the study recommends the 'ERISAfication' of retiree welfare benefits. I believe that's the direction Congress is heading," says William J Miner, an actuary with The Wyatt Co. in Chicago.

"I feel the climate is right in Congress to establish minimum vesting and participation requirements," he says.

Mr. Miner believes, however, that while Congress may enact participation and vesting standards during this session, because of their complexity, the funding issue may not be dealt with until next year.

The Internal Revenue Service's actuarial department is now in "somewhat of a quandry" developing rules for retiree medical plans under DEFRA, and its input would be sought in any regulation that would be established, he says. It will take the department some time to develop the necessary expertise, says Mr. Miner.

But, all this new attention on retiree welfare benefits is making employers look twice at what they have been offering or considering offering to retirees.

"There's a growing awareness, and it's going to be increasing over the next few years," says Harper L. Garrett, vp and director of professional services for the New York-based Human Resources Management Group, an Alexander & Alexander Services Inc. unit.

Some employers that had been planning to introduce retiree health care programs are holding back, out of fear of being hit with huge liabilities, consultants say.

"I am not telling our consultants to push retiree health benefits—in no way am I doing this," says M.P. Dickenson, chairman of Miller, Mason & Dickenson Inc., based in Conshohocken, Pa. "I think it's fraught with all sorts of costs and future problems."

Continued from facing page

have not been sued—and could be," says one consultant.

And, many employers do provide post-retirement health benefits to retirees. A recent Hewitt Associates survey showed that 94% of the responding employers offered health benefits to retirees that had been salaried employees.

"If I were counseling an employer, I'd say, 'Understand there's a risk there, and perhaps the battle you want to fight is elsewhere,'" says Tom Garabedian, a consultant in Hewitt's Rowayton, Conn., office.

"I don't think there's any magic elixir" to help avoid a court fight over cuts, agrees Albert Cole Jr., director of group consulting at New York-based Buck Consultants Inc.

But there are steps employers can take to prevent disputes from erupting and to have a legal leg to stand on if they do end up in court.

"The best you can do is pretend you're going to get sued" and then determine the best position to take, says John Hickey, a consultant at Kwasha Lipton in Fort Lee, N.J.

"The first step is to find out how big a problem you've got," says David L. Glueck, Chicago-based vp of Towers, Perrin, Forster & Crosby. "You have to analyze where you are."

A study of precisely what the employer has communicated to its retirees through the years about their rights to post-retirement health benefits is necessary.

"To maintain that health benefits be frozen in perpetuity and only improved is unreasonable," says Dave Kempken, Bethlehem Steel's former employee benefits manager, who is now a consultant in the Milwaukee office of William M. Mercer-Meidinger Inc.

Yet, that is just the impression employees may have gotten from employers, consultants say.

What an employer's rights are depend on what it has told employees, benefits consultants say, pointing to the Bethlehem decision.

To determine what impression employees are getting about their post-retirement benefits, employers should scrutinize summary plan descriptions, plan documents, folders and handouts highlighting benefits, letters mailed to employees concerning benefits, contents of retirement training sessions and other oral communications.

The key to developing a retirement benefit plan that does not unwittingly tie employers to open-ended commitments is clear, plain language that is supported by all other communications, both written and oral, consultants say.

"Make sure the employees who are counseling people who are about to retire also emphasize the fact that the benefits are subject to change," says Hewitt's Mr. Garabedian.

Continued on next page

Retiree benefits

Continued from preceding page

Lawrence Mitchell of Mitchell & Hartmann Inc. in Sherman Oaks, Calif., recommends employers "spend a lot more time with employees explaining to them how the benefits came about, how much they cost, and what the effect would be of their not making changes, and, in effect, just laying their cards on the table.

"Management, at times, is a bit paranoid, and is afraid to let people know the truth, and locks themselves into a corner, and in effect, makes any disclosure difficult," he says.

"Often, while a company will embark on an elaborate campaign for active employees, retirees are given a 'quick and dirty' notice, says Kwasha Lipton's Mr. Hickey. "Spend a little bit of money on it."

Even if no changes are planned for several years, employers should start to communicate and "set the stage now," says Harper L. Garrett, vp and director of professional services for the New York-based Human Resources Management Group, an Alexander & Alexander Services Inc. unit.

Once an employer has determined exactly what it has communicated to employees about post-retirement benefits and decides to proceed with cost containment, it can take further steps to avoid being sued.

First, they should cut retirees' health care benefits in conjunction with changes in active employees' benefits.

"If they simply single out the retired people" they increase their risks of being sued, says Charles Walls of Daskais & Walls Inc. in Chicago.

If the retiree and active employee cutbacks are consistent, "it's much more defensible and appropriate," agrees Michael Carter, senior vp of Philadelphia-based Hay/Huggins Co. Inc.

Many companies, says Kwasha Lipton's Mr. Hickey, are introducing copayments and deductibles for their active employees, and then passing them onto retirees.

Another approach is to have a trade-off, says Mr. Mitchell of Mitchell & Hartmann Inc. Retirees may agree to a cut in health benefits in exchange for something else, like increased death benefits.

Consultants also say a relatively small change, like a deductible or a copayment, is much more likely to be accepted by retirees than a drastic one, like terminating health care benefits, which was the case with White Farm.

By making health care benefits partially contributory, rather than withdrawing them altogether, employers have a stronger legal position if they are sued, says C. Richard Donovan, senior vp of Baltimore-based Herget & Co. Inc.

Mr. Hickey said that at Borden Inc. in Columbus, Ohio, retiree medical benefits were successfully cut back (*BI*, March 12, 1984), but Borden had stressed its right to cut benefits and had made a number of changes in its benefits structure over a period of time.

"Some were good and some were bad," he says, but the important point is that a precedent for change had been established.

Compared with Bethlehem Steel, many employers are in relatively good positions to cut back on retiree benefits, says Dan Klein, a staff attorney for A.S. Hansen Inc., based in Deerfield, Ill.

"Most programs do have a lot more flexibility than Bethlehem Steel," he says. "Most employers haven't said to their employees that you will have coverage for life at no cost."

Still, whether an employer decides to cut retiree benefits can come down to whether the final results will be worth the effort, says Kwasha Lipton's Mr. Hickey.

Some employers have an attitude of "We're not going to mess with existing retirees," he says. They decide to concentrate instead on cutting benefits for future retirees, he explains.

These companies generally have relatively few retirees and believe cutting their benefits is simply not worth the risk, Mr. Hickey says.

On the other hand, older, more mature companies in the basic industries such as steel, who have a "humongous" number of retirees, are willing to take the risk of doing something to cap high retiree health care costs, he points out. "They're the ones who are much more concerned with lawsuits."

Other consultants point out that unionized companies may be particularly vulnerable to lawsuits when retiree benefits are cut because the unions can draw on labor law to fight their cases.

For example, when White Farm's contract with the UAW expired in 1984, the company notified the union that it planned to reduce health care benefits for retirees. The UAW's response was to acquire an injunction in U.S. Federal District Court in Minneapolis last fall that barred White Farm from cutting retiree benefits.

A source familiar with the actions said White Farm was attempting to reduce retiree health care benefits to levels that had been established for active workers. It was asking "for typical cost-cutting measures. . .like mandatory second-surgical opinions and elimination of first-dollar coverages," he said.

However, now it has agreed to maintain current benefits.

When employers are dealing with unions, "you've got a whole additional set of laws" employees can use to pursue a remedy, says TPF&C's Mr. Glueck. And, often in a union shop, the relationship between the employer and employees is "much more of an adversarial situation," says Mr. Carter of Hay/Huggins.

On the other hand, Mr. Hickey says an employer dealing with a union may actually be in a better position than an employer with non-union employees because the collective bargaining agreement may give him the right to change a plan.

"I'm not sure there's any difference at this point in time," counters Hansen's Mr. Klein.

"It depends more on what the employer has done than whether the employees are union or non-union as a group."

Even if the employer is dealing with non-union employees, it may decide that tampering with current retirees' benefits is just not worth the risk of ending up in court and instead may focus on the benefits promised future retirees.

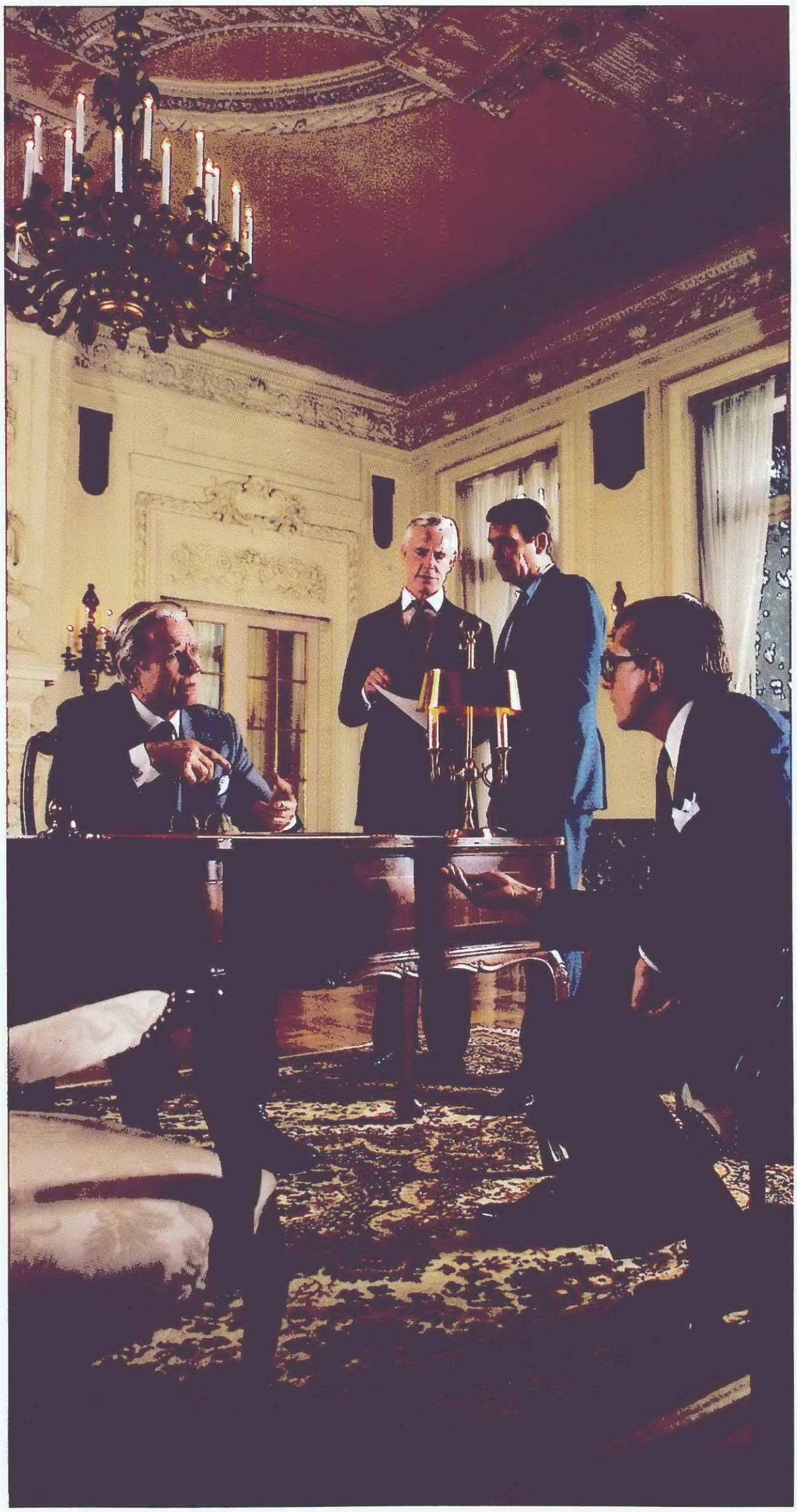
"There would appear to be little limitation for those not retired," says Buck Consultants' Mr. Cole.

Retirees, in a sense, have a completed contract, explains Herget's Mr. Donovan. They have done their part, and now it's the employers' turn to do their part. But, with active employees, "Legally, you have an open field to run in," he says.

Benefit consultants warn that even if a company has relatively few retirees now, they should take a careful look at their plan, with an eye toward the future.

"You should still spend the time and think about what your policies should be so it doesn't become a big liability for you," says Hewitt's Mr. Garabedian. It's certainly easier to rein in your commitment today, he says, "when it's not all that important to your employees," than it will be when they mature and are ready to retire.

"Don't bury your head," he warns. ■



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The Protection Connection

info

• A new risk management tool is now available from the International Risk Management Institute Inc. The Exposure Survey Questionnaire is designed to help with **risk identification** through interviews with management personnel by risk managers, consultants and brokers. The guide contains more than 500 questions on company operations and practices that can affect property and casualty loss exposures and risk management or insurance costs. The brochure costs $24.95; overseas purchasers add $15. Contact International Risk Management Institute Inc., 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231.

• A look at legal, ethical, funding, and liability issues inherent in **employee assistance programs** is now available from the California State Psychological Assn. The brochure is directed toward the mental health professional who manages or directs an EAP program. To order, send $6 to the California State Psychological Assn., Division of Clinical and Professional Psychology, 2100 Sawtelle Blvd., Suite 201, Los Angeles, Calif. 90025.

• An anti-arson brochure is now available from the American Re-Insurance Co. The publication, "Arson—A Burning Issue," was designed to increase the awareness of the **problems of arson** and offer suggestions to reduce the crime. The brochure includes an underwriter's guide and a fire investigation guide. Copies of the brochure can be obtained by contacting Linda Macklin, Director of Communications, American Re-Insurance Co., One Liberty Plaza-91 Liberty St., New York, N.Y. 10006.

• Hospital involvement in **health care coalitions** is the subject of the American Hospital Assn.'s "Guidelines on Hospital Involvement in Health Care Coalitions." It encourages active hospital participation in broad-based coalitions, and it includes advice on assessing local interest in forming a coalition, structuring coalitions and recommended activities for coalitions. The cost is $1.80 for AHA members, $2.25 for non-members. Contact AHA Services, P.O. Box 99376, Chicago, Ill. 60693.

• InterGuard's Guard Apparel & Textile Program Brochure describes the company and the features of a 3-year-old **group insurance program** currently being offered in New Jersey and Pennsylvania. Also covered in the brochure is an explanation of the unique coverages and financial features being incorporated into this program. To obtain a free copy, write InterGuard Ltd., Guard Center, 16 S. River St., P.O. Box A-H, Wilkes Barre, Pa, 18703.

• **"Liability Beyond the Insurance Contract,"** a 100-page monograph published by the Society of Chartered Property & Casualty Underwriters, identifies trends in extra-contractual damages and explores what the insurance industry may face in the future from courts and legislatures. The monograph is composed of 10 treatises written by attorneys and other experts in the field. Cases and examples cited in the monograph provide a broad view of the subject. The publication includes practical steps that insurers can take to avoid or defend themselves against allegations of bad faith or punitive damage suits. The cost is send $24 for U.S. residents, $29 for non-U.S. residents. Contact the Society of CPCU, Publications Division, Kahler Hall, Providence Road, Malvern, Pa. 19355.

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Cost-containment savings are often hard to document

By CAROL CAIN

Group health insurers and claims administrators are bragging about colossal savings produced for clients by a variety of cost-containment measures, even though they admit these savings cannot be precisely measured or compared from insurer to insurer.

For example, John Hancock Mutual Life Insurance Co. in Boston is touting that it saved clients more than $200 million last year through the use of cost-containment programs. However, these savings also reflect changes in benefit plan designs, like increased coinsurance and deductibles, which some consider cost shifting rather than true cost-containment devices.

Aetna Life Insurance Co. in Hartford, Conn., reports that eight cost-containment devices saved more than $935 million during 1984. However, this figure represents gross savings and does not take into account the administrative costs of the various programs.

Chicago-based Blue Cross & Blue Shield Assn., says cost-containment measures saved subscribers to BC/BS plans throughout the country $6 billion last year. But that number includes savings from alternative delivery systems—like health maintenance organizations and preferred providers organizations—as well as cost-containment devices.

However, these insurers, as well as others, note that companies' savings cannot be compared since each insurer's program differs, along with types of employers insured and the methods used to compute the savings.

"There isn't all that much historical data" on cost-containment devices, notes Kevin McCarthy, second vp of group life/medical products for Union Mutual Life Insurance Co. The Portland, Maine-based company primarily insures clients with less than 150 employees.

"Sure, each carrier has some numbers, but only for their programs," he said, noting that the savings reported by each insurer will change with the plan's demographics.

"The numbers are dramatic," points out Robert E. Kelly Jr., president of Kelly & Associates Inc. in Chicago, the nation's sixth-largest administrator of self-insured health plans.

"These are significant cost savings areas, but cost savings are byproducts of demographics and plan design," said Mr. Kelly, who questions how an insurer can quantify cost savings across the board when 100 people in one plan can be totally different than 100 people in another.

Samuel X. Kaplan, president of U.S. Administrators Inc. in Los Angeles, the nation's second-largest health plan TPA, also stresses that demographics must be considered when reporting savings.

When an insurer or administrator cites a savings from coordination of benefits, Mr. Kaplan asks, how many of the people covered by the plan are retirees or women?

Insurers agree with this point.

"With coordination of benefits, there is a difference in savings depending on the demographics of the people," said a spokesman from CIGNA Corp. in Hartford, Conn. "For example, an employer with a large percentage of female workers would have a larger savings because they traditionally are covered by the other spouse."

"There are a number of ways to

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Cost-containment savings hard to measure

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measure savings" but each can be questioned, notes William Rosenberg, manager of utilization and cost analysis for Metropolitan Life Insurance Co. in New York.

For example, in a pre-admission review program, if 10 employees out of 100 are denied hospital stays at full coverage, some would interpret that as a documented savings of 10 hospital stays. Mr. Rosenberg would not.

"What you're really trying to do is measure a given in some program against what would happen if you didn't have that program. . .and you can spend all kinds of money to scientifically measure this" and still only come up with a savings estimate, Mr. Rosenberg said.

Employee benefit consultants also agree that the savings reports are, at best, estimates.

"We can get a reasonable sense about what these things might do, but if you add up all the estimated percentages, they will add up to more than the whole," said Len Marinaccio, senior consultant and head of the group benefits division for The Wyatt Co. in New York.

"At the end of the year, you can save money, but you can't say whether it was because of one factor or another," he explained.

Mr. Marinaccio noted he and nine other senior consultants from Wyatt discussed such cost savings at a staff meeting in Dallas last month. Although the consultants said they could supply figures and percentages for cost-containment savings, they added they would be uncomfortable doing so since each set of numbers would be unique to a particular client rather than a general trend.

"We seem to know that one-third of all surgeries in this country are unnecessary, but you won't save one-third of your costs with second surgical opinion programs," Mr. Marinaccio said, stressing there are intangible factors that cannot be measured but play a key role in how much can be saved.

One of those unmeasurable factors is the so-called "sentinel effect." according to Metropolitan's Mr. Rosenberg: "Once we implement our cost managment strategies, doctors and hospitals become aware we're looking over their shoulders."

Insurers agree that there probably is no way to report exact savings.

"There's not a system to quantify these numbers in an exact way," notes a CIGNA spokesman, specifically referring to outpatient surgeries and second surgical opinions. He said there is no way of knowing whether an employee would have had the procedure done on an outpatient basis anyway.

So instead of reporting the exact amount saved, CIGNA, as do many other insurers, can sometimes give only rough estimates of savings from cost-containment procedures, says Kathleen Daley, CIGNA's assistant director of marketing.

For instance, based on 1983 statistics, surgeries performed on an outpatient rather than an inpatient basis generally accounted for savings of 1% to 2% of premium, Ms. Daley said.

"But that percentage will vary based on the geographic area and plan design," she added. CIGNA also estimates that this program saved the cost of 1.5 inpatient days for each outpatient surgery, but that's only an estimate, Ms. Daley noted.

To get a better handle on the savings from outpatient surgeries, CIGNA is joining with the University of Pennsylvania this month in a two-year research project that will track all such surgeries.

Even though insurers and administrators admit they cannot calculate exact savings statistics, they are beginning to use savings data as sales tools to keep old clients and attract new ones.

In some cases, the cost-containment programs monitored are add-ons to a health insurance policy, like second surgical opinion and hospital bill audit programs.

In others, cost-containment devices are built into the program as part of the administrative procedures furnished by a company.

For instance, Aetna offers a computerized system that checks all surgical, medical and dental claims to make sure charges fall within reasonable and customary guidelines. This program, part of the claims-processing procedure, saved employers and employees $60.7 million in 1984, said Katharine Worthington, manager of claims, policy and programs in Aetna's employee benefits division.

Aetna also reports savings from several other cost-containment programs, which together totaled $935.1 million last year, Ms. Worthington said, though this figure represents gross savings before administrative expenses are subtracted.

Coordination of benefits accounted for the largest savings—some $798.4 million—which translates to about 13% of all net paid claims, Ms. Worthington said, noting this figure includes Medicare benefits.

Aetna also says it saved:

- $55.3 million by reviewing medical and dental claims for medical necessity.
- $8.3 million from its individual care management program, in which alternatives to hospital stays are sought.
- $3.2 million from its hospital discount program in which hospitals agree to give discounts in exchange for priority claim handling.
- $1.7 million from fraud investigations; $5.3 million for monitoring hospital stays.
- $2.2 million in hospital audits.

"We do try to monitor savings from every program that we implement. . .but in some programs the savings are easier to quantify than in others. In some we have to rely on assumptions and projections," said Gerry Schade, assistant vp with Aetna.

For instance, Aetna has not been able to track savings for second surgical opinion programs, pre-admission certifications or ambulatory surgeries, Ms. Worthington said.

Savings from those same cost-containment programs, and several others, cannot be tracked by The Travelers Insurance Cos., according to a spokeswoman.

However, John Hancock reports it saved its clients more than $200 million last year as a result of coordination of benefits, the monitoring of reasonable and customary charges, using generic drugs, pre-admission certification, hospital reviews and second surgical opinions.

The insurer will not break that figure down for "competitive" rea-

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'Dr. Rex knows best' is message to employees

SAN DIEGO, Calif.—Comic strips, while most often thought to amuse or entertain, can also carry an educational message to employees, one benefit communication company believes.

The firm, Benefit Communicators Inc., has obtained permission to reprint an early drawing of the comic strip character "Rex Morgan M.D." and is using it in a poster telling employees of the need to be conscious of health care costs.

"Rex Morgan M.D." chronicles the daily lives of Rex, a clean-cut family doctor in an unnamed Midwest community, his nurse June Gale and their patients. The strip first appeared in 1948 and is circulated worldwide in more than 350 newspapers by News America Syndicate.

"In 37 years, Rex has never smoked a cigarette," proclaims Dr. Nick Dallis, who has authored the strip since its inception. And rarely if ever, has Rex been shown drinking liquor, he adds.

It's this persona that Benefit Communicators hopes will draw attention. "There's a certain power physicians have when they say something —that's the real punch to this," explains Rick Galvin, the company's vp-sales. People often have "an authoritative feeling" about the words of a medical professional, he says.

The three-color poster reads: "Health Care Costs—It's not a problem for the 'other guy'—It's a problem that directly affects all of us. . .every employee and every company."

'I kept trying to think of what Rex would say and what he'd think, and that's what we finally arrived at,' explains Bill Spencer, vp and creative director with Benefit Communicators.

Mr. Spencer says most clients have reacted positively to the poster, but he recalls one Chicago employer that would not display it.

'It may have been too cartoonish for their corporate environment," he theorized.

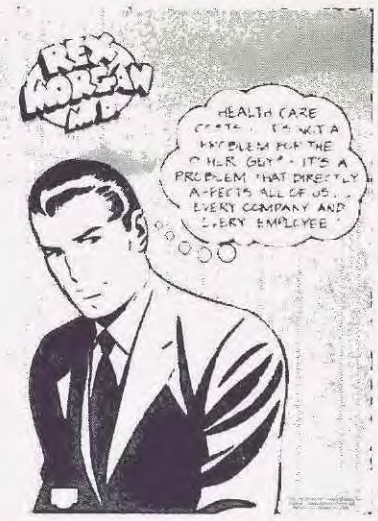
But, JoEllen Walsh, assistant secretary at Morgan Services Inc., a linen supplier, explained, "We felt that the relationship between the comic strip character and the corporation's name was inappropriate."

Benefit Communicators first tapped the good doctor when Mr. Spencer met Dr. Dallis at a wedding reception in Scottsdale, Ariz., in 1983.

Dr. Dallis also writes "Apartment 3-G" and "Judge Parker," but the drawings for these strips and "Rex Morgan M.D." are done by cartoon artists.

Benefit Communicators obtained the drawing at no cost because "this was a public service-type thing," said Dr. Dallis, who is still licensed but no longer practices medicine.

The company has printed 25,000 copies of the Rex Morgan poster and has distributed them to 25 clients so far. ■



Savings statistics

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sons, said Robert Grudzinski, Hancock's director of cost-containment services.

BC/BS, however, was able to break down its $6 billion savings from cost-containment measures used by both Blue Cross plans, which typically write hospitalization coverage, and Blue Shield plans, which typically write major medical coverage.

Blue Cross plans saved $1.492 billion through negotiated contracts with hospitals and the use of diagnosis-related groups. Another $1.915 billion was saved through coordination of benefits, $963 million was saved through settlements of disputed claims and utilization reviews and $27 million through the use of outpatient procedures and pre-admission certification.

Blue Shield plans saved some $974 million through monitoring usual, reasonable and customary charges, another $508 million was saved through coordination of benefits and $76 million was saved through utilization reviews.

Savings from outpatient services —like ambulatory surgery, home health care, pre-admission diagnostic tests and hospice care— have been broadened by individual BC/BS plans during the past year, said President Bernard R. Tresnowski when he announced the $6 billion savings.

A growing number of BC/BS plans cover second surgical opinions, and even third opinions, when elective surgery is recommended, he said. And enrollment in plan-owned HMOs is increasing dramatically, he added, noting that there also is a rapid subscriber growth in PPOs that negotiate with health care providers for reduced rates.

The goal of many of the BC/BS cost-containment programs is to shift the delivery of medical services away from expensive hospital settings, Mr. Tresnowski said.

Pre-admission certification programs alone are saving millions for subscribers of the 27 BC/BS plans that now have such programs in place, he noted. For instance, BC/BS of Northern Ohio in Cleveland has saved $33 million since its pre-admission certification program started in September 1983, he said. And BC/BS of South Carolina in Columbia reports a savings of $4.4 million in 1984 as a result of its statewide pre-admission certification program.

BC/BS of Minnesota in St. Paul is still compiling its 1984 savings, but reports for 1983, a savings of $350,000 plus the elimination of 4,500 inpatient days as part of a program that retrospectively reviews charges for in-patient psychiatric and chemical dependency claims.

That $350,000 was derived from direct claims denials, said Ann

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Gjelten, director of health economics for the Minnesota plan.

The plan also saved some $10 million in 1983 through negotiated prices and utilization programs with 28 hospitals in the Twin Cities area.

While BC/BS supplies dollar figures when citing savings, Metropolitan usually reports savings in percentages.

Since almost all Metropolitan poliycholders have different plans, it is difficult to come up with a savings figure, says Mr. Rosenberg.

"We really feel strongly that our reputation is at stake" when Metropolitan publicizes cost savings, said Mr. Rosenberg. "We feel we have to document the results."

Metropolitan believes it is savings big bucks with its new PPO programs, but it is very careful how it discusses those savings. For instance, it has recently completed an extensive analysis of its Met-Elect PPO in Miami. That study shows that in the first year's experience, after discounts, charges from the preferred providers were 33% lower than fees charged by non-preferred providers, he said.

Met-Elect has saved the Dade County School District in Miami an estimated $2.1 million in hospital costs for the first nine months of 1984, the company says. In addition, employees who used preferred providers in this program saved $1.1 million in out-of-pocket costs. Combined, these savings represent about 15% of the $21.5 million of claims paid by school district plans during the study period.

Other insurers are using cost-to-savings ratios, in addition to dollar figures or percentages, to illustrate their cost-containment savings.

For instance, CIGNA notes a net savings ratio for second surgical opinions in 1984 of 10.31-to-1, which means that $10.31 is saved for every $1 spent on the program, said Ron Hwalek, assistant director of cost-containment programs.

This compares with a 10.19-1 ratio for 1983, he said.

Other savings figures for CIGNA's second surgical opinion program include:

- Total net savings—$2.6 million in 1984, compared with $1 million in 1983.
- Disability weeks avoided—2,100 weeks in 1984, compared with 933 in 1983.
- Number of participants in the program—4,200 in 1984, compared with 1,631 in 1983.
- Number of avoided surgeries —760 in 1984, compared with 366 in 1983.
- Total costs—$250,000 in 1984, $98,872 in 1983.

But these savings don't reflect items like the cost of temporary employees and overtime when an employee is hospitalized, Mr. Hwalek said, adding that when those types of "invisible savings" are considered, the overall documented savings figure could easily triple.

It has only been during the past five years that data collection and reporting capabilities have improved, allowing insurers like CIGNA to obtain some quantifiable results, Mr. Hwalek said. But some areas still are relatively soft, he said, pointing to concurrent hospital utilization reviews.

However, based on two separate studies—one in Connecticut and another in Colorado—CIGNA believes that such a program saves $3.50 for every $1 spent.

But the most dramatic cost savings reported by CIGNA come from a new focused review of certain hospital procedures, specifically surgical and medical specialties. Mr. Hwalek said this was a sensitive area and would not list the procedures for fear of discrimination charges.

The program, piloted in mid-1984, saved participating employers $1.7 million, for a cost savings ratio of 33.30-to-1. Of the 1,500 claims reviewed, charges were reduced by an average 43%, he said.

Prudential Insurance Co. of America also cites cost-to-savings ratios for some of its cost-containment programs. For instance, the net savings to policyholders (after administrative charges) for second surgical opinion programs is $7.08 for every $1 spent, said Amy Knapp, senior consultant of cost-containment operations for the Newark, N.J.-based insurer. The figures are based on data from the first half of 1984.

This ratio reflects avoided surgeries and expenses not paid by employers for surgeries that did not comply with the second surgical opinion policy, she said.

When Prudential studied claims from policyholders in the Western United States and compared plans with second surgical opinion provisions with those without, it found 34% fewer elective procedures per 1,000 lives for plans with the second surgical opinion provisions.

And for pre-admission and concurrent review services, Prudential shows a net savings of $8.16 for every $1 spent, based on data from the first three quarters of 1984.

Third-party claims administrators also are estimating the savings for cost-containment measures.

For instance, Los Angeles-based American Benefit Plan Administrators Inc. notes it saved one client, a union health trust fund, $636,000 in 1984 by auditing hospital bills and reviewing claims.

This particular client paid between $30 million and $35 million in claims during 1984, said Irv Baldinger, the TPA's senior vp.

The savings were a result of 456 hospital audits and 520 medical claims reviews, he said. The TPA handles claims from large employers in Southern California that self-insure group health plans.

Intracorp in Wayne, Pa., a disability management subsidiary of CIGNA, has been tracking savings from hospital audits, pre-admission certification and continued hospital stay review programs.

Hospital audits show an average savings of 4% to 6% of paid claims by catching errors on bills, said Don Wilson, director of product managment for Intracorp.

And through its pre-admission certification and continued hospital stay review programs, Intracorp shows about a 4.2% reduction in admissions and 19.1% reduction in actual hospital days.

Coordination-of-benefits savings were tracked by Employee Benefits Claims Inc. in Minneapolis. But Christopher J. Dunlap, the TPA's executive vp, could only say that COB savings could range from 1% to 20% of the cost of a health plan. He noted that savings would differ based on the region and how many women were covered by the plan.

Coordination-of-benefits data compiled by U.S. Administrators Inc. showed COB procedures produced an average savings equal to 13.1% of paid claims. However, the TPA's president, Mr. Kaplan, again notes that this average varies depending on the age and sex of the covered employees.

Some other savings noted by U.S. Administrators include: hospital audits of bills more than $10,000, 21.2% of paid claims; reasonable and customary charges review, 4.7% of paid claims; utilization review, 8.4% of paid claims; pre-certification, 10.6% of paid claims; and subrogation, 2.9% of paid claims.

U.S. Administrators is beginning to track savings from second surgical opinions, but Mr. Kaplan said any meaningful savings have to be computed from a five-year longitudinal tracking program.

"I don't think you can really measure the savings unless (it's) tracked over five years. . .and no one is doing that," he said. ■

Group plan shouldn't pay transplant costs: Survey

BROOKFIELD, Wis.—The cost of highly experimental medical procedures should be paid by nationwide catastrophic or pooled high-risk funds rather than traditional health care plans, suggests a survey of the benefit professionals.

The International Foundation of Employee Benefit Plans' quarterly National Opinion Panel, which drew 126 responses, included a request for comments on payment for transplants and other experimental procedures.

The responses, according to the IFEBP, indicated the benefit professionals thought the responsibilities of a health plan trustee are purely financial, and that trustees should not have to make life-and-death decisions about whether to pay for experimental procedures. "This is purely a cost question for trustees," one panelist said.

Many thought the cost of such experimental procedures might be accommodated through higher copayment levels or other plan changes, but one respondent warned that under such an approach, "we will continue to 'nickel-million' and 'dime-million' our plans to their demise."

Several respondents suggested the establishment of nationwide catastrophic or pooled high-risk funds pay for such coverages.

Some panelists said these pools should be be developed by the insurance industry. And, some said the pools should be funded by the federal government.

"Congress should act to enable Americans to keep pace with medical science progress," one said.

Another respondent said, "What we have here is a situation roughly analogous to Columbus appealing to Ferdinand and Isabella; if we don't come up with the dough, there may be whole continents of good for humanity that shall not come to life."

Other areas covered by the survey included:

- The federal deficit. Some 81% of the respondents felt the deficit and further erosion of the tax base will be the federal priority most likely to affect benefits in 1985.
- Excess pension plan assets. Some 73% of the panelists said these assets should not be subject to excise tax upon reversion; 25% said the assets should be taxed.
- Medicare. The survey asked about various proposed solutions to Medicare's financial crisis. A whopping 92% of the respondents supported building incentives into Medicare for participants to seek lower-cost care, and 65% favored limiting reimbursment through diagnostic-related groups. In contrast, only 31% supported raising the eligibility age for Medicare to 67 from 65.
- 401(k) plans. Eighty percent of respondents opposed the Treasury Department's plan to prohibit the plans. However, 78% favored more stringent withdrawal rules, to guarantee the use of the plans for retirement savings rather than tax-sheltered short-term savings.

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Free copies of the survey are available from the IFEBP, Public Relations Department, P.O. Box 69, Brookfield, Wis. 53008-0069.

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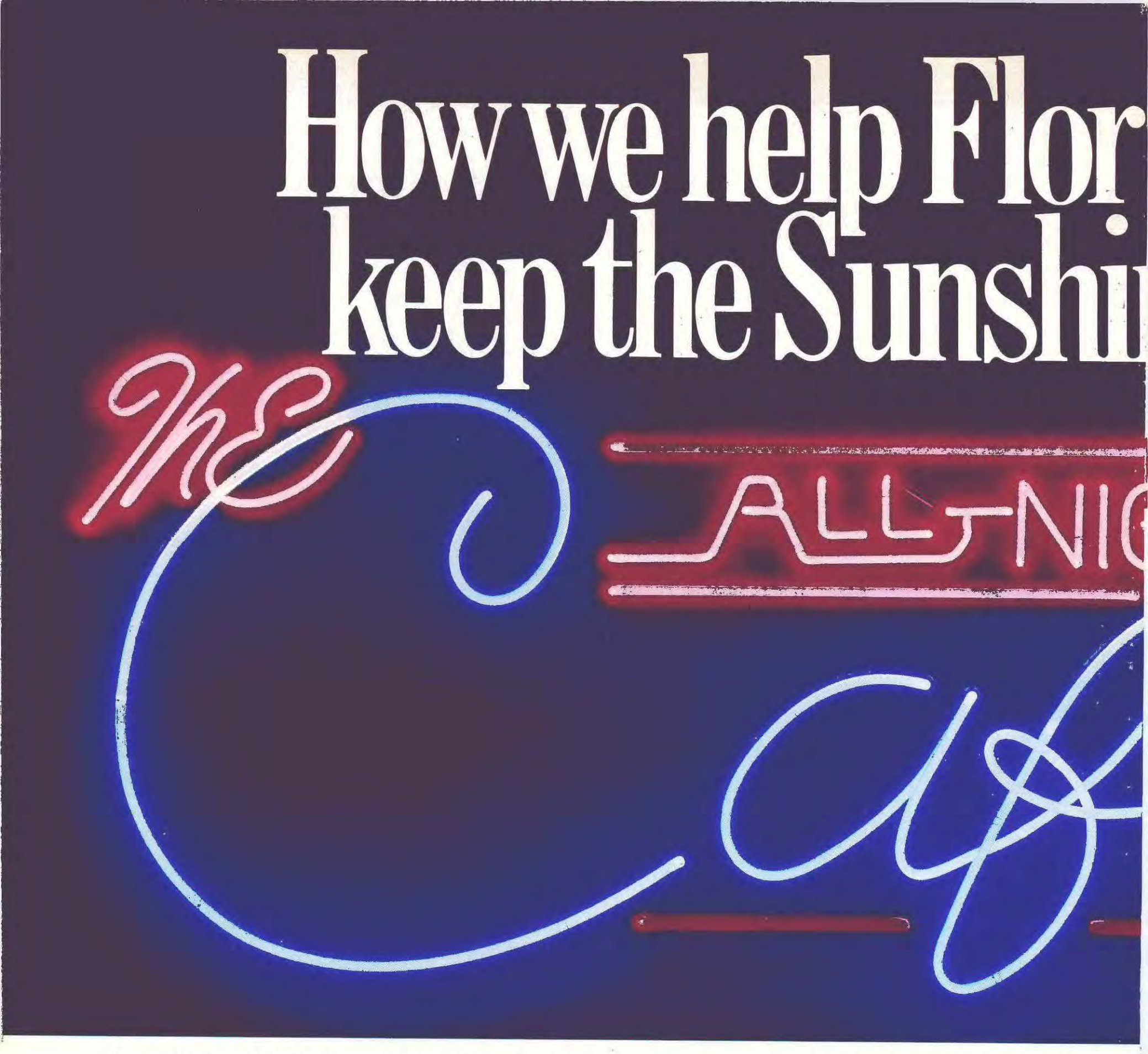

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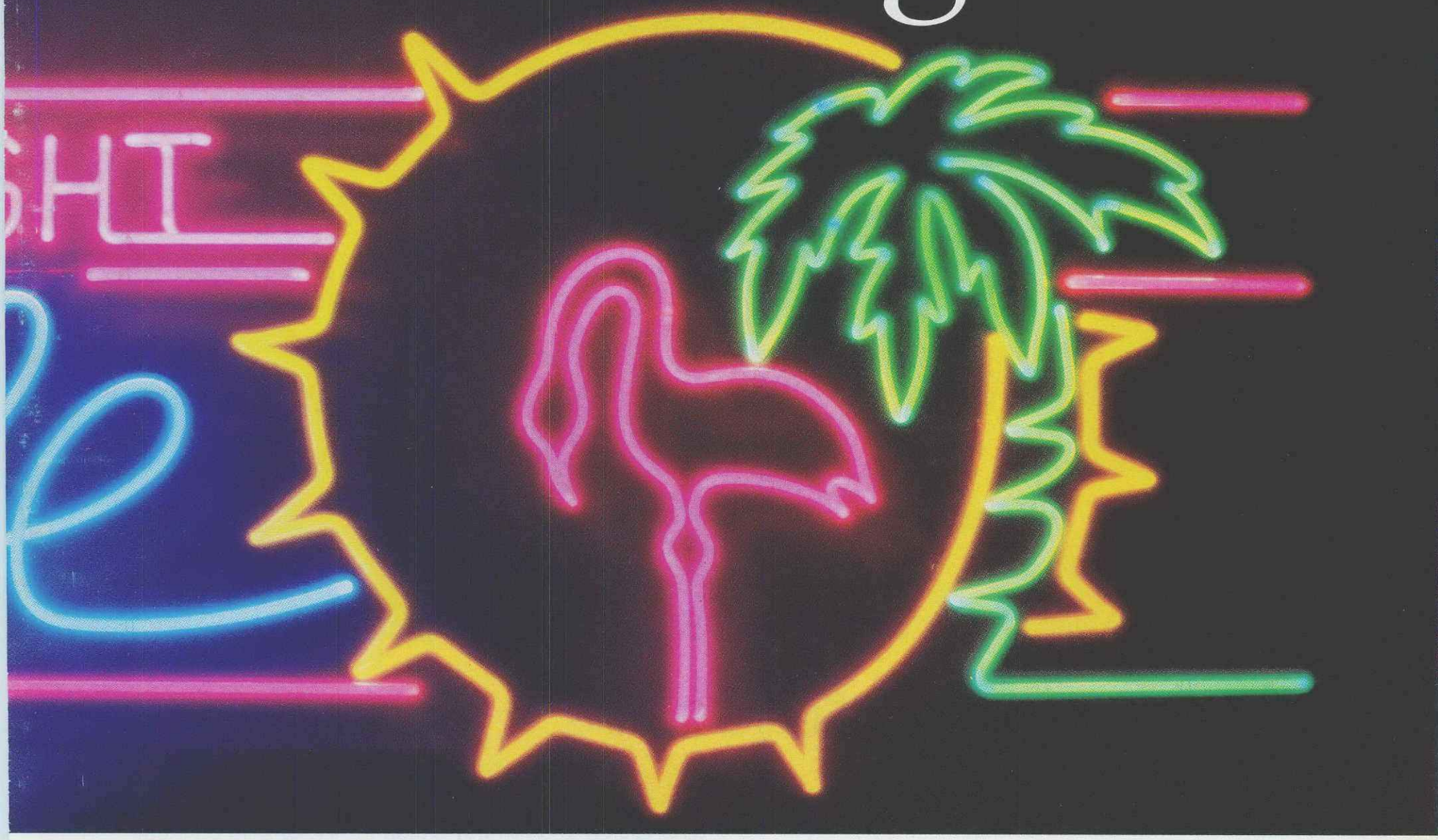

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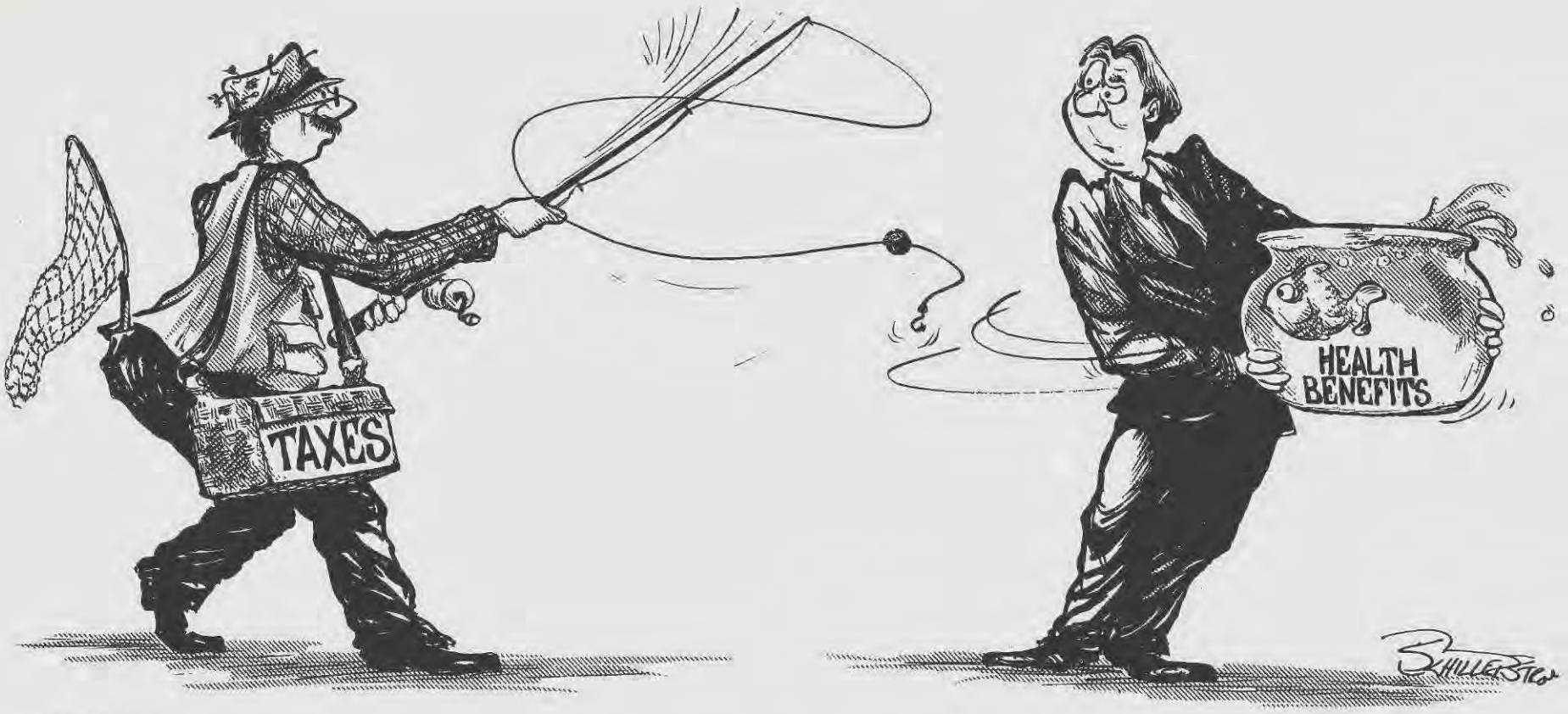

Illustration: Roger Schillerstrom

BENEFIT TAX DEBATE

Current system unfair, costly to federal budget

By Alain C. Enthoven

THE UNLIMITED EXCLUSION of employer contributions to health care premiums from employees' taxable income must be reined in.

This practice not only robs the government of an ever-increasing amount of revenue, but also encourages excessive and unwise use of health care.

Furthermore, it discriminates in favor of the higher-paid employee over the lower-paid and the employed person over the unemployed or self-employed.

However, it is not necessary to eliminate the entire tax exclusion. Instead, the tax subsidy should be limited and made available to all.

The Congressional Budget Office estimates that the unlimited exclusion of employer contributions toward health care premiums from the taxable incomes of employees cost the federal budget $30.1 billion in 1984, up from $19.8 billion in 1981.

And, two recent events have made it likely that the estimated revenue loss by 1986 will be much higher.

First, in May 1984 the Internal Revenue Service issued proposed rules governing the use of flexible spending accounts and other benefit plans that qualify under Section 125 of the tax code. These rules allow employees to avoid paying taxes on their health insurance premium contributions by paying for them with pretax dollars through salary reduction agreements with their employers.

Thus, instead of roughly 77% of group health insurance premiums being tax-sheltered because they are paid for by employers, that percentage in the future will grow to include premiums paid by employees through FSAs.

Second, the Health Care Financing Administration recently revised upward by 18% the estimated volume of private health insurance premiums, mainly by including self-insured plans omitted from previous data sources. Private health insurance premiums for 1983 were estimated at $110.5 billion.

Health insurance costs have been growing at a much faster rate than the gross national product, but even if they grew only at the same rate as the GNP, premiums would reach about $144 billion by 1986. Under even quite conservative assumptions, this would produce a revenue loss to the federal budget of $46 billion to $49 billion if employer contributions to employee health care premiums are not considered taxable income to employees.

These numbers illustrate the first thing wrong with the current tax subsidy to health insurance: The revenue loss to the federal government is large and growing too fast.

The government has to do something to bring the growth of its outlays and tax subsidies into line with the GNP. A limit on tax-free employer contributions to employees' health care premiums seems to be the obvious way to do this.

The second thing wrong with the current tax treatment of health insurance is that it reinforces the cost-increasing incentive in the health care financing and delivery system.

In a group of average taxpayers, if the employer were to increase pay by $100 a year, about $40 would go to federal income and payroll taxes and state income taxes. If instead the employer were to raise the health benefits contribution by $100, the full $100 would go toward health benefits.

Continued on next page

Benefits couldn't bear the weight of taxation

By Philip Briggs

DESPITE THE GROWTH of government programs, the United States has avoided to a large extent the European-style cradle-to-grave benefits system.

Instead, we have favored what, during the 1930s, was called the three-legged stool concept—Social Security, personal savings and employer-provided benefits.

Forty years ago, tax incentives wisely were put in place that have made the third leg—employer-provided benefits—a viable, efficient means of providing insurance against the risks of disability, illness and death to a great majority of Americans and their dependents.

Now there are those in Washington and elsewhere, legitimately concerned with closing the federal deficit gap, who say the private benefits system should be a prime source of revenue.

They say "fringe benefits" have become, for many employees, 30% to 45% of total compensation and ought to be taxed.

For one thing, that figure applies only if you count every conceivable type of benefit—which many people do not have—and Social Security—which is not private and which is the fastest-expanding element in anyone's package of benefits.

The basic private benefit coverages—life and health insurance and pensions—account for only part of that figure. Typically, life insurance would be less than 1%; health insurance, 3% to 4%; and pensions, about 5%.

Estimates vary as to the amount of revenue that would be raised by taxing benefits, but they run as high as $80 billion annually. That would, indeed, go a long way toward closing the deficit.

It would also destroy the very system that the proponents of this measure see as a continuing source of revenue. The means of raising this revenue would be to withdraw the tax incentives that made the system possible.

The private system has worked so well for so long that the advocates of this measure apparently believe that it will continue to function, even without the tax incentives.

This kind of thinking implies a lack of understanding of what makes the group insurance mechanism work. Because employers pay most, if not all, of the cost, everybody signs up.

But, if the direct cost of benefits is transferred to the employees, they will also have to be offered cash in lieu of remaining in the plan.

Given that choice, young, healthy employees will opt out, probably in favor of using the money to buy a home or something else. Lower-salaried employees, who need the money to put food on the table, also will leave the plan. Only older workers and those who are ill and absolutely cannot do without benefits will remain.

This kind of adverse selection would make providing benefits for the remaining workers a costly proposition for employers. Many, especially if they are small businesses, might actually be faced with the choice of dropping benefits or being driven out of business by the cost of maintaining them. The effect on small businesses in this country and those who depend upon them for their livelihoods would be particularly significant.

Entire industries, particularly those where life and health insurance costs are

Continued on next page

perspective

System is unfair

Continued from preceding page

The typical response has been for the employer to pay most or all of the employee's health insurance premiums with pretax dollars instead of paying the employee the amount in cash and leaving the employee to pay the premiums with net aftertax dollars.

And, the trend has been to cover very comprehensive benefits including, for example, routine dental expenses, so that they too are paid with pretax dollars.

The consequence of this comprehensive coverage has been to insulate consumers from the cost of medical care and to destroy the cost-consciousness of the employee in medical purchasing decisions.

The government has been struggling to cap Medicare and Medicaid outlays, programs that help the aged and some of the poor. Yet, through the tax laws, it is subsidizing open-ended private-sector demands, and bidding up the price for health care. A new approach is needed to create some cost-consciousness in the choice of health care coverages. A limit on tax-free employer contributions to health care premiums would help.

A third major defect is that the current system is very unfair. The tax break is worth much more to upper-income employees and the employed than to lower-income employees and the unemployed.

The main reason for this is that employer contributions are much larger for upper-income employees than for lower-income employees. In 1983, employer contributions averaged $301 for households with $10,000 to $15,000 in income, but $1,471 for households with incomes of $50,000 to $100,000.

The Congressional Budget Office estimated that in 1983 the tax exclusion for these contributions was worth $83—or 0.65% of income—to households in the $10,000 to $15,000 income category, and worth $622—or nearly 1% of income—to those in the $50,000 to $100,000 category.

What is the philosophical or economic basis for the exclusion? Is it to adjust gross income to make it better reflect ability to pay? If so, then why shouldn't low-income families get at least the same tax subsidy as the well-to-do? The actual distribution of these benefits fits better with the explanation that they are distributed according to political power, not need.

There are also "horizontal inequities." Two people with the same income and medical needs get very different tax breaks when one is employed and the other isn't employed or is self-employed. Worse yet, some families lose their health insurance altogether when they lose their breadwinner. Others manage to hold onto insurance, but they lose the tax break that previously subsidized it.

There is a basic question of fairness here. The cost of this tax break for middle- and upper-income people has eclipsed federal spending on Medicaid and will soon reach the cost of Medicare! Congress has moved effectively to cap Medicaid and Medicare, and more cuts are on the way. It doesn't seem unreasonable to think about capping this open-ended entitlement of the employed middle class.

Still another major defect of the present tax treatment of health insurance is that, because it is tied to employer contributions, it reinforces the link between jobs and health insurance.

This greatly increases the complexity of arranging insurance for the uninsured. A recent study by the National Center for Health Services Research estimated about 9% of the under-65 population, or 19 million people, are not covered at all by public or private health insurance.

An additional 9.4% are insured only part of the year. When people lose their health insurance because they lose their jobs, there is no effective way for many of them to buy health insurance. They go without insurance until they become seriously ill, and then they have to spend their savings before receiving free care.

Many of them might buy insurance if it were available and they had the same tax subsidy as employed people.

Several remedies for these defects have been proposed.

Some propose abolishing the entire tax exclusion for employer contributions to employee health care premiums. I do not agree with that and will not defend it.

If we want widespread private health insurance, we need some powerful financial incentive to motivate healthy people, who don't expect medical bills, to buy health insurance anyway. Otherwise, only the sick will buy insurance and the premiums will rise out of sight.

Instead, I believe the exclusion should either be limited or replaced with a limited refundable tax credit. And, the same tax break should be available to all people, whether they are employed or not.

Although some insurance industry pamphlets being circulated merely state that "the federal administration is proposing to tax employees on employer contributions to group health insurance plans," it is important to note elimination of the exclusion it is not being proposed.

In its fiscal 1985 budget, the Reagan administration proposed to limit tax-free employer contributions to health care premiums to $175 per month for a family plan and $70 for an individual plan. It was estimated this would have produced an extra $4 billion in revenue in 1985.

There are various ways the administration's proposal might be implemented. One would be for employers to include their contributions in the reported incomes of employees. Or, employees could take the allowable exclusion on their own tax returns.

An important advantage of this approach is that the same exclusion could be made available to all, regardless of employer contributions. Taxpayers would support the exclusion by a receipt from their health insurance plan. Tax fairness would be greatly enhanced.

An alternative I have proposed is to replace the exclusion with a refundable tax credit, usable only for the premiums paid to a qualified health insurance plan and available to all, whether they have an employer contribution or not.

A qualified health insurance plan would be one that met certain conditions such as catastrophic expense protection, so that very sick people would not become a public burden. It also would offer continuity of coverage so people that lose their jobs could continue their present health care coverage at their own expense for a year at the approximate group rate.

The credit would be equal to 40% of each person's or family's health insurance premium payments (or the employer's) up to $60 per month for an individual, $120 for a couple and $180 for a family in 1986. The limit would be adjusted upward each year in proportion to the GNP per capita.

If everyone took advantage of it, such a credit would cost the federal budget about $47 billion in 1986, about what the present exclusion would cost. But, it would bring the rate of growth into line with the GNP.

It also would be equally available to rich and poor, employed and unemployed. And, it would help many people maintain private health insurance even when they are not covered through a group plan, thus reducing the burden on the public sector.

A cap on the exclusion, or a tax credit, would make people cost-conscious in their choices of health plans that cost more than the tax-subsidized limit. This is especially important now in light of so many new economical alternative health care plans.

Such alternatives could make a major contribution to the solution of the national problem of health care costs. But, they won't be able to unless they have a fair chance to compete.

This means that employers have to stop paying 100% of the employee's premium, no matter what plan an employee chooses. Instead, employers must offer a fixed-dollar contribution, no greater than the cost of an economical plan, so the employee who chooses the more costly plan will have to pay the extra cost himself.

Despite what opponents say, a tax cap or tax credit won't destroy employer-provided health insurance. Employers will still want good health insurance arrangements for employees as a way of recruiting and keeping them. ■

Alain C. Enthoven is a professor in the graduate school of business at Stanford University. He has been a major supporter of legislation to require employers to offer employees a choice of health care plans to stimulate competition. He also was one of the first to suggest capping tax-free employer contributions to employee health care premiums.

Taxation would doom benefit system

Continued from preceding page

higher than average because employees may face occupational hazards, could be forced to drop coverage if adverse selection drove those costs higher.

Add to that the geographical factor—states such as New York and California have higher health care costs than many others. Even larger employers in high-cost states would be hard put to keep a plan hit by such adverse selection.

Hospitals, many of which are striving to be more cost-efficient in the face of rising competition, could be overwhelmed with bad debts because they would have to treat more persons who had no coverage.

The current system is not perfect. We all know that health care inflation has been a national concern in recent years.

However, in 1984, we did see a significant reduction in such important areas as the rate of hospital admissions and lengths of stay. We are making great progress in slowing the rise of health care costs, and I think that trend will continue. The insurance industry, government, business, providers and employees must continue to work together to bring costs down. Taxing benefits, however, is not the correct way to contain health costs.

The proponents of taxation also say that, even if people did opt out of private group coverages, they would use the money to buy their own health insurance.

Very likely they would not. And, even if they did, they would still be without group life and disability insurance, and probably without the pension coverage that many millions rely on as the cornerstone of their personal financial security. The money they would get when they dropped out of their employers' plans would not be sufficient to replace all their benefits with personal coverages.

I'm afraid that this is a spurious argument, stemming either from a lack of understanding of the group mechanism or of human nature or both. The American public has grown used to "rich" plans and first-dollar coverages. They are only beginning to understand the need for cost efficiency. Taxation will not, on its own, cause them to opt for cost efficiency. The key to having employees use benefits efficiently is giving them a financial stake in the use of those benefits.

As the various pressures caused by taxing benefits combine to unravel the private system, it would not be long before large numbers of uncovered people needed care—those who had opted out of health care plans, their dependents and those whose employers discontinued plans because of the cost of maintaining them.

Ultimately, there would be increasing pressure—irresistible as a presidential election approached—for the federal government to "do something."

There are those who justify national health insurance on no basis other than the emotional rationale that the United States is the only civilized, industrialized country that does not care for its people. The appeal of this argument would, under the scenario I have just described, be irresistible to any politician who intended to get elected or to remain in office.

And, what would such a system, implemented in haste to stem a public outcry, be like? Nothing, we can be sure, like the private system it would replace.

Under the system we have now, employers can shop the marketplace and obtain the kind of custom-designed coverage that best suits their needs and the needs of their employees. Or, they can elect to self-insure and obtain administrative services from an insurer.

The concept of flexible benefits and cafeteria plans is an outgrowth of the need to tailor a plan as closely as possible to people's changing needs.

Granted, until recently it was usually only the larger employers who could take advantage of this kind of sophisticated plan design. But, in today's marketplace, it is also possible for small firms to buy into "pooled" coverages and take their choice of a variety of "off the shelf" products designed specifically to provide them and their employees with the kinds of benefits once available only to large employers.

All this would be swept away with the demise of private insurance plans. In their place would come a kind of complicated, bureaucratized uniformity, available to everybody and suitable to very few.

Given the government's cost-efficiency in administering Medicare and Medicaid, we can only assume that such a nationalized health care system would be a mammoth consumer of tax revenues. And wouldn't that be an irony? It would have resulted from an effort to raise revenue.

If expensive, tax-consuming health care reduced to the lowest common denominator is the price of closing the budget deficit by taxing the private benefits system, I strongly encourage the advocates of this measure to rethink their ideas before they do immeasurable, irreversible damage to both the physical and the fiscal health of the nation. ■

Philip Briggs is an executive vp of Metropolitan Life Insurance Co. in New York.

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New health care partnerships: True love?

By Joseph Marlowe

Whether the new health care partnerships are characterized as arranged marriages, shotgun weddings—or love at first sight—will help to determine whether real change can occur in the American system.

UNDER INCREASING pressure to make the nation's health care system more efficient, providers and payers of these services are being forced together in new, and potentially uneasy, alliances.

Whether such togetherness will be characterized as arranged marriages, shotgun weddings—or love at first sight—will help to determine whether real change can occur in the American health care system.

The courtship among the various providers and consumers is going to be very different in the future. All the new pairings—doctors and hospitals, businesses and hospitals, insurers and businesses, insurers and employees, hospitals and hospitals, insurers and doctors—will have a profound effect on the future of health care partnerships.

The substantial oversupply of physicians and the recent sharp drop in hospital occupancy rates fuel these new arrangements between suppliers and purchasers of medical care.

Those of us who keep close tabs on developments in the marketplace are astounded by this quickening pace of change. The growth of alternative delivery systems, like health maintenance organizations and the ensuing vertical and horizontal integration among medical providers, adds volatility to a system that slumbered along without significant change for many years.

As alternative delivery systems proliferate, employers will become more receptive to offering numerous medical plan choices to employees. The attractiveness of flexible benefits to both the employer and the employee, encouraged by the availability of competing medical delivery systems, will help speed the process.

The two most prominent examples of alternative delivery systems are health maintenance organizations and preferred provider arrangements (preferred provider organizations). During the past 18 months, HMO enrollment has grown by 18% nationally. Nearly 400 HMOs nationwide satisfy the medical care needs of more than 15 million Americans.

In metropolitan areas such as Philadelphia, Boston, Los Angeles and San Francisco, 10 or more HMOs operate in the same marketplace. The apparent attractiveness of these HMOs will have significant implications for group medical insurers, physicians and hospitals.

One response to HMOs has been the rapid growth of PPOs. Indeed, the mad mating frenzy among hospitals, physicians, insurers and employers is a dramatic, if not always well-conceived, effort to create an alternative to HMOs and traditional medical plans.

The early PPO models tend to permit indiscriminate membership to large numbers of providers with little thought given to the style of practice of the various players. Many of these PPOs will fail. Third-party payers, as they become more comfortable in negotiating with these strange new medical entities, will assist in structuring more-efficient models.

Joseph F. Marlowe is director of health care management services at The Hartford Insurance Group, Hartford, Conn.

Hospitals and other medical care providers will have to assume more financial risk in the provision of services through per-diem or diagnostic-related group reimbursements or capitation systems. In the process, medical providers will face intense pressure to improve an expensive, inefficient health care delivery system.

Hospitals will explore direct-marketing arrangements to employers and third-party payers, but the employee benefits market does not readily lend itself to such simplistic changes. Brokers and consultants must be courted, and insurers must participate in order to provide non-medical collateral lines such as life insurance, long-term disability and weekly disability.

Increasingly, hospitals and physicians will form joint ventures to achieve, among other objectives, improved negotiating positions vis-a-vis employers and third-party payers. Hospitals will unite to improve their prospects for the future.

The new hospital alliances are the best examples of this trend. The Voluntary Hospitals of America—an alliance having more than 400 hospitals, 63,000 beds and more than $7 billion in annual revenue—has assumed a leadership role among voluntary, non-profit hospitals. The American HealthCare System—an alliance of 223 hospitals, approximately 45,000 beds and some $5.6 billion in annual revenue—combines 26 different multihospital systems.

On the investor-owned side, Hospital Corp. of America has acquired Johnson & Johnson's Home Health Care Inc. HCA also intends to buy 80% of the Lovelace Medical Center's 235-bed hospital and group medical facility in Albuquerque, N.M. HCA also has purchased Hill, Richards & Cos., an administrator of self-insured health and workers compensation insurance programs.

There is no area of the health care market that is not subject to significant competition from these increasingly flexible giants. HCA and Humana—the artificial heart benefactors—are in the forefront of a movement by medical providers to combine the administration of group medical plans with the delivery of medical services.

Third-party payers are in a state of radical transformation as a new breed of medical experts on staff shake up the conservative establishment. Insurers will de-emphasize the traditional health insurance and compete for service agreements that reward them for effective health care management. To the extent that insurers insure traditional fee-for-service plans, they will demand tighter utilization controls and higher copayments.

There will be new demands on actuarial services, as more financial incentives are offered to enrollees who restrict their choices to more cost-effective providers. Insurers no longer will have the luxury of competing solely for the benefit manager's preference as a means of delivering a whole package of insurance products. Rather, they will have to focus their marketing energies on individual employees, since a single insurer's medical plan might be one of a half-dozen or so being offered to employees in a group. Insurers will have to become more competitive in the role of "manager of patient services," not solely as reimbursers of such services. This will have profound implications for relations with medical providers, as insurers begin to tread on formerly sacred turf.

Insurers will not survive the demands for cost containment without working effectively with medical providers. We can expect more emphasis on linking provider reimbursement to achievement of targeted utilization objectives.

Third-party payers and employers will demand more information in the new competitive climate, as the system seeks out only truly "quality" providers. The medical community, and in particular the American Medical Assn., has clung to secrecy about service and expense data, under the guise of protecting the confidentiality of the physician-patient relationship.

The revolutionary PPO directs medical consumers to selected physicians and hospitals, thereby limiting freedom of choice. It is not enough to know that these providers guarantee less-expensive care—we also must be sure that they practice high-quality medicine. Withholding such information impeded the traditional free-market values espoused by the AMA.

The oversupply of physicians, along with surplus hospital capacity, offers both opportunities and dangers to physicians and third-party payers. As alternative delivery systems proliferate and enrollment increases, physicians who are unwilling to accept financial risk-sharing or tight review controls will have fewer patients to treat. These physicians will have to provide proportionally more services to fewer patients to realize target incomes.

Insurers that ignore the challenge of dealing directly with medical providers to develop innovative medical plans will be stuck with less-attractive third-party compensation arrangements.

It is inevitable that the business community, often represented by third-party payers, will be more of a partner in hospital operations. Hospitals will be held accountable to these parties in the same manner that they are accountable to other major revenue sources.

During the next three years, as third-party payers introduce stringent patient utilization management programs for both fee-for-service and alternative delivery systems like PPOs, relationships with many medical providers will be strained, if not broken. However, at the same time, these parties will be searching for opportunities to combine their resources to gain competitive advantages or maintain market share.

The medical marketplace will force all the players together in marriages that may not be made in heaven, but that do offer real opportunity for quality and efficiency. ■

General liability insurer tapped

legal briefs

A highway contractor recovered a judgment of nearly $150,000 from its general liability insurer, under a ruling of a Louisiana appellate court.

Merrick Construction Co. Inc. contracted with the state for road construction work. St. Paul Fire & Marine Insurance Co. executed a surety bond to guarantee Merrick's obligation to the state and to hold the state harmless from any loss arising from Merrick's negligence. Merrick also carried a general liability insurance policy with Hartford Fire Insurance Co.

As a result of a car accident on the roadway worked on, a suit was filed against Merrick, the state and others alleging that Merrick was negligent in the performance of its work. Hartford undertook Merrick's defense in the main action. The state also sued St. Paul under Merrick's surety bond.

St. Paul tendered the defense of this suit to Merrick, which tendered it to Hartford. Hartford refused to defend since St. Paul was not a named insured under Hartford's policy. Merrick then hired an attorney and expended nearly $150,000 in fees. Merrick sued Hartford to recover the fees. The trial court ruled for Merrick.

The appellate court said St. Paul's defense costs were covered under the Hartford policy because the liability of Merrick to defend arose by operation of law out of the bond that St. Paul executed, warranting Merrick's workmanlike performance of the road construction.

According to the court, the liability of Merrick to St. Paul arose not just from the guaranty but from the legal provisions governing suretyship and that the general purpose of liability insurance is to cover this type of legal liability. St. Paul's being a stranger to the Hartford policy, the court said, was irrelevant. *Merrick Construction Co. vs. Hartford Fire Insurance Co.*, Court of Appeal of Louisiana, April 3, 1984.(*BI*/04/M.-$5) ■

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

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Auditing helps cut hospitalization costs

By MARGARET LeROUX

Hospital bills may be produced by computers, but it's old-fashioned, line-by-line, manual auditing that is helping an increasing number of employers save on hospitalization costs.

Auditors at Arthur Young in Chicago estimate that overpayment of hospital bills can add as much as $300 million annually to the cost of insured and self-insured health care plans.

Employers and their insurers are paying for medication not given, services not rendered and procedures not performed.

In fact, Equifax Services in Atlanta, one of the leading hospital bill audit firms, says it found errors in 98% of the bills it audited in 1984. Average unsupported charges in the more than 9,000 group major medical bills Equifax audited in 1984 were $1,359. The average size of bills audited was $38,768.

Intracorp of Wayne, Pa., another larger auditor of hospital bills, says about 92% of the 20,000 bills it audited last year contained errors.

The mistakes are pouring out of the same computer systems that hospitals hoped would streamline their billing procedures.

In response, a growing number of employers and insurers are turning to independent audit firms, like Equifax and Intracorp and their competitors, to scrutinize hospital bills. Some benefits consultants and third-party claims administrators also do hospital bill auditing.

According to a 1984 survey by consultant Hewitt Associates in Lincolnshire, Ill., the number of employers that have their employees' hospital bills audited increased to 68% compared with only 39% in 1982.

Consequently, the independent auditing firms have seen their volume of business increase dramatically.

For example, Republic Service Bureau in Naperville, Ill., which has been auditing hospital bills for 12 years, says its business has increased by more than 20% a year for the last two years.

And, American Claims Evaluation Inc. in Jericho, N.Y., says its hospital bill audit business has doubled in 1984 compared with 1983.

The scrutinizing is paying off in many cases.

Travelers Insurance Co., which had about 3,650 hospital bills for its group health policyholders audited last year, reported savings of $5.5 million.

At Aetna Life & Casualty Insurance Co., auditing of 4,305 hospital bills uncovered overbillings of $3.84 million.

And, Connecticut General Life Insurance Co., a CIGNA unit, saved $2.50 for every $1 it spent on hospital bill audits last year.

Sometimes, the savings from just one audit can be phenomenal if the hospital bill is unusually large. The National Assn. of Letter Carriers, which provides health care coverage for 190,000 members and their dependents, has Equifax audit its bills. It found $56,000 in overbillings in a $396,000 bill for a 180-day hospital stay.

The savings realized from audits of hospital bills are small compared with the nation's overall annual health care costs, but "audits serve notice to hospitals that we are looking for accurate bills and will only pay for services given and documented," says Ron Hwalek, assistant director of cost-containment programs at Connecticut General.

Employers also are convinced that hospital bill audits are a worthwhile cost-containment measure.

Working with an audit firm gives an employer that self-funds its health care benefits, especially if it is a small or medium-sized company, more clout in negotiating with hospitals, according to Bob Stein, vp of Miller Fluid Power Co. in Bensenville, Ill.

"It's almost impossible to do an audit yourself," Mr. Stein added, "unless you have someone on your staff with the medical background and experience that most audit firms have."

When any of Miller Fluid Power's 500 employees or their dependents files a health care claim of more than $3,000, it is audited by

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Self-Insured Benefit Services, a Park Ridge, Ill., third-party claims administrator.

"We saved between $5,000 and $10,000 last year on claims that totaled $500,000," Mr. Stein said.

"Any employer that has a fairly liberal health plan will have to audit hospital bills," he said. "In no other area of the company would a billing of $500,000 go unchallenged."

The cost of on-site audits "is money well-spent, even if you learn that all the charges are justified, when the hospital in question is one a lot of your employees use," said Rebecca Belmont, manager of pensions and health benefits administration at Snap-On Tools in Kenosha, Wis.

The audits have a sentinel effect, she added. "Because of the possibility of being audited, some hospitals are being more careful."

To find the undocumented charges in hospital bills, the audit process for hospital bills usually includes two steps.

First, bills of a minimum size, generally $10,000, are pre-screened by the group health insurer, self-funded employer or a third-party claims administrator.

Most audit firms also will pre-screen hospital bills, although some charge a nominal fee for that service.

The Hospital Medical Audits Department of American Claims Service Bureau in Chicago offers its hospital bill audit clients access to a computer data bank of audit results on every hospital it has audited over the past two years.

"This helps in our pre-screening process to show our clients whether an audit of a particular hospital is cost-effective," says Marill L. Crouse, assistant vp of hospital medical audits.

Obvious mistakes turn up through pre-screening. "On one of our employee's hospital bills, our TPA noticed that every time the patient was given Maalox, it was charged at a rate of $71.14 per tablespoon," said Ms. Belmont of Snap-On Tools. The resulting overcharge was $2,660.

"We put in a call to the hospital, a computer error was discovered, and we got a corrected bill," she added.

On the other hand, sometimes pre-screening will indicate that the cost of an audit would not be justified.

"One $150,000 hospital bill we sent in for pre-screening came back with a note from the TPA saying that yes, the bill is huge, but everything on it is legitimate," Ms. Belmont said.

"You have to know something about the cases you are screening. Some are just expensive cases and all the audits in the world aren't going to change that."

If pre-screening uncovers problems, the next step usually is to send the bill to an auditing firm.

Bills usually targeted for an audit are those in which the charge for room and board is less than 60% of the total bill and bills in which half or more of the ancillary fees are for a one-time service.

When a suspect bill is referred to an independent audit firm, the next step is for an auditor—most frequently a registered nurse—to go to the hospital to conduct an on-site audit.

The auditor requests the patient's medical records and compares notations on the patient's medical chart to the charges on the bill to see if every procedure billed is documented.

In particular, the auditors look for charges that are unrelated to the diagnosis. For example, one auditor found that a patient being treated for a broken finger was charged for a CAT scan.

After the auditor completes the review of the medical records and hospital bill, some meet with representatives of the hospital's billing department to work out an immediate settlement. Other firms allow a hospital a few weeks to document charges that were originally unsupported before reporting back to their clients.

Still other auditors simply report their findings to their clients and let the clients negotiate billing changes with the hospital.

The cost of a hospital bill audit varies with the auditing firm. For example, some firms charge an hourly rate, capping the fee at a percentage of the total bill.

Others operate on a contingency fee basis, sharing the savings with their clients.

This type of arrangement "made the audit program easier to sell to my boss," said Kevin Westley, benefit manager for MacMillan Inc. in New York. "On some audits where the savings are less than $100, if

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Hospital audits

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you're paying an hourly rate, you're paying out more than you're saving."

Even though paying its auditor, American Claims Evaluation Inc., on a contingent basis cut MacMillan's savings of $23,000 in hospital overbillings to $11,500, Mr. Westley believes the auditing program is still effective.

"It's a painless way of putting in a cost-containment measure that produces immediate results," he said.

When a group health insurer has a hospital bill from a policyholder audited, the insurer picks up the cost as part of the services covered by the policyholder's premium.

The most common source of errors on hospital bills, according to audit firms, is data entry. A $10 charge is wrongly input into the computer at the hospital as a $100 charge or a procedure is identified by an incorrect code, which then triggers an incorrect charge.

According to Equifax, errors are most often found in billings for pharmaceuticals administered to the patient and supplies used to care for him or her. Billings for intravenous care and laboratory tests produce the next-highest number of errors.

In some cases, however, errors found in hospital bills are not in the employers' favor. And, most of the audit firms interviewed report to the hospital cases of underbilling as well as overbilling.

For example, last year when Federal Express in Memphis, Tenn., had Intracorp review a $107,000 hospital bill, the auditors found that Federal Express had been undercharged by $5,000.

This "unfortunately brought our net savings from auditing down to less than one-half of 1% of our total hospital bills," according to Bonnie McKeever, senior manager of group insurance.

"With the exception of that bill, our savings would have been closer to 4% of our total hospital costs," she said. "If I could capture that amount, I'd feel the audit program is worth it."

Not all auditors, however, point out undercharges in bills to the hospitals.

"We feel it's the hospital's responsibility to produce a bill that's accurate," according to Roger Reedy, vp of sales for Republic Service Bureau. "We're there working for our client, not the hospital," he added.

Unbilled charges can be found in 77% of all bills audited, says Equifax.

Will hospital bill auditing eventually produce more correct hospital bills?

Yes, say some consultants. "I think we're going to see hospital administrators being tougher," according to Allen DeGraw, a consultant with Kwasha Lipton in Fort Lee, N.J.

"They're going to crack down on the kinds of errors being spotted by auditors," he added.

As the number of hospitals being audited increases, fewer errors in billing should occur, he said.

But Republic Service Bureau's Mr. Reedy disagrees. "When we started doing hospital bill audits 12 years ago, I thought we'd be auditing ourselves out of a job within a few years," he said.

"But there's been no indication that the kinds and amounts of errors in hospital bills today are any different than those we saw five or 10 years ago."

However, some hospitals have reacted to the growth in auditing of their bills by charging exorbitant audit fees.

"Most hospitals charge a nominal fee to cover their time and effort of supplying records," according to June Novak, vp of American Claims Evaluation.

"But, we've seen some outrageous fees. Some hospitals charge from $5 to $15 per hour plus the cost of benefits for the time an employee is made available to assist with the audit. That can add up to $500 to the cost of an audit," she added.

"Most of our clients refuse to pay exorbitant audit fees," said Don Wilson, director of product management for Intracorp. "When a hospital's audit or finance departments try to block an outside audit, the matter is usually resolved by a call to the hospital administrator."

"Some hospitals feel threatened," said Mr. DeGraw of Kwasha Lipon. "They feel like they're being invaded by auditors who are just looking for mistakes in their billing."

As a solution to the conflict between hospitals and outside auditors, Mr. DeGraw suggests sharing the cost of the audit.

"Whoever comes out on top should pay," he said. "If an audit finds $1,000 in unbilled charges and $500 in unsupported charges and the cost of the audit is $300, why not have the hospital, which is coming out ahead, pay the cost of the audit?"

The key to success in cost containment, he added, "is when everybody wins."

At the American Hospital Assn. in Chicago, Susan Melcer, senior staff specialist in the department of hospital finance, said that the decision on whether to charge audit fees is at the discretion of the hospitals.

In some cases, she said, "an adversarial relationship does exist.... Some auditors are not experienced, and the way they conduct an audit may not be appropriate."

She said the AHA has prepared a technical advisory bulletin on setting policies for audits. ■

Choose auditing company wisely

Before choosing a company to scrutinize employees' hospital bills, employers should scrutinize the potential audit company.

When checking into an audit company, experts say, employers should consider:

- Fee structure. Does the company charge an hourly fee, or is there a flat fee per audit? Some companies charge on a contingency basis, and the employer pays only when savings are uncovered.
- References: Get the names of benefit managers the company has worked with and ask them about their experience with the firm. Ask, for example, if their savings met their expectations.
- The audit itself. What kind of information will you receive—a memo outlining your savings or a complete report, including a copy of the actual audit? Does the report from the audit company give you information and figures useful for compiling experience data?
- Qualifications. Who is doing the audit? Do auditors have a medical background? What procedures does the company use?

This last point is especially important, noted June Novak, vp of American Claims Evaluation Inc.

"The audit firm represents your company in dealing with a hospital. Determine that their manner of doing business is consistent with your own company's ethics," Ms. Novak said. "You don't want to alienate a hospital when your employees will be needing its services in the future."

datebook

MARCH 31-APRIL 3. 1985 Corporate Benefits Management conference in Orlando, Fla., sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. Also, **June 2-5** in Williamsburg, Va., and **Aug. 18-21** in Lake Tahoe, Nev. Registrar, IFEBP, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis., 53005-0069; 414-786-6700.

APRIL 1-5. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; $695. Also, **June 10-14** in Atlanta. Registrar, ILCI, P.O. Box 345, Loganville, Ga. 30249; 1-800-554-6001, 404-466-2208.

APRIL 2. Credit Enhancement Insurance workshop in Dallas, sponsored by The Society of Chartered Property and Casualty Underwriters; $95 for members, $120 for non-members. Also, **May 3** in New York and **May 23** in Miami. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2735.

APRIL 3-5. Successful Retirement Planning Programs workshop in Boston, sponsored by Retirement Advisors Inc.; $450. Also, **April 24-26** in San Francisco, **June 26-28** in Chicago, **Oct. 16-18** in Kansas City, Kan., and **Nov. 6-8** in New York. Registrar, 919 Third Ave., New York, N.Y., 212-421-2400.

APRIL 9. Toxic Substances in the Workplace Disclosure conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $40 for members; $60 for non-members. Also, **April 11** in Springfield, Ill. Carol Jenson, ISCC, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

APRIL 10. 1985 Public Employee Benefit Plans workshop in Boston, sponsored by the International Foundation of Employee Benefit Plans; $140 for members; $165 for non-members. Registrar, IFEBP, P.O. Box 69, Brookfield, Wis. 53005-0069;414-786-6700.

APRIL 11-12. Physical Security: Practice & Technology workshop in Denver, sponsored by the American Society for Industrial Security; $285 for members; $375 for non-members. Registrar, ASIS Headquarters, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

APRIL 14-19. Risk & Insurance Management Society 23rd annual conference in New Orleans, sponsored by RIMS; $545 for members; $645 for non-members; reduced fees for part of the conference. RIMS, Conference Department, 205 E. 42nd St., New York, N.Y. 10017.

APRIL 15-16. Practical Management Oversight Risk Tree seminar in Sacramento, Calif., sponsored by the International Loss Control Institute; $280. Registrar, ILCI, P.O. Box 345, Loganville, Ga. 30249; 1-800-554-6001, 404-466-2208.

APRIL 15-19. Safety in Chemical Operations course in Chicago, sponsored by the Safety Training Institute of the National Safety Council; $595 for members; $740 for non-members. Registrar, Safety Training Institute, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

APRIL 16. Surety Claims '85—New Directions in Suretyship conference in Seattle, sponsored by CMA Consulting Group; $230. Also, **April 18** in Dallas, **April 30** in Hartford, Conn. Arlene Brower, Conference Coordinator, CMA Consulting Group, 170 E. Hanover Ave., Morristown, N.J. 07960; 201-267-7171.

APRIL 17-19. Systematic Incident Investigation seminar in Sacramento, Calif., sponsored by the International Loss Control Institute; $420. Registrar, ILCI, P.O. Box 345, Loganville, Ga. 30249; 1-800-554-6001, 404-466-2208.

APRIL 18-19. Third Annual Financial Services institute in New York, sponsored by the Practising Law Institute; $390. Registrar, 810 Seventh Ave., New York, New York 10019; 212-765-5700.

APRIL 18-19. Lessons from Success conference in Washington, sponsored by The American Assn. of Preferred Provider Organizations and Health Care Competition Week; $445 members or subscribers; $490 for non-members or non-subscribers. Conference Registrar, AAPPO, 4301 Connecticut Ave., NW #139, Washington, D.C. 20008.

APRIL 18-19. A Brief Course in Reinsurance in New York, sponsored by The College of Insurance; $145. Laura Mckeon, Professional Development Programs, The College of Insurance, One Insurance Plaza-101 Murray St., New York, N.Y. 10007;212-962-4111.

APRIL 22-23. Basic Computer Security conference in Chicago, sponsored by the American Society for Industrial Security; $270 for members; $360 for non-members. Registrar, ASIS, 1655 N. Fort Myer Dr., Arlington, Va. 22209; 703-522-5800.

APRIL 24-26. Advanced Computer Security Conference in Chicago, sponsored by the American Society for Industrial Security; $330 for members; $440 for non-members. Registrar, ASIS, 1655 N. Fort Myer Drive, Arlington, Va. 22209; 703-522-5800.

APRIL 22-23. Asset/Liability Management: Profitability and Risk in a Time of Change conference in Washington, sponsored by Peat Marwick and Darling & Associates; $675. Also **May 16-17** in New York, **June 3-4** in San Francisco, **July 22-23** in Boston. Registrar, Executive Education Department, 810 Seventh Ave., 28th Floor, New York, N.Y. 10019; 1-800-762-3932.

APRIL 22-26. Managing Program Implementation seminar in Atlanta, sponsored by the International Loss Control Institute; $695. Registrar, ILCI, P.O. Box 345, Loganville, Ga. 30249; 1-800-554-6001, 404-466-2208.

APRIL 23-25. Laboratory Safety Course in Chicago, sponsored by the Safety Training Institute of the National Safety Council; $375 for members; $470 for non-members. Registrar, Safety Training Institute, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

APRIL 25-26. A Brief Course in Ocean Marine Insurance in New York, sponsored by The College of Insurance; $145. Russel Fershleiser, Professional Development Programs, The College of Insurance, One Insurance Plaza-101 Murray St., New York, N.Y. 10007;212-962-4111.

APRIL 28-MAY 1.The 1985 National Council of Self-Insurers meeting in Charleston, S.C.; $250 for members, $325 for non-members. Registrar, NCSI, 10 S. Riverside Plaza, Suite 1530, Chicago, Ill. 60606; 312-454-5110.

APRIL 29-MAY 3. Accredited Safety Auditor seminar in Atlanta, sponsored by the International Loss Control Institute; $775.50. Registrar, ILCI, P.O. Box 345, Loganville, Ga. 30249; 1-800-554-6001, 404-466-2208.

APRIL 29-MAY 3. 12th International Assn. of Industrial Accident Boards and Commissions Workers Compensation college in Tucson, Ariz., sponsored by IAIABC, $300 for members; $400 for non-members. Registrar, IAIABC College, P.O. Box 79109, Jackson, Miss. 39336; 601-366-4582.

APRIL 29-MAY 3. Assets Protection Course II —Practical Applications in Atlanta, sponsored by the American Society for Industrial Security; $650 for members; $695 for non-members. Registrar, ASIS, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

APRIL 29-MAY 1. Product Safety and Liability workshop in Madison, Wis., sponsored by the Department of Engineering and Applied Science; $495. Professor Richard Moll or Diane Lange, University of Wisconsin, Extension, Department of Engineering & Applied Science, 432 N. Lake St., Madison, Wis. 53706; 800-262-6243

APRIL 30. Environmental Impairment Liability workshop in Spokane, Wash., sponsored by The Society of Chartered Property and Casualty Underwriters; $60 for members; $75 for non-members. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2735.

MAY 1-3. "Coalition for the '80s: Investing Our Political Capital" conference in Washington, sponsored by the Assn. of Private Pension and Welfare Plans; $350 for members ($380 after April 10); $385 for non-members ($415 after April 10). APPWP, 1331 Pennsylvania Ave. N.W., Suite 719, Washington, D.C. 20004; 202-737-6666.

MAY 2-3. International Reinsurance Law conference in London, sponsored by Union Internationale des Avocats, British Insurance Law Assn. and Business Law Communications Ltd.; about $242 for members; about $270 for non-members. Registrar, Business Law Communications Ltd., 53 Fleet St., London, EC4 1BY; 01-353-8154.

MAY 5-8. The Seminar for Non-Insurance Professionals in New York, sponsored by The College of Insurance; $540. Laura Mckeon, Professional Development Programs, The College of Insurance, One Insurance Plaza-101 Murray St., New York, N.Y. 10007; 212-962-4111.

MAY 6-10. Highly Protected Risk Property Conservation course in Long Grove, Ill., sponsored by the Kemper Group; $400; free for Kemper HPR-insured property owners. Also, **Oct. 7-10** in Long Grove. W.P. Thomas Jr., Manager, Engineering Resesarch & Staff Development, HPR Department, A-1, Long Grove, Ill. 60049; 312-540-3380.

MAY 6-10. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $500; 10% discount for two or more registrants from the same company. Also **Sept. 9-13 and Nov. 11-15** in Long Grove. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

MAY 9-10. Retail Security conference in Washington, sponsored by the American Society for Industrial Security; $295 for members; $385 for non-members. ASIS, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va., 22209; 703-522-5800.

MAY 13-15. Product Safety and Liability Prevention: The Role of Human Factors Engineering seminar in Madison, Wis., sponsored by the University of Wisconsin; $495. Professor Richard A. Moll, University of Wisconsin-Extension, 432 N. Lake St., Madison, Wis. 53706; 800-262-6243.

MAY 14-16. Petroleum/Chemical Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also, **June 11-13, June 24-26, July 16-18, Aug. 20-22, Sept. 10-12 and Oct. 1-3**, all in Marinette. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

MAY 21-23. Industrial Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also, **June 18-20, Aug. 6-8, Sept. 17-19 and Oct. 7-9**, all in Marinette. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

MAY 30-31. Association Type Captives conference in Grand Cayman, Cayman Islands, sponsored by the government of the Cayman Islands; prices range from $765 to $1,213, including registration and three nights of accommodations. Jacqui Mason, Captive Insurance Conference, Transnational Conference Centre, P.O. Box 69, Grand Cayman, Cayman Islands, British West Indies; 7-4666, Telex 4216 transit.

JUNE 4-6. Utilities Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also, **July 30-Aug. 1 and August 27-29**, all in Marinette. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

House panel to consider national pension policy

washington

By JERRY GEISEL

WASHINGTON—A House subcommittee will begin hearings this week on how a national retirement income policy can be shaped.

The March 21 hearing by the Labor Management Relations Subcommittee will focus on such broad issues as the importance of employee benefits to workers and the role of the private sector vs. the public sector in providing those benefits.

In addition to these broad issues, the subcommittee also will consider:

- What are reasonable retirement income goals and what means can be developed to achieve them?
- What should be the essential components of a national retirement income policy, including the relative roles of governmental, individual and employer-sponsored programs?
- Of what importance are welfare benefits, such as health and life insurance, in providing retirement income security?
- To what extent should a national retirement income policy address the areas of coverage, benefit portability, vesting, retirement plans vs. capital accumulation plans, the role of Individual Retirement Accounts in providing retirement income, appropriate level of retirement income and retirement ages?
- How should a national retirement income policy be implemented and administered?

The hearing will begin at 10 a.m. in Room 2175 of the Rayburn House Office Building. The subcommittee also has additional hearings scheduled for April 2 and 3 at 10 a.m. in Room 2261 of the Rayburn Building.

Product liability bill

The Senate Commerce Committee this week will hold its first hearing of the year on federal product liability legislation.

The March 21 hearing is expected to focus on recent changes to a federal product liability bill, S. 100, introduced by Sen. Robert Kasten, R-Wis. (*BI*, Jan. 14).

Those changes, designed to increase congressional support for the bill, include deleting a provision in a similar bill—S. 44, introduced by Sen. Kasten last session—that said a manufacturer could be hit with only one punitive damage award for any single defect in a product it produced.

In the current bill, a judge rather than a jury would determine the amount of punitive damages to be awarded.

In addition, the bill has been reworded to make clear that that it does not apply to environmental pollution incidents, like the release of toxic gas at the Union Carbide Corp. plant in Bhopal, India.

But, other provisions in the Kasten legislation remain the same as those in the bill that last year cleared the Commerce Committee but died on the Senate floor after a threatened filibuster by Sen. Alan Cranston, D-Calif.

For example, the current measure bars plaintiffs from suing manufacturers if they are injured by a capital goods product, like a printing press, that was more than 25 years old at the time of the accident.

The bill also would bar suits filed on the basis of strict liability in cases where a plaintiff alleged that an injury was caused by defective product design.

Under strict liability, a plaintiff only has to prove that a product was defective; it is not necessary to prove that the manufacturer also was negligent.

The hearing will begin at 9:30 a.m. in Room 253 of Russell Senate Office Building.

OPIC official named

Robert B. Shanks, a former Justice Department attorney, has been named vp and general counsel for the Overseas Private Investment Corp., the federal agency that provides political risk insurance to U.S. companies investing abroad.

Before joining OPIC, Mr. Shanks was a deputy assistant attorney general at the Justice Department's Office of Legal Counsel.

Mr. Shanks, who earned his law degree from the University of Virginia School of Law in Charlottesville, also was a law clerk to Supreme Court Justice William Brennan Jr.

Malpractice crisis

The Assn. of Trial Lawyers of America doesn't believe there is a medical malpractice insurance crisis.

According to an analysis prepared by ATLA, a Washington-based trade group:

- The cost of medical malpractice insurance in 1983 was less than one-half of 1% of total U.S. health care costs of $355.4 billion.
- In 1983, the per-capita cost of health care was about $1,500, of which just $6.08 was for medical malpractice insurance premiums.
- The average doctor spends 2.3% of gross income for malpractice insurance, compared with 2.3% on "professional car upkeep" and 1.2% on continuing education.
- Fifty-seven percent of doctors spend less than $5,000 each year on malpractice insurance premiums, while 12% spend more than $15,000.

Meanwhile, ATLA says it will oppose any proposal to place limits on contigency fee arrangements. In that system, an attorney representing a plaintiff receives no fee until he or she obtains an award for his client, and then the fee is a percentage—often one-third—of the award.

Such arrangements ensure that accident victims can retain legal talent to fight companies with much bigger resources, ATLA says.

"How many of us could afford to hire a lawyer on an hourly basis to

Continued on next page

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pursue a negligence case against the vast resources of an insurance company in a case which might require the expenditure of tens of thousands of dollars just for expenses?. . .Very few of us could even start such a case," ATLA says.

Multiemployer plans

About 10% of multiemployer pension plans surveyed by the General Accounting Office are financially distressed, and the GAO says their collapse could wipe out the Pension Benefit Guaranty Corp.

The GAO study that 14 of 149 multiemployer plans could not withstand further financial deterioration without posing a substantial risk to the PBGC's insurance program, which guarantees workers' and retirees basic benefits if their plans collapse.

The 14 plans all were poorly funded; had negative cash flow or barely enough income to pay benefits; and a declining number of active participants.

For example:

- In the aggregate, the assets of the 14 unnamed plans covered only 22% of their vested benefits. Twelve of the plans were less than 50% funded and eight of the 12 had funded less than 32% of their vested benefits.
- In 13 of the 14 plans the number of working participants was declining and in one plan there were no participants who were currently employed.

These 14 financially distressed plans had $3.7 billion in unfunded vested benefits, according to the GAO. Their failure would overwhelm the PBGC which, as of the end of fiscal 1983 had $25 million in assets in its multiemployer plan insurance program to pay benefits to participants of collapsed multiemployer plans.

The significance of this potential liability and the effect that it could have on the PBGC's multiemployer insurance fund emphasizes the need to improve the financial condition of distressed plans, the GAO said.

Seat belt laws urged

Mandatory seat belt laws should be enacted by the states, an insurance industry trade association says.

Such laws are needed because public awareness campaigns urging the use of seat belts have not worked, according to Sally Ann Kirkpatrick, senior legislative counsel in the Washington office of the Alliance of American Insurers.

Speaking last month before the House Appropriations Subcommittee on Transportation, Ms. Kirkpatrick said the failure of public information programs to get people to buckle up has made the mandatory use laws necessary.

For example, Motorists Information Inc., an organization formed by U.S. automakers, spent some $1.75 million in 1977 in the Detroit area to promote belt use.

When the Department of Transportation measured the effectiveness of the 10-week campaign, which included radio, television and billboard ads, it found "no response" to the effort, Ms. Kirkpatrick told the subcommittee.

By contrast, when a mandatory seat belt law took effect in 1983 in Great Britain, seat belt use shot up to 95% from 40%, she said.

If all passenger car occupants used seat belts at all times, some 12,000 to 15,000 lives could be saved a year, Ms. Kirkpatrick said, citing statistics compiled by the National Safety Council.

III vp appointed

Marc Rosenberg, a former congressional staffer, is the new vp for federal affairs in the Insurance Information Institute's Washington office.

Previously, Mr. Rosenberg had been staff director on the House Energy, Environment and Safety Subcommittee. He also was a special projects director for former Rep. Charles W. Whalen, R-Ohio, and closely followed product liability issues.

The III is an educational and public relations organization supported by property/casualty insurers.

Budget office report

Social Security could garner billions of dollars in payroll taxes if newly hired state and local government workers were covered under the program, the Congressional Budget Office says.

The CBO estimates that Social Security revenues would increase by more than $7 billion between 1986 and 1990 if all government workers hired after Dec. 31, 1985, were brought under the Social Security system.

Under the Social Security Amendments Act of 1983, state and local governments no longer were allowed to opt out of Social Security. However, the amendments did not require state and local governments that never signed up or already had left Social Security to join the program.

Currently, about 70% of state and local government employees are covered by Social Security, the CBO says.

Also, the CBO, which is Congress' research arm, estimates enactment of a Treasury Department proposal to cap tax-free health insurance premiums would increase federal income tax revenues by $35.3 billion between 1986 and 1990 and would boost FICA tax revenues by $14.1 billion during the same period.

Under the Treasury's tax simplification plan, employers' health care costs that exceed $175 a month for family coverage and $70 a month for individual coverage would be included as taxable income to employees (*BI*, Dec. 3, 1984).

The CBO notes that proponents of a health care tax cap say that providing tax-free health care benefits to workers has unnecessarily increased the demand for health care services and thus driven up medical costs.

The opponents argue, among other things, that the tax would be unfair to workers who live in geographic areas with high health care costs, according to the CBO. Those workers would more likely be covered under group health care plans in which the employers' health insurance premium exceeded the cap than workers who live in areas with low health care costs. ■

Compensation not sufficient, Brooks & Dooley members say

By STACY SHAPIRO

LONDON—A proposal by Lloyd's of London managing agents Brooks & Dooley (Underwriting) Ltd. to pay syndicate members about 2 million pounds ($2.14 million) to compensate them for the alleged misappropriation of syndicate funds is not sufficient, a syndicate member says.

About 400 Lloyd's members belonging to syndicates managed by Brooks & Dooley say they still plan to go to court to reclaim the money the names believe they are owed.

"We intend to commence legal proceedings, if only as a formality," said Mark Farrer, chairman of the names' committee financing the court action.

"We do not find the Brooks & Dooley offer terribly convincing without full disclosure of the facts. And, there has never been full disclosure of the facts," he said. "The proposal is a helpful step forward and shows that they are moving in the right direction, but they have some way to go," Mr. Farrer added.

The syndicate members will base their litigation on the findings of a Lloyd's disciplinary committee that last year charged that Lloyd's underwriters Raymond Brooks and Terence Dooley benefited from reinsuring the syndicate with Fidentia Marine Insurance Co. of Bermuda (*BI*, July 16, 1984).

Lloyd's has expelled Mr. Brooks as a member of the marketplace, while Mr. Dooley has been temporarily suspended (*BI*, Dec. 17, 1984).

The money offered to syndicates will be raised by liquidating Fidentia and its sister company, Coral Insurance Co. Ltd.

Last summer, the disciplinary committee's inquiry estimated transactions between the Brooks & Dooley syndicates and Fidentia from 1970 to June 1983 generated for Fidentia a net profit of 6.2 million pounds ($6.6 million). Some syndicate members say this is what Brooks & Dooley should pay them.

In two letters to the members written last month, Brooks & Dooley Underwriting Chairman Jack Alston explained the proposal to pay the 2 million pounds and why the proposed settlement is smaller than the 6.2 million pounds of profit allegedly reaped by Fidenita.

The proposal has already been approved by Coral Trust in Bermuda, owner of Coral Holdings, which, in turn, is the holding company of Fidentia, Coral Insurance Co. Ltd. and Court Agencies Ltd., confirmed James Pearman, a partner with the Bermuda law firm of Conyers, Dill & Pearman.

The agreement has also been approved by the directors of Fidentia and Coral Insurance, he said.

"These are suggestions for consideration," said Mr. Pearman, who is a trustee for Coral Trust and a director of Fidentia and Coral Insurance. "We have no idea what response we will get from the names or from Mr. Brooks."

Under the proposal, outlined in the first letter by Mr. Alston:

- The trustees, the board of Fidentia and the board of Brooks & Dooley Underwriting maintain that they have no legal liability to the names for any of the matters referred to in the Lloyd's disciplinary committee report on Fidentia.
- Fidentia and Coral Insurance will be liquidated, "with the lion's share of any eventual surplus made available to the names."

Coral Insurance will first be liquidated and will pay—with a contribution from Brooks & Dooley Underwriting—600,000 pounds ($642,000) to the members.

Then, Fidentia will be liquidated "as soon as practicable." Because it conducts business with companies other than the Lloyd's syndicates in question, the insurer cannot immediately be liquidated.

"The directors would find it impossible to evaluate reserves for the recent business, other than at a level that would prohibit the release of any funds to the names," Mr. Alston said. Therefore, Fidentia's business will be run off during a three-year period.

"Current indications are that the eventual surplus (in Fidentia) would be in the region of $1 million to $1.5 million," subject to fluctuations for additions to loss reserves, according to the letter.

- Members will be invited to appoint a director to the board of Fidentia to represent their interests.

Mr. Alston said he wishes more money were available to the names, but he pointed out in the subsequent letter that claims must be paid.

The 6.2 million pounds of profit cited in the Lloyd's report will be cut significantly by claims payments, he said, adding that the profit cited in the Lloyd's report is misleading because it is only an estimate, based on the amount of interest of certain reinsurance treaties collected.

Mr. Alston also told *Business Insurance*, "You can only get out of a person what is in the handbag. Our offer is what is in the handbag." ■

Official issues warning on fronting programs

By ROBERT A. FINLAYSON

LOS ANGELES—Risk managers should be "extremely careful" when reviewing the financial backing of fronting programs for captive insurance companies, the deputy commissioner of the California Insurance Department advises.

"The extent to which you have a pure fronting program, the less the retention, the more dangerous the situation becomes," Deputy Commissioner Roxani M. Gillespie told a recent joint meeting of the Los Angeles City and Orange County chapters of the Risk & Insurance Management Society.

Ms. Gillespie said the California Insurance Department has looked into the possibility of issuing regulations for captive fronting programs, but "up to now, we have felt comfortable dealing with things on a case-by-case basis."

The deputy commissioner pointed out that some insurance company rating organizations "are taking a very jaundiced look" at reinsurance programs for fronting arrangements that are backed by letters of credit.

"I think that, where the banking industry is concerned, we have a different situation than we had in the 1970s," she said. "Before running to finance anything, I sure as heck would be extremely careful.

"The greater the reliance on banking systems that may or may not be sound, the greater the reluctance" on the part of the Insurance Department to accept the fronting program, she added.

Ms. Gillespie also said the department's caution extends to captive insurance companies themselves.

"As a regulator, I'll tell you, we really are not very fond of captives," she said. "We've seen some funny ones, and there probably are a lot more even funnier ones hiding out there in the weeds."

Ms. Gillespie urged the RIMS members to make more of an effort to communicate with the Insurance Department.

"In the two years that I've been in the department, it has surprised me how little we hear from you, how little we hear about your concerns and even how little we see you represented in Sacramento."

The legal community, however, is well-represented in the state capital, according to Ms. Gillespie.

"Until I came to the department, I didn't realize the extent to which the legal community is well organized," she said. California's trial lawyers are "very alert" and "very vocal" and "well-repesented in Sacramento."

Ms. Gillespie also said that California risk managers should put tort reform at the top of their agenda.

"If I were to set an agenda and say, 'Where does this group really need to get involved in the political process?' I would put tort reform way at the top of the list."

In addition to getting more involved in the political process, Ms. Gillespie said risk managers must do a better job of educating the public on the impact that multimillion-dollar tort verdicts have on the business community.

"I don't think the public is really aware of what we're talking about. I think they continue to see insurance and business as providing a bottomless pit of money," she said.

She added that until the public understands the "inequalities" in the current tort system, "the bills are going to get a lot higher." ■

Du Pont establishes work safety record

WILMINGTON, Del.—Employees of E.I. du Pont de Nemours & Co. reported 0.2 lost workday injuries per 200,000 hours worked for 1984, highlighted by record safety performances by Conoco, Du Pont's energy subsidiary, and Consolidation Coal Co., its coal subsidiary.

Du Pont received awards for its 1984 safety performance from the National Safety Council, the Chemical Manufacturers Assn. and the Compressed Gas Assn.

And, Conoco received the first National Safety Award for Excellence from the U.S. Department of Interior for environmental protection and human safety in offshore oil and gas operations. ■

Sturge may list stock on London exchange

By STACY SHAPIRO

london line

LONDON—Sturge Holdings P.L.C. may be the first Lloyd's of London underwriting management agency to be listed on the London Stock Exchange.

"The board has agreed that we should approach the stock exchange about obtaining a listing by way of an introduction," Sturge Chairman David Coleridge recently told Sturge stockholders.

"This we plan to do this year," said Mr. Coleridge, who is also junior deputy chairman of Lloyd's. "Dealings in our shares should then be much easier than they have been under the present rather restricted market."

Last May, Sturge offered a limited number of shares to Sturge directors and their immediate families; Lloyd's members that use Sturge as their members' agency; and a select number of financial institutions. Now, more than 25% of Sturge's equity is outside the control of its directors, Mr. Coleridge said.

Listing the company on the stock exchange will allow anyone to buy shares, although Sturge is not issuing new shares.

Also, last year, Sturge's capacity for its managed syndicates increased by 100 million pounds ($1.07 million) to 413 million pounds ($441.9 million), including the recent acquisition of another agency, R.A. Edwards & Co. (Holdings) Ltd. (*BI*, March 11).

"We anticipate this trend (of increased capacity) will continue, as considerable additional capacity for 1986 will be needed to take account of both the decline in sterling against the dollar and the hardening of insurance premium rates," Mr. Coleridge said.

Howden growth

The glut of insurance business coming to London this year has prompted Lloyd's of London broker Alexander Howden Ltd. to double its claims and administrative staff.

The wholesale brokerage arm of Alexander Howden Group P.L.C. has also named a new deputy chairman.

"We are expanding the company's resources to match the recent significant increase in business," said Dennis L. Mahoney, chairman of Alexander Howden Ltd.

"(Howden wants to) maintain a fast, responsive service for clients on the process settlement of claims," he said. "We have also strengthened the technical and documentation division so that all functions run smoothly and efficiently, from the analysis of underwriting information and preparation of submissions to underwriters, to issuance of cover notes and processing of policies."

As a wholesale insurance broker, Alexander Howden Ltd. deals with other brokers around the world that want to place business in the London marine, non-marine, aviation and some reinsurance markets.

In addition to increasing staff, Alexander Howden Ltd. has appointed Bernard D. Steinart as deputy chairman. Before he joined Howden in 1984, Mr. Steinart specialized in placing utility risks at McGriff, Seibels & Williams Inc. of Birmingham, Ala.

In addition to these changes, the Alexander Howden Group appointed Francis N. Marjoribanks as chief financial officer and director of the group. Mr. Marjoribanks, who has been with Howden since 1983, previously was with accountants Deloitte Haskins & Sells in London.

U.S. invasion

The London market is swarming with American executives and risk managers looking for capacity that they cannot find in the United States.

For example, a big team of brokers from Marsh & McLennan Inc. accompanied an entourage from Union Carbide Corp. to try to place Carbide's portions of its umbrella liability insurance coverages (BI, March 11).

Apparently the group, which created a stir in the market, filled one underwriter's board room.

In addition, sources in the London market report that officials of American banks also are arriving in London in search of fidelity and other types of coverage.

Still, brokers in Lodnon feel this is only the beginning of the surge of Americans who will be flying to London to place their insurance this year.

"It isn't an avalanche yet, and we will see more as the year goes by," said one Lloyd's of London broker. "There was a lull after Jan. 1 renewals between mid-January and mid-February. Now we are seeing more business come in.

"But, is the market willing to take all the business?" he asked. The answer isn't in yet.

New rules announced

Britain's Department of Trade and Industry has established new rules for winding up insurance companies in England and Wales.

The new rules, which became effective March 1, replace the existing winding-up provisions in the Insurance Companies Act of 1958.

Among the changes are new rules that deal with life insurance policies, said a Department of Trade spokeswoman. Previously, life insurance policies were considered part of an insurance company's assets when an insurer was liquidated.

Now, however, the new rules separate life insurance business from the rest of the business of an insurance company being liquidated. The liquidator must honor the life insurance policies unless the British courts decide that payment can be stopped, the spokeswoman said.

Firm to be wound up

The Department of Trade and Industry wants to wind up a company that sold extended warranty insurance in Manchester, England.

The department has announced that it will petition for the compulsory winding up of the company, Bloomside Ltd., in High Court April 22. The court has appointed an official receiver to act as provisional liquidator until the hearing.

Bloomside is not an authorized insurance company, the depart-

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ment said.

Bloomside offered extended warranty insurance through an estimated 1,400 retailers to thousands of people who bought home appliances and wanted to extend the manufacturers' warranties. According to the Department of Trade and Industry, some 55,000 of these warranties are still in force.

Ransom insurance

The British government is considering banning the sale of kidnap and ransom insurance in Northern Ireland offered by Lloyd's of London and other British underwriters.

During a recent debate in the House of Commons, Parliament member John Hume asked Douglas Hurd, secretary of state for Northern Ireland, whether Mr. Hurd intended to ban the sale of kidnap and ransom insurance in Northern Ireland. Mr. Hume said the policies, which cover ransom payments, are "a positive encouragement to kidnapping and other such terrorist activities."

Mr. Hurd replied that the British government is looking into the policies. He said he has heard arguments both for and against the coverage.

Lloyd's underwriters have contacted the government, giving reasons for allowing the policies, a Lloyd's official said.

Survey of benefits

The employee benefit division of Lloyd's of London broker Reed Stenhouse Financial Services Ltd. is surveying more than 700 multinationals in the United Kingdom to determine such things as how many use multinational pools for their benefit plans and what kinds of benefits are provided to employees both in Britain and overseas.

"Our research to date indicates that very few U.K.-based multinational companies have been able to take advantage of the potential cost savings which would flow from multinational pooling of their insured employee benefit plans," said Andrew Dawson, director of the international division of Reed Stenhouse Finance.

"(There are) savings which might typically be 7.5% to 10% of annual costs."

The survey has two parts, Mr. Dawson said. The first part covers how British-based multinationals deal with employee benefits in the United Kingdom and the companies' attitudes toward the kinds of benefits British employees should receive.

The second part covers what kinds of benefits British-based multinationals provide to their overseas employees.

So far, 35 companies have answered the survey, but no conclusions have yet been reached. Mr. Dawson hopes about 70 companies will answer the survey by the deadline, which is today.

Reed Stenhouse Financial's employee benefits division is the second-largest benefit consultant in Britain, according to Mr. Dawson. ■

Study says smoking doesn't hinder work

PRINCETON, N.J.—Many insurance managers believe that smoking in the workplace does not hinder employee productivity, a recent survey indicates.

Insurance managers, along with financial and real estate managers, were among some 2,000 first-line supervisors and local union officials included in the survey by Response Analysis Corp.

Fifty-five percent of insurance, financial and real estate managers who responded to the survey said that smoking while working does not have a significant impact on employee productivity.

In addition, 77% of respondents said that smoking during work breaks has little effect on productivity.

And, most of the respondents said that employers should not discriminate against smokers when hiring. Eighty-eight percent said they disagreed with the statement: "Not hiring people simply because they smoke makes sense."

Of those respondents who said their businesses do not have smoking regulations, 50% said a ban would not affect morale.

"We believe that those we interviewed for the survey are uniquely qualified to make sound judgments concerning smoking's effect on productivity," said Alfred Vogel, senior vp at Response Analysis, who directed the research.

"First-level managers directly observe employees all day long, and must be particularly sensitive to factors influencing productivity," he said. ■

National Employee Benefits Institute conference

PBGC opposes excise tax on asset reversions

By JERRY GEISEL

ATLANTA—The Pension Benefit Guaranty Corp. is opposed to the Treasury Department's plan to impose an excise tax on reversions from terminated overfunded pension plans, a top PBGC official says.

The special excise tax on reversions, which is one of many provisions in the Treasury Department's radical plan to simplify the tax code (*BI*, Dec. 3, 1984), was not cleared with the PBGC or any other federal agency, says Roderick J. O'Neil, associate executive director at the PBGC.

Mr. O'Neil

Mr. O'Neil told participants at the National Employee Benefits Institute conference in Atlanta that an excise tax on plan reversions is "chilling and totally counterproductive."

If legislators seriously consider the tax, it could accelerate terminations of pension plans by employers that want to recapture excess assets before they are hit with the excise tax, he said.

"I hope this item will not become part of the president's (tax reform) proposal and will not see light on Capitol Hill," Mr. O'Neil said.

Congressional attempts to restrict pension plan terminations also can backfire, Mr. O'Neil noted.

For example, when Rep. Edward Roybal, D-Calif., introduced legislation last year that would have made it virtually impossible for financially secure companies to terminate overfunded plans, more companies began to consider terminations before it was too late, he said.

"We may now be seeing a rush out the door caused by the very people who seek to prevent" terminations of overfunded plans, Mr. O'Neil said. He noted that termination filings increased sharply after the Roybal and Treasury Department proposals were unveiled.

Mr. O'Neil touched on a wide variety of other pension issues in his address, entitled "A National Pension and Benefit Policy: PBGC's Perspective."

For instance, Mr. O'Neil said:

• The PBGC is continuing to study whether "risk-related" termination insurance premiums are feasible. Currently, all employers with defined benefit plans—regardless of the financial condition of their pension plans—pay the PBGC the same annual premium, which is currently $2.60 per plan participant.

The revenues generated by those premiums are used by the PBGC to guarantee workers and retirees their basic retirement benefits when companies fail and lack sufficient pension plan assets to pay benefits.

• The PBGC doesn't have enough assets to pay benefits to participants in terminated plans the agency has taken over. To finance future benefit payments, the PBGC is asking Congress to raise the annual termination insurance premium to $7.50 per plan participant.

'I hope this (excise tax on pension plan reversions) will not become part of the president's proposal and will not see light on Capitol Hill,' says Roderick J. O'Neil, associate executive director of the PBGC.

• Along with a premium increase, the PBGC will ask Congress to pass legislation now being drafted, to make it more difficult for employers that intend to stay in business to terminate underfunded plans and shift the liabilities to the PBGC.

• Defined benefit plans, despite a recent reputation of being old-fashioned and cumbersome, are not dinosaurs. In fact, defined benefit plans continue to grow, a reflection of the fact that "this is the best type of plan which can statisfy employer and employee needs," Mr. O'Neil said.

The risk-related premium issue dates back to 1974 when Congress, in establishing the PBGC, decided that employers with pension plans would all pay the same termination insurance premium to the PBGC. At that time the annual premium was $1 per plan participant.

In 1978, the annual PBGC premium was boosted to the current $2.60 per plan participant, and now the PBGC is seeking a further increase to $7.50.

As the premium employers pay increases, more and more employers say it is unfair that a company

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Meeting draws 100 employers

ATLANTA—More than 100 employers attended the National Employee Benefits Institute conference, held March 4-5 in Atlanta.

The NEBI, a benefits lobbying group based in Washington, was formed in 1977 to keep employee benefit managers up to date on benefit issues in Washington and to help managers communicate with their legislators, said NEBI Executive Director Richard A. Van Deuren, who also is an attorney with Reinhart, Boerner, Van Deuren, Norris & Riselbach in Milwaukee.

Most of NEBI's approximately 100 members are members of the Fortune 1,000, Mr. Van Deuren said.

More information can be obtained by contacting NEBI at 2550 M St. N.W., Suite 785, Washington, D.C. 20037; 800-558-7258.

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with a well-funded pension plan that poses no risk to the PBGC insurance system should pay the same premium as a company with a poorly funded plan.

Those employers say premiums should be based on a pension plan's funding level. Employers with well-funded plans would pay less than companies with poorly funded plans.

The PBGC now is studying whether a risk-related premium system is feasible and expects to make recommendations to Congress later this year. That study was ordered by Congress when it passed the Multiemployer Amendments Act, the 1980 law that makes employers that withdraw from underfunded multiemployer pension plans liable for paying a share of those plans' liabilities.

While Mr. O'Neil expressed sympathy with the concept of risk-related premiums, he noted that such a system—if not designed properly

'Dismantling or constraining the private pension system in favor of other forms of savings plans. . .in pursuit of some short-term revenue gain, will be detrimental to. . .the long-term health of our economy,' says the PBGC's Mr. O'Neil.

—could overwhelm the administrative resources of the PBGC, which is a relatively small federal agency with less than 500 employees.

"One nightmare we hope to avoid is a system of individual risk-rating of each of the 112,000 plans we insure, and the consequential issuance of official governmental financial ratings of 112,000 private enterprises," he said.

If the PBGC were required to individually rate every pension plan it insures, the agency would need 250 more employees and $20 million more in revenue to pay for the higher administrative costs, Mr. O'Neil said.

Although risk-related premiums will be considered in the future, the PBGC is pressing Congress for an overall increase in premiums right now.

More premium income is needed because, as Mr. O'Neil puts it: "The PBGC's present assets and sources of income are inadequate to meet our future commitments."

The income generated by the $2.60 premium has turned out to be inadequate because the PBGC is paying out more benefits than anticipated because of the takeover of a number of large underfunded pension plans, including large plans sponsored by Dallas-based Braniff International Corp. and White Farm Equipment Co. in Oak Brook, Ill.

At the end of September 1984, the PBGC's deficit stood at $462 million.

Unless Congress acts soon on the premium increase, the deficit will continue to grow. By 1989, the deficit is projected to increase to about $1.3 billion, and it could top $5.5 billion in 1999.

"Obviously, if no action is taken, we will be mortgaging that much more of our workers' future," Mr. O'Neil said."

Coupled with the PBGC's request for a premium increase will be a move for comprehensive legislation to make it more difficult for employers to shift their pension liabilities to the PBGC, according to the agency.

Under the Employee Retirement Income Security Act, the PBGC has a right to the assets in the terminated plan as well as 30% of a company's net worth.

Since the timing of the termination is up to the employer, a company can fold a pension plan when it has little or no net worth. As a result, some companies might be able to dump their underfunded pension plans onto the PBGC at a comparatively low cost and then start a new retirement plan.

To curb that loophole in the PBGC insurance program, the PBGC probably will propose that terminations of underfunded plans will be restricted to companies "truly" in financial distress, Mr. O'Neil said.

Those companies then would have to work out an arrangement with the PBGC, giving the agency a share of future profits to pay for unfunded benefits.

"This is a proposal similar to any private industry arrangement of finances between debtors and creditors," Mr. O'Neil said.

Although the PBGC is facing problems in the future—such as its huge deficit and a Congress that hasn't acted on the agency's previous requests for premium hikes and changes in its insurance program—all is not gloom and doom in the nation's retirement plan network, Mr. O'Neil noted.

To those who say that defined benefit plans are a thing of the past, Mr. O'Neil has a message: It isn't true.

The number of defined benefit plans continue to grow, he said. In fact, since the passage of the Employee Retirement Income Security Act of 1974, the number of new defined benefit plans has exceeded terminations in every year except in 1976. In 1976, terminations were unusally high because many ERISA rules went into effect then and many employers folded their defined benefit plans rather than meet those new rules.

Mr. O'Neil said defined benefit plans will continue to grow because of what he described as their superiority to defined contribution plans.

In defined benefit plan, there is a promise to pay a specific benefit at a certain date. That promise is backed by the PBGC insurance system, he said.

By contrast, in a defined contribution plan, the employer only promises to contribute a certain amount to the plan, which places the risk of investment performance of the plan on participants.

"The consequences can be disappointing, or even tragic, if investment performance does not live up to the participant's hopes, or if the participant chooses to retire in a severely depressed market," Mr. O'Neil said.

The future of the nation's pension plans hinges on the outcome of a debate in Washington over whether contributions to retirement plans should continue to receive favorable tax treatment, Mr. O'Neil said.

"The basic tax arrangements that encourage pension savings and pension plans may be called into question," Mr. O'Neil worries.

"Dismantling or constraining the private pension system in favor of other forms of savings plans, as some have suggested," or eliminating tax incentives "in pursuit of some short-term revenue gain, will be detrimental to employees, employers and the long-term health of our economy," Mr. O'Neil pointed out.

He said a dismantling of pension plans would inevitability lead to more dependence on the Social Security program. And, Social Security recently flirted with bankruptcy before Congerss took steps to shore it up, including higher payroll taxes.

"Do you think Social Security can afford the long-term costs that such steps would entail?" Mr. O'Neil asked. ■

Congress may enact law to speed vesting: Chandler

By JERRY GEISEL

ATLANTA—Requiring employers to offer more-rapid vesting schedules in their retirement plans could be the next pension change Congress makes, a congressman predicts.

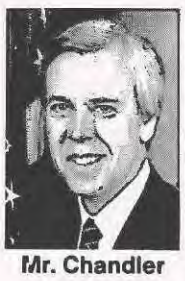
Rep. Rod Chandler, R-Wash., predicts Congress will consider whether the 10-year vesting schedule, the standard in the overwhelming majority of pension plans, is fair to workers who change jobs frequently.

"I can promise you that pressures will develop (in Congress) for vesting changes," Rep. Chandler told the National Employee Benefits Institute conference in Atlanta.

Rep. Chandler is frequently referred to by benefit lobbyists as the "next Erlenborn," a reference to former Rep. John Erlenborn, the Illinois Republican who became known as a pension expert during his 20 years in Congress.

Mr. Erlenborn retired from Congress earlier this year to join a law firm, and benefit lobbyists have worried that his expertise on pension issues will be hard to replace.

Like Mr. Erlenborn, Rep. Chandler serves on the House Education and Labor Committee, which has jurisdiction on pension issues. And, his speech at NEBI indicates that Rep. Chandler, who was first elected to the House in 1982, already has developed a deep interest in employee benefit plans.



Mr. Chandler

Rep. Chander spoke on a wide range of benefit topics, including the need for a national retirement income policy, why lump-sum pension benefit distribution rules should be tightened, the financial problems of the Pension Benefit Guaranty Corp. and the need to reduce employer pension plan reporting burdens.

Rep. Chandler noted, for example, that despite the enormous growth of pension plans since World War II, some fundamental questions about pensions have not been addressed by policymakers.

"We need to think through a national retirement income policy," he said. Such a policy, he said, would address such questions as:

- Are pension plans for retirement only?
- How should vesting schedules be designed?
- What should the federal government do to encourage employers to provide pension plans?

Demographic changes that will put new pressures on all retirement plans—both public and private—demand that a retirement income policy be developed, Rep. Chandler said.

The number of retirees will rapidly increase after the turn of the 20th century when the baby-boom generation of the late 1940s and early '50s begins to retire.

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Cap tax-free benefits, legislator says

ATLANTA—It's time to limit the amount of tax-free benefits employers can provide employees, a congressman says.

"Should health care benefits be provided tax-free? . . .Should the tax-free exclusion be continued?" asked Rep. Willis Gradison, R-Ohio.

Answering his own question, Rep. Gradison, a member of the House Ways and Means Committee, told participants at the National Employee Benefits Institute conference in Atlanta that there should be an overall limit, above which the cost of employer-provided benefits would be included as taxable income to employees.

This cap should apply to all benefits employers provide, so that no single benefit is discriminated against, Rep. Gradison said.

Senate Majority Leader Robert Dole, R-Kan., last year discussed a proposal that employees should be taxed on employer benefit costs that exceeded $260 a month per worker.

However, Sen. Dole, who made the proposal when he was chairman of the Senate Finance Committee, never formally introduced his plan.

Rep. Gradison did not suggest a specific dollar amount for the cap, but he dismissed concerns, often heard in insurance industry and union circles, that employees would drop employee benefit coverages rather than pay taxes on benefits they might never use.

He noted, for example, that term life insurance has continued to grow, even though Section 79 of the Internal Revenue Code limits to $50,000 the amount of tax-free coverage employers can provide to an employee.

However, the Treasury Department, as part of its tax simplification plan, wants to repeal Section 79 and wipe out the tax-free status of the first $50,000 of coverage of term life insurance.

Rep. Gradison said unlimited tax-free benefits are not fair to people not covered under employer plans.

"It is an equity issue," he observed. While employees get their benefit coverages tax-free, the self-employed, like farmers, must use aftertax dollars to buy their benefit coverages, he said.

In addition, as benefit costs increase and employers take greater tax deductions for benefit expenses, it will become more and more difficult to lower tax rates, he added. ■

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For example, in 1940, there were 100 workers contributing payroll tax dollars into the Social Security program for every retiree drawing benefits. Now that worker-retiree ratio is 3-to-1, and by 2020 there will be just two workers for every Social Security beneficiary, he said.

"Clearly private pension plans must respond to these changes," Rep. Chandler said.

In fact, the House Labor Management Relations Subcommittee will hold hearings this week and in April on a national retirement income policy (see story, page 58).

Rep. Chandler also said Congress should change tax policy on lump-sum pension distributions to discourage workers from spending distributions before retirement.

Currently, a company can distribute a vested benefit in cash when a worker leaves before retirement. This distribution gets favorable tax treatment, known as 10-year forward averaging.

But, Rep. Chandler said that instead of saving that money for retirement, employees often spend it.

"Something is needed to discourage lump-sum distrbution withdrawals," he said, because when money intended as retirement income is spent for other purposes, it puts pressure on the federal government to provide added support when the person retires.

Rep. Chandler said the financial plight of the PBGC, the federal agency that guarantees workers' and retirees' basic pension benefits when corporate pension plans fail, demands that Congress consider the PBGC request for a termination insurance premium increase.

"PBGC's premium increase definitely will be considered," he said, adding that the agency's current deficit of $462 million could rise to more than $1 billion by 1989 unless Congress approves the hike.

The annual PBGC premium, which all employers with defined benefit plans must pay, has been $2.60 per plan participant since Jan. 1, 1978. The PBGC wants the premium increased to $7.50.

Rep. Chandler also said he is sympathetic to the concerns of employers, who say the government requires them to file an array of pension reporting forms and then doesn't use the information.

"It is ridiculous to require employers to file Form 5500s (an annual report that contains financial information about a pension plan's operations) and then store them in (government) basements," he said, pledging he would press for electronic filing of these forms.

He also told employers to watch for changes Congress may make this year in the Civil Service retirement plan covering newly hired federal employees.

When Congress, as part of 1983 legislation shoring up the Social Security program, decided federal employees hired after Dec. 31, 1983, are covered under Social Security, legislators also said a new government retirement plan should be established for those workers.

The decisions Congress makes on components of the federal plan, such as vesting schedules, could become a model of what employers will be expected to offer, he said.

And, Rep. Chandler said he is considering introducing legislation to allow employers to take surpluses out of their pension plans without terminating the plan. Such reversions would be acceptable, he said, as long as the plan still had more assets than liabilities after funds were withdrawn.

Buck Consultants Inc. in New York already has asked federal agencies to allow reversions so long as a defined benefit plan—after a transfer of funds—would have assets equal to pay at least 125% of its benefit liabilities (*BI*, March 4). Regulators have not responded to the Buck proposal.

While the Buck proposal would apply in situations where assets are transferred from an overfunded defined benefit plan to a defined contribution plan, like a 401(k) salary reduction plan, Rep. Chandler would not place any restrictions on how the funds could be used, as long as a surplus remains in the defined benefit plan after a transfer.

He said if employers have to contribute more to pension plans to make up for funding shortfalls due to adverse investment experience, it is only fair that they should be able to recoup surpluses when plan assets increase beyond what is needed to pay promised benefits.

Turning to another area, Rep. Chandler said politics played a role in Congress's decision to divide responsibilities for enforcing and administering the Employee Retirement Income Security Act among three agencies—the PBGC, the Labor Department and the Internal Revenue Service—and not let one agency regulate ERISA.

"It's politics. Regulators say, 'I don't want other people on my turf,'" Rep. Chandler said. ■

Tax bill won't include benefits: Congressman

By JERRY GEISEL

ATLANTA—Congress will not change the tax status of employee benefits this year, one congressman says.

"While everything will be on the table. . .benefits will survive the Congress' knife," Rep. Wyche Fowler, D-Ga., said at the National Employee Benefits Institute conference in Atlanta earlier this month.

Other congressmen who also addressed the NEBI meeting would not predict whether Congress would pass tax legislation that would affect employee benefits.

But, two of the congressmen advised the benefit managers attending the conference that they must lobby Congress now if they want to preserve the tax-preferred status enjoyed by employee benefits.

Rep. Fowler noted that legislators are currently reluctant to include employee benefits in a tax bill since they are still digesting all the benefit changes included in last year's tax bill, the Deficit Reduction Act of 1984.

Those changes include limits on how much employers can contribute to Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts; a two-year freeze on increasing maximum benefits offered by defined benefit plans and contributions made to defined contribution plans; and new rules for benefits, like airline employee free travel passes, not previously covered by the tax code (*BI*, July 2, 1984).

Rep. Fowler

Still, Rep. Fowler warned, benefits remain an inviting target for congressional attack because of the large amounts of revenue that could be gained if they are taxed. That revenue could then be used to reduce the federal budget deficit.

"The debate about benefits (taxation) has reached a particularly high pitch because of the Treasury Department's tax simplification proposal," Rep. Fowler said.

That proposal, among other things, calls for the elimination of 401(k) salary reduction plans and tax-free cafeteria benefit plans. Also, employer contributions for group health plans that exceed $175 a month for family coverage and $70 a month for individual coverage would be included as taxable income to employees.

Employees also would be taxed on employer contributions for term life insurance, dependent child care, van pooling, tuition reimbursement and group legal benefits (*BI*, Dec. 3, 1984).

Rep. Fowler says support for the Treasury plan comes from those who believe that taxing employee

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benefits would gain a huge amount of revenue for the federal government.

In addition, some say allowing employees to receive tax-free benefits isn't fair to those who are not covered by employer-provided benefit programs, Rep. Fowler noted.

But, Rep. Fowler fears that if benefits are taxed and employees drop coverages, there will be pressure on the federal government to provide those benefits.

If employers want to prevent employee benefits from being part of this year's tax bill, they will have to start to lobbying now, advised Rep. Richard Shelby, D-Ala.

Once momentum for tax reform gets going, it could be too late to stop changes in the employee benefit area, Rep. Shelby said.

To prevent adverse changes, Rep. Shelby told employers to encourage their workers to become involved in the lobbying movement.

"You must tell employees what will happen (if benefits are taxed). Something will be taken away from them," he said.

And employers themselves have to get in the thick of the lobbying battle. "Let the mail come in and identify what you want to keep. It (saving benefits) depends on what you do," he said.

The Treasury Department's tax simplification plan, Rep. Shelby continued, is stored in word processors and, like anything kept in computers, it can be changed.

"It is up to you to see that benefits are taken out," Rep. Shelby said.

Government agencies do change their minds—when they are lobbied by employers. For example, the Treasury Department agreed to reconsider its rules on records employers must keep on use of company cars after a barrage of corporate complaints that the rules were too cumbersome, Rep. Shelby noted.

In a related benefit area, Rep. Shelby observed that support for government programs that provide benefits to the elderly, like the Social Security program, is fading among the young professional middle class, a group increasingly referred to as "Yuppies."

'You must tell employees what will happen (if benefits are taxed). Something will be taken away from them. . . .Let the mail come in and identify what you want to keep,' advises Rep. Richard Shelby, D-Ala.

"They say they will take care of themselves," he said. "That is why they want IRAs and Keoghs."

An IRA, or Individual Retirement Account, allows workers to contribute up to $2,000 a year into a retirement savings account where the money earns interest tax-free. A Keogh plan, used by the self-employed, allows annual tax-deductible retirement contributions up to a $30,000 maximum.

A third congressman, Rep. James J. Duncan, R-Tenn., noted that there "could be a free-for-all on overhauling the tax code" this year.

Rep. Duncan, a member of the House Ways and Means Committee, the House committee that will consider tax legislation, said all tax preferences, including tax-favored employee benefits, are likely to be examined by Congress.

But, Rep. Duncan made clear that he favors allowing employers to provide tax-free benefits to employees.

The development and spread of employer-provided benefit plans, he noted, have prevented the establishment of a costly national health insurance program.

The fourth congressman to address the NEBI conference, Rep. James Quillen, R-Tenn., would not predict whether Congress will enact a tax reform bill with employee benefit provisions, but like Rep. Shelby, he noted that employers should begin to lobby now.

"I'd recommend that everyone in the benefits field to get out their fire brigades now," Rep. Quillen advises.

The Ways and Means Committee often considers tax bills in closed-door sessions, so lobbying has to be done now, he said.

Rep. Quillen also told the NEBI participants: "I stand by your side," a reference to his support for the tax-favored status of employee benefits. ■

Premium growth slows on New York exchange

By DOUGLAS McLEOD

NEW YCRK—Premium volume on the New York Insurance Exchange continues to grow, although at a slower pace than in previous years.

And, underwriting and net losses reported by exchange syndicates are growing as well.

Exchange syndicates posted aggregate gross written premiums of $345.6 million in 1984, up 22.5% from $282.2 million in 1983.

This compares with increases of 80.4% in 1983 from gross written premiums of $156.4 million in 1982 and 115.7% in 1982 from gross premiums of $72.5 million in 1981.

Aggregate earned premiums totaled $217 7 million in 1984, up 45.9% from $149.2 million in 1983. The exchange's combined ratio, however, hit 137.3% in 1984, up from 119.6% in 1983 and 114.1% in 1982.

Underwriting losses rose 102.8% to $81.1 million last year from $40 million in 1983, while investment income climbed only 30% to $37.3 million in 1984 from $28.7 million the year before.

The exchange syndicates posted an aggregate net loss of $35.2 million last year, up 245% from the syndicates' net loss of $10.2 million in 1983.

Exchange President and Chief Executive Officer Donald E. Reutershan said the losses are a "direct reflection of the industry having experienced in 1984 its worst underwriting loss ever."

Mr. Reutershan added he hopes the turn in the property/casualty underwriting cycle will produce better results for the syndicates in the future.

Mr. Reutershan says he 'would not be surprised' if a new syndicate forms by the end of March.

The exchange has experienced "some lessening in capacity," in part because some syndicates have hit exchange-imposed underwriting guidelines, Mr. Reutershan said.

The guidelines have required the syndicates either to stop underwriting, add new capital or restructure their retrocessional programs.

Several of the exchange's largest syndicates have chosen to temporarily stop underwriting, including First New York Syndicate Corp., Realex Group N.V. and Burt Syndicate Inc.

Two others—North Star Syndicate Inc. and Chubb Syndicate Inc. —plan to withdraw from the exchange altogether, though these decisions are unrelated to the exchange's underwriting limits (*BI*, March 4).

Other syndicates are engaged in a "re-evaluation of their underwriting standards before they accept new business," Mr. Reutershan said. He added, however, that "capacity is an elusive concept," and syndicates that have temporarily stopped underwriting may take steps to resume at any time.

The syndicates' aggregate policyholder surplus dropped 3.6% to $182.6 million at year-end 1984 from $189.5 million at year-end 1983. Policyholder surplus had climbed 19.2% in 1983 from $159 million in 1982.

Mr. Reutershan pointed out, however, that the exchange moved up to fifth place in the Reinsurance Assn. of America's ranking of U.S. reinsurers by policyholder surplus.

Deposits to the exchange's security fund, which is intended to safeguard the solvency of member syndicates, rose 17.9% to $29.7 million from $25.2 million in 1983.

Syndicates pay 0.75% of gross written premiums into the fund after an initial deposit of $500,000. The exchange has 45 syndicate members and 104 broker members.

The syndicate members' total, however, includes Commercial Union Insurance Cos.' CU Syndicate Inc., which announced plans to withdraw from the exchange last year. It also includes North Star Syndicate, which has filed a petition with the exchange's board of governors to withdraw, and Chubb Syndicate, which has not yet filed the required petition.

New syndicates may join the exchange shortly, though. Mr. Reutershan said he "would not be surprised" if a new syndicate were formed by the end of March. He added that he expects others to follow.

Separately, the board of governors has proposed an amendment to the exchange's bylaws raising the amount of capital required for new syndicate formation.

The amendment, which must be ratified by two-thirds of the syndicate and broker members, would raise to $5 million from $3.55 million the amount of capital required to form a syndicate writing either life/health or property/casualty business.

It would also raise to $10 million from $6.55 million the capital required for syndicates planning to write both life/health and property/casualty risks.

A vote on the amendment is expected at the exchange members' meeting April 8. ■

Tillinghast expands with three mergers

Consulting and actuarial firm Tillinghast, Nelson & Warren Inc. has added three more consulting firms to its international operations through mergers in California and Connecticut.

Independent Actuarial Services of Connecticut will combine its practice with the Tillinghast office in Hartford. The firm provides casualty actuarial services to captives, municipalities, malpractice specialty companies and traditional insurers.

Brian R. Demsey & Associates of Newport Beach, Calif., an employee benefit consultant, joins the Tillinghast's southern California organization.

And, Mund, McLaurin & Co. of Los Angeles, a risk management consulting practice in Pasadena, Calif., will become part of Tillinghast's Irvine, Calif., operation.

All the newly acquired firms will assume the Tillinghast name.

Last December, Tillinghast completed the merger of independent risk management consultant Risk Planning Group Inc. of Darien, Conn. (*BI*, Dec. 10, 1984). That merger doubled the size of Tillinghast's professional risk management consulting staff and boosted Tillinghast to the top spot in the *Business Insurance* ranking of the largest risk management consulting firms (*BI*, Feb. 18).

Oil-risk insurer formed

Underwriters Indemnity Co., a newly formed property/casualty insurer based in Houston, will provide coverages for petroleum-related risks.

The new company is capitalized at about $1.5 million and will write coverages in Texas on an admitted basis and as a surplus lines insurer in other states.

Edwin H. Frank III, president of Underwriters Indemnity, said the company will specialize in well control or "blowout" insurance, general liability and umbrella liability coverage for oil lease operators and non-operators.

He said the company would provide limits up to $20 million on well control risks and $6 million for umbrella policies.

It also plans to offer financial guarantee coverages for some investments, Mr. Frank noted.

Underwriters Indemnity is located at 8 Greenway Plaza, Suite 1450, Houston, Texas 77046; 713-961-1300.

Oregon PPO

A new preferred provider organization is now available to employers in Portland, Ore.

The PPO, CareMark Services Inc., began operations Feb. 1 with about 265 physicians and four Metropolitan Hospitals Inc. facilities: Emanuel Hospital, Fort Hood Medical Center, Meridian Park Hospital and Physicians & Surgeons Hospital.

VNA Health Resources, which specializes in home health care, is also participating.

Employees of the Metropolitan hospital system will be CareMark's first enrollees. CareMark expects to enroll 22,000 subscribers by February 1986.

The PPO will be managed and marketed through Pyramed International Inc., as health care management firm in Los Angeles.

Pyramed will spend about $800,000 over the next two years promoting the PPO, it says. CareMark will operate similar to Community Care Network, a San Diego health care system managed by International Medical Exchange, a Pyramed affiliate.

Pyramed will track and monitor quality of care at both CareMark and CCN with a computerized data base of health care utilization information. Pyramed is also developing a credit card payment system for the PPOs.

The Brougher Agency Inc. is working with Pyramed to bring businesses that have between 11 and 500 employees into the PPOs. Brougher, based in Greenwood, Ind., is offering a series of excess and stop-loss products to help employers of this size self-insure their group medical plans.

After three years, Pyramed and Brougher expect to enroll in CCN 20% of the approximately 8,600 San Diego businesses with 11 to 500 employees.

CCN operates with 17 hospitals and more than 900 physicians (*BI*, Oct. 31, 1984).

markets

Social services cover

Black/White & Associates, an excess and surplus lines brokerage based in San Francisco, has expanded its social service agency program to all states west of the Mississippi River.

The program offers coverages for non-profit, government-funded agencies that provide community services.

Auto policies, workers compensation, umbrellas and fidelity coverages are available through Black/White.

National Union Insurance Co. underwrites the coverages, which carry limits up to $1 million.

More information is available from Black/White at 130 Montgomery St., Suite 300, San Francisco, Calif. 94104; 415-433-5773.

Poe acquires agency

Poe & Associates Inc. in Tampa, the 16th largest U.S. brokerage, according to the annual survey by *Business Insurance*, has acquired the Baldwin Insurance Agency of Miami.

C. Jackson Baldwin, president of the Miami agency, will continue to hold that position.

Mr. Baldwin also has been named a vp with Poe & Associates.

Baldwin will continue to operate at its current location at 840 Biscayne Blvd., Miami, Fla. 33132; 305-374-8181.

Mergers/acquisitions

American General Corp. of Houston has completed its sale of **Lincoln American Life Insurance Co.** to **Conesco Inc.**, an insurance holding company in Carmel, Indiana. Lincoln American, headquartered in Memphis, was acquired by American General in 1980 as part of the company's acquisition of **Lincoln American Corp.** Lincoln American Life last year reported assets of around $113 million.

Crownx Inc. in Toronto, Ontarios has completed a previously announced acquisition of **Beutel Goodman & Co. Ltd.** ■

Dow Jones benefit helps workers stay fit

benefit beat

Dow Jones & Co. Inc. is helping its employees work out at their favorite health clubs.

As part of its wellness program, the New York-based company has offered to reimburse employees for half of the cost of their fitness programs, up to $200 annual maximum.

According to Nick Marino, manager of benefits and salary administration, more than 90% of the company's employees—about 37,000 employees across the country—are covered by the wellness program and eligible for the "fitness benefit." The benefit was first offered in April 1984.

Mr. Marino said the company reimburses employees for memberships in centers that provide "qualified activities." These centers include health clubs, tennis or racquetball clubs, and others that offer aerobic exercise classes.

"It can't be one of those classroom settings," Mr. Marino said. "It has to be a physical program."

The benefit does not cover memberships in bowling leagues or country clubs, or enrollment in martial arts classes.

Mr. Marino said that between 15% and 20% of eligible employees took advantage of the company's offer in 1984, and that percentage is increasing in 1985.

The program has cost Dow Jones about $50,000 so far, he said, adding that the company maintains the money has been well-spent.

"Covering medical costs is only one aspect of health care," Mr. Marino said. "Covering wellness is also definitely cost-effective—and it raises morale and reduces absenteeism."

Alcohol programs

The alcoholism treatment programs for both salaried and hourly employees of the Seattle-based Boeing Co. have been changed to reduce coverage for inpatient care but increase coverage for outpatient care.

"We tried to change the plan design so that reimbursement did not show a preference for inpatient treatment over outpatient treatment," said Nancy Cannon, manager of employee benefits cost control.

The new plans, which took effect last year, provide the same level of benefits for salaried and hourly employees. The plans pay 80% of the cost of alcoholism treatment, up to an annual maximum of $3,200, regardless of whether the treatment is done on an inpatient or outpatient basis.

"We've looked at the programs, and $3,200 a year buys a pretty good treatment plan," Ms. Cannon said. "(Employees) can decide for themselves where to apply the dollars."

Before the changes took place, Boeing's 51,000 salaried and 27,000 hourly employees had separate alcohol treatment plans.

Salaried employees were reimbursed 80% of the cost of inpatient treatment, subject to a $50 deductible, up to the $500,000 lifetime maximum benefit under Boeing's total health care package.

However, if salaried employees sought treatment on an outpatient basis, they were reimbursed for only 50% of the charges, up to a $2,000 annual maximum.

Previously, hourly employees were reimbursed for 80% of the cost of inpatient treatment, subject to a $100 deductible. This reimbursement was capped at the $20,000 lifetime maximum benefit hourly employees received for psychiatric and substance abuse treatment.

However, if hourly employees received treatment on an outpatient basis, they were reimbursed for only 50% of the cost, up to an annual maximum of $1,500.

Boeing's health care program for salaried employees is underwritten by Aetna Life Insurance Co.; its health care program for hourly employees is underwritten by Blue Shield of Washington.

Tenneco PPO

Employees at Houston-based Tenneco Inc. can now choose a special preferred provider option that provides medical care for many catastrophic health problems.

The Select Provider Program is being offered to some 45,000 Tenneco employees and dependents who are covered under the company's self-insured indemnity health plan and not enrolled in a health maintenance organization.

The program, which was introduced in November, provides a list of approximately 100 doctors and three Houston hospitals that will provide care for employees and dependents with cardiovascular, neurosurgical or carcinogenic conditions.

To be eligible for care under the program, employees must pass a pre-certification review. Participants receive first-dollar coverage for all health care expenses related to their condition; deductibles and co-payments are waived.

Under Tenneco's indemnity health care plan, employees pay per-person deductibles of between $100 and $200, depending on salary, with a $300 maximum family deductible. In addition, employees pay 20% of expenses over the deductible, up to a per-person stop-loss cap of between $1,000 and $1,500, depending on salary.

Employees must go to Houston to receive treatment under the Select Provider program. They are not reimbursed for travel or lodging expenses, although Tenneco helps employees find inexpensive lodging and provides some free transportation while they are there, according to Barbara Channell, medical plan and cost-containment staff consultant.

Tenneco is planning to expand the program to include hospitals in the Chicago area and on the East Coast, she noted.

Since November, several people have taken advantage of the program, Ms. Channel said, adding that employee reaction has been "very positive."

Kemper 401(k) plan

Kemper Group in Long Grove, Ill., is offering a 401(k) savings plan to approximately 10,000 employees. The plan replaces Kemper's traditional savings plan and consolidates with the company's profit-sharing plan.

Since Jan. 1, employees have been able to contribute up to 5% of their salary to the 401(k) plan. Kemper will match all contributions at the rate of 10 cents on the dollar, according to Jeff Emans, corporate benefits administrator.

In addition, Mr. Emans said, the company will put contributions from Kemper's profit-sharing plan into employees' 401(k) accounts, along with any forfeitures that are realized.

Kentucky medical plan

Some 88,000 employees of the state of Kentucky and its Board of Education have a new comprehen-

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sive medical plan that provides more reimbursement for both major medical and hospitalization expenses.

The new plan, underwritten by Blue Cross/Blue Shield of Kentucky, became effective Jan. 1. The plan pays the first $10,000 of room and board expenses for hospitalization. After the $10,000 maximum is reached, employees must pay a $100 individual and $200 family deductible and 10% of expenses over the deductible, up to out-of-pocket maximums of $200 for individual coverage and $600 for family coverage. The plan pays 100% of expenses exceeding these maximums, up to a lifetime maximum benefit of $1 million.

The new major medical plan also pays for expenses not covered under the hospitalization part of the plan, such as doctors' visits in or out of the hospital, surgery and prescription drugs.

Kentucky's previous hospitalization plan, also underwritten by Blue Cross/Blue Shield, paid 100% of room and board for the first 70 days of hospitalization, plus $25 for doctors' visits on the first day and $10 a day for doctors' visits for the following 69 days.

Expenses incurred after 70 days in the hospital were reimbursed under the previous major medical plan. This plan required employees to pay a $200 individual or $400 family deductible and 20% of expenses over the deductible, until the employee had received $25,000 in reimbursement. Then, the former plan paid 100% of all expenses, up to a lifetime maximum of $250,000.

The new comprehensive medical plan, called the Key Care Plan, also provides a hot line that employees can call with questions on their medical coverage.

The new medical plan will expire June 30, 1986.

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Maryland is investigating underwriter

ROCKVILLE, Md.—Maryland's Attorney General's Office and Insurance Division are investigating Eastern Indemnity Co. of Maryland, which was declared insolvent by a Montgomery County Court Feb. 11.

The 5-year-old company primarily wrote surety business and some workers compensation coverage for contractors, said Thomas Barbera, Maryland's deputy insurance commissioner. It was licensed in about 40 states but wrote most of its business in the Sun Belt.

The Insurance Division tried to find a buyer for the company from mid-December, when it was placed in rehabilitation, until Jan. 28, when it was placed in liquidation, Mr. Barbera said.

The Maryland Insurance Division first examined Eastern's operations late last fall, after receiving complaints from insureds that allegedly were not receiving their claims payments quickly, he said.

"Our examiners found things that led us to believe it would be appropriate to put the company in rehabilitation," Mr. Barbera said.

During that initial examination, the Insurance Division found that liabilities exceeded known assets by $4 million to $5 million.

The current outstanding liability is a "moving target," according to Mr. Barbera. He said surety specialists are conducting a claims audit.

Exactly why the company got into financial trouble still is unclear.

"It wasn't insurance problems . . . .It was not the book of business, it was not rating and it was not marketing," said Mr. Barbera, who refused to elaborate further.

However, Paul Grimm, a Baltimore attorney who is counsel for the receivership, confirmed that the attorney general's office is investigating the matter.

C. Graham Perkins, Eastern Indemnity chairman of the board, president and treasurer, was not available for comment. His Rockville, Md., attorney, Darrel Longest, declined to comment.

According to A.M. Best Co., Eastern Indemnity reported direct premiums of $3.3 million, policyholders' surplus of $6.4 million, a combined ratio of 136% and an underwriting loss of $395,000 for the first half of 1984. ■

Iowa counties' captive afloat following infusion of capital

By CAROL CAIN

DES MOINES, Iowa—It appears to be clear sailing again for the Iowa State Assn. of Counties' Bermuda-domiciled captive insurance company, which was stuck in financially troubled waters at year-end.

The captive, GIF Insurance Co. Ltd., needed an infusion of $500,000 in capital late last year to meet Bermuda's solvency margin and stay in business (*BI*, Dec. 24-31, 1984). ISAC asked each of its 99 members to contribute $10,000 to keep the captive running.

Contributions were eventually received from 51 counties, said John Torbert, executive director of ISAC. However, only $490,000 was raised because all the counties did not contribute the $10,000 requested.

Therefore, the association contributed the remaining $10,000, Mr. Torbert said. ISAC, which was formed in 1971, owns and operates the captive insurer.

"We've turned the corner sharply," Mr. Torbert said.

GIF insures workers compensation and general liability risks tailored to specific exposures of county governments. The captive was formed in 1979, when some Iowa counties were facing dramatic premium increases or having difficulty finding specialized liability coverages.

'When we did the year-end statements for December 1983, it was considered that it was getting close to getting unprofitable,' says Peter Strong of Independent Management Group Ltd., the captive's management company.

However, only 49 of the 99 Iowa counties purchase insurance through the captive.

In addition to the $500,000 raised through the contributions, a "fairly substantial" increase in premiums on renewals also has boosted the captive's funds, according to Mr. Torbert.

But, despite the increase, only one county failed to renew its liability policy through the captive, he said, adding that county did make a contribution to save the captive.

GIF first began to realize financial problems early last year.

"When we did the year-end statements for December 1983, it was considered that it was getting close to getting unprofitable," said Peter Strong, president of Independent Management Group Ltd. in Hamilton, Bermuda, GIF's management company.

The captive's monetary woes mainly are the result of a 1982 Iowa Supreme Court decision that adopted a comparative negligence standard and joint and several liability, Mr. Torbert said.

Under a comparative negligence standard, which has been adopted by almost all states, a defendant pays damages equal to its share of liability. For example, if a county is found 40% liable for an accident, it must pay 40% of any award.

However, under joint and several liability, a defendant that is partly liable could end up paying the full amount if the judgment can't be collected from other parties.

That Supreme Court decision exposed all units of government, like the counties, to greater liability than they had in the past, Mr. Torbert said. And, he said, GIF was caught off guard.

"We saw the number of lawsuits increase and the dollar amount of lawsuits increase," he said.

However, after the court ruling, the Iowa Legislature passed a law that public entities cannot be held jointly and severally liable if it is determined they are less than 50% responsible for an accident.

And, the number of lawsuits and the amount of money sought in the suits is on the decline, Mr. Torbert said, which also is adding to the financial solvency of the captive. ■

Utah law to require state fund to cover residual comp risks

By CAROL CAIN
and JULIE TRUCK

SALT LAKE CITY—Utah's new comprehensive insurance law, which, among other things, will require the state's workers compensation insurance fund to cover the residual market, is awaiting Gov. Norman H. Bangerter's signature.

The new law will replace the Utah Insurance Code and is a recodification of all of Utah's insurance laws, said Dane Leavitt, counsel for the 10-member Utah Insurance Laws Revision Commission.

The commission spent four years drafting the new law, which was introduced in the Legislature in early February by Sen. Fred W. Finlinson, R-Murray. It was passed by the Senate Feb. 19 on a 24-2 vote and then was passed by the House Feb. 25 on a 61-6 vote.

The new law, which will take effect July 1, 1986, also will create a 10-member task force to hold hearings on the provisions during the next year. The Utah Legislature adjourned Feb. 27.

The role of the task force will be to seek public comment and then, during the next legislative session, propose amendments to the law.

In addition to having the State Insurance Fund write coverage for the residual workers compensation market, the new law also:

- Automatically will allow up to a 25% upward deviation in workers compensation rates from those filed by the National Council on Compensation Insurance.
- Calls for the elimination of a premium tax on health insurance, which annually generates about $4.5 million for the state.
- Redefines the state's guaranty associations and creates a new preassessment Health Insurance Guaranty Assn. The current Utah Life & Health Guaranty Assn. is funded on a post-assessment basis.
- Adopts stringent financial requirements for insurers in an effort to prevent insolvencies.
- Clarifies and strengthens the requirements for both ceding and assuming insurers in reinsurance transactions, and sets rules about when a ceding insurer may take credit for reinsurance.

But, a major component of the new law is that the Utah State Insurance Fund will handle the residual market for workers compensation insurance.

Currently, Utah's admitted insurers that write workers compensation coverage are prohibited from refusing an application for workers comp coverage.

However, under the new law, only the State Insurance Fund would be required to accept all applications for workers compensation insurance, Mr. Leavitt said.

The new law also allows workers compensation insurers to deviate upwards of 25% without prior approval from the insurance commissioner when their rates are filed.

Rates still will be filed by the New York-based National Council on Compensation Insurance, Mr. Leavitt said, but insurers would be allowed the automatic 25% deviation, and they could seek additional deviations from the insurance commissioner, he added.

Currently, prior approval for deviations is required, but such approval has been quite common in the past few years, according to an Insurance Department official.

In the health insurance arena, the new law calls for the elimination of a premium tax on health insurance because of "unfairness," Mr. Leavitt said.

"The tax is unevenly (collected) from among the state's citizens," Mr. Leavitt said, explaining that many people are insured through programs that fall under the jurisdiction of the Employee Retirement Income Security Act or other types of arrangements in which there is no premium tax.

"So some are paying, and others don't," he said.

The premium tax has generated between $4 million and $4.5 million annually, and it will be "painful" for the state to lose this revenue, Mr. Leavitt noted.

The new law also calls for the creation of a separate Health Insurance Guaranty Assn., which will annually assess insurers that write health care coverage 0.5% of their previous year's health insurance premium volume in Utah. That money will be used to cover claims if a health insurer becomes insolvent.

Insurers will be assessed annually until the fund accrues to $6 million. Any funds collected or interest earned exceeding $6 million would be returned to insurers on a pro rated basis.

Currently, insurers that write health insurance belong to the Utah Life & Health Guaranty Assn., which has the authority to assess up to 2% of the previous year's premium volume in Utah in the event of an insolvency.

The new code also addresses the financial solvency standards of both property/casualty and life/health insurers by requiring them to maintain a compulsory surplus.

"This is probably the most revolutionary segment of the new code," Mr. Leavitt said. "Not only will insurers be required to maintain a minimum required capital, but also a compulsory surplus, which is a formula. . .sensitive to the volume of business, classifications of business and types of assets of the insurer."

For example, the compulsory surplus would be much lower for a new insurer that has written no business than for an insurer that's already writing $100 million in business, Mr. Leavitt said.

The requirements also would be higher for insurers writing health insurance than for those writing life insurance because of the volatile nature of health coverage, Mr. Leavitt said.

Utah's new law deviates from most other insurance departments' financial requirements, which usually treat insurers identically, "even though the risks they bear are anything but identical," Mr. Leavitt said.

And in the area of reinsurance, the new Utah codes sets out in detail the standards for receiving credit for reinsurance, which are based on a model credit for reinsurance act adopted by the National Assn. of Insurance Commissioners last year (*BI*, June 6, 1984).

Mr. Leavitt said there already is a credit for reinsurance law on the books in Utah, "but it is very vague."

According to the new law, to satisfy the security requirements for reinsurance, an assuming insurer must fulfill one of the following requirements: be an admitted insurer; post a letter of credit with the ceding insurer; give some other specific type of security to the ceding insurer; have a security deposit with a New York bank or the Utah insurance commissioner; or be on the state's list of accepted non-admitted insurers.

About half of the estimated 1,400 admitted insurers in Utah write property/casualty coverage, and about one-third of those write workers compensation policies. The State Insurance Fund also writes workers compensation coverage.

Some 40 insurers are domiciled in Utah, the majority of which write life insurance.

Various constituencies are expected to comment and offer changes on the new insurance code within the next few months. Any new changes in the marketplace, in particular those developing in the area of banks and insurance, also are expected to be addressed in amendments before the bill takes effect next year, according to Insurance Commissioner Roger C. Day. ■

California storm losses total $15 million

NEW YORK—Insured losses as a result of damage from a major windstorm that affected portions of the state of California on Jan. 12-13 are estimated at $15 million by C.E. Hermanson, who is vp of the property claims services division of American Insurance Services Group Inc.

California counties that reported the heaviest damage were Los Angeles, San Bernardino, Riverside and Orange.

The windstorm was assigned Catastrophe Number 54 by the Insurance Services Office. ■

around the states

California bill would limit amount insurers can cede

SACRAMENTO, Calif.—A bill filed in the California Legislature would prohibit insurers from ceding more than 90% of assumed liability under insurance contracts, except for workers compensation policies.

S.B. 442 introduced by Sen. Alan Robbins, D-Van Nuys, is designed to "safeguard California policyholders by making sure that risks are monitored prudently by domicile insurers," according to Sheldon Davidow, a staff consultant to Sen. Robbins.

Mr. Davidow says the bill is not intended as an attack on fronting arrangements provided by licensed insurers for captive insurance companies. Rather, he says the bill is a result of Sen. Robbins' concern about the use of reinsurance by California insurers.

"When you know you've got first-dollar responsibility, you tend to watch the risk a little closer," he says.

Under a fronting program, an insurer issues an insurance policy to a corporation but then reinsures all or a substantial portion of the risk with the policyholder's captive insurer or another insurer designated by the policyholder.

Mr. Davidow says that Sen. Robbins plans to use the bill as "a vehicle to explore the (reinsurance) issue more thoroughly." And, he says that Sen. Robbins is seeking the business community's input on the legislation.

"The final shape of the bill depends on the input we get from industry," Mr. Davidow explains.

Sen. Robbins hopes to have hearings on the bill by mid-May.

The California Insurance Department is studying the bill, but has not yet formulated a position on the measure, according to Brian L. Walkup, staff council for the department. Mr. Walkup says the department is examining the effect the bill would have on fronting arrangements.

N.J. medical coverage

VERONA, N.J.—New Jersey employers should be able to exclude medical coverage for employees' non-work-related automobile accidents, an employers' group argues in an appeal to the 3rd U.S. Circuit Court of Appeals.

The Verona-based Employers Assn. of New Jersey, which represents 750 companies, is fighting a new state law that allows motorists to use their employer-provided health plans to pay a portion of any medical bills resulting from personal auto accidents.

Since Dec. 3 of last year, the New Jersey Auto Insurance Freedom of Choice and Cost Containment Act has allowed motorists to choose deductibles of $500, $1,500 or $2,500 on the personal injury protection coverage in return for a premium deduction. Since most motorists are employed, employer health plans would fill the gap while reducing

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the cost of insurance, according to a state Insurance Department spokesman.

The employers' group, which was joined as a plaintiff by the New Jersey State AFL-CIO, argued that allowing the deductible was "an intrusion into the collective bargaining process."

They claim that only the federal government, and not the state, could control employee benefits.

On Jan. 24, U.S. District Court Judge Harold Ackerman issued a written opinion in which he said that the state's authority to regulate insurance was not pre-empted by two federal laws that the plaintiffs cited, the Labor Management Relations Act and the Employee Retirement Income Security Act.

Judge Ackerman said in his decision, "Congress intended that states be free to regulate the terms of insurance coverage and the relations between insurers and their insureds, even if that regulation has some indirect effect on the collective bargaining process and the terms of the employee benefit plans."

The new law is designed to provide money-saving options for New Jersey motorists.

They previously paid the highest rates in the nation for first-dollar coverage from auto insurers, who alone paid their accident-related medical bills to the maximum policy limits.

Employers fear that the new state law will cause health care costs to rise, although no figures were available because few motorists thus far have taken advantage of the maximum deductible, said Harold Hawkey, the association's executive director.

California limo limits

LOS ANGELES—Operators of limousine services in California are seeing a 429% increase this year in state-mandated minimum limits for accident and liability coverage.

Minimum limits had been $350,000 for several years. However, the state Legislature has adopted a two-stage increase that will raise limits to $750,000 on Jan. 1.

Limits will increase again to $1.5 million on Nov. 19, according to Richard Collins, senior transportation engineer with the state's Public Utilities Commssion.

The increase applies to operators of limousine services with a maximum of 16 passengers.

There has been 96% compliance with the first-stage increase, according to Mr. Collins. "There have been not too many squawks," he added.

However, a bill has been introduced that would place a $500,000 cap on the required coverage limit for limousine services with fewer than eight passengers, according to an aide to bill sponsor State Sen. Herschel Rosenthal, D-Los Angeles.

Sen. Rosenthal chairs the Senate's Committee on Energy and Public Utilities.

Small operators will be especially hard-hit by the second-stage increase, the aide said.

The Legislature adopted the increases for all limousine services in California after the federal Bus Regulatory Reform Act of 1982 required $1.5 million in coverage for services that transported passengers across state lines, said Mr. Collins.

NAIC vp to leave post

KANSAS CITY, Mo.—E. Benjamin Nelson will return to his private law practice in Omaha, Neb., after a three-year hitch as executive vp to the National Assn. of Insurance Commissioners.

Mr. Nelson, who was an insurance regulator in Nebraska from 1975-1976, was brought on staff to reorganize, restaff and relocate the NAIC.

In 1982, the national association was based in Brookfield, Wis.

Technical enhancements to the association's solvency surveillance system and improved communications both within the organization and with those on the outside, were among the tasks accomplished during Mr. Nelson's tenure.

A search committee has been appointed and Mr. Nelson is planning to leave in mid-June, just after the NAIC holds its annual summer meeting in Kansas City.

Staff appointments

TALLAHASSEE, Fla.—Several staff appointments have been announced by Florida Insurance Commissioner Bill Gunter.

Daniel Y. Summer has been named the director of the Division of Insurance Rating. He succeeds Gerald Wester, who recently was promoted to deputy insurance commissioner.

In addition, Dale Hazlett has been named assistant director of the Division of Insurance Company Regulation, and Margaret Veigas has been named to succeed Mr. Hazlett as chief of the Bureau of Rates.

Mr. Summer has been an Insurance Department attorney since 1979.

As director of the Division of Insurance Rating, he will be responsible for the department's review of rate and policy filings for all lines of insurance.

Mr. Summer has a bachelor's degree in finance from the University of Florida and a law degree from the University of Florida College of Law.

Mr. Hazlett had headed the Bureau of Rates since 1983, and previously had been the Insurance Department's economic analyst for a year, during which he developed a computerized recordkeeping system and insurance data base.

In his new position with the Division of Insurance Company Regulation, he will help direct the department's regulation of the 1,400 insurance companies operating in Florida.

Mr. Hazlett received both a bachelor's degree in business administration and a master's degree in economics from Florida State University.

Ms. Veigas joined the department in 1979. She previously was chief of the Bureau of Worker's Compensation. She left the department briefly in 1984, returning to work in the Division of Risk Management as a workers compensation claims administrator.

As chief of the Bureau of Rates, she will direct the department's actuarial staff in its review of insurance company rate filings and in the collection and analysis of statistical data. She has a bachelor's degree in history and political science from St. Joseph College in West Hartford, Conn., and is a graduate of the Insurance Institute of America.

Commissioner named

TRENTON, N.J.—Hazel Frank Gluck, who has been active in state and local government in New Jersey, is the state's new insurance commissioner.

Ms. Gluck, who was sworn in March 11, most recently was director of the New Jersey State Lottery. Before that, she served a term in the New Jersey General Assembly and on various county and local boards (*BI*, Feb. 4).

Ms. Gluck will replace Kenneth Merin, who was appointed acting New Jersey commissioner in April 1984 after the resignation of Joseph F. Murphy (*BI*, April 16, 1984).

Mr. Merin, who had been the governor's deputy general counsel, will become the director of the governor's office of policy and planning. ■

Court rulings on pollution exclusion conflict

Continued from page 2

Techalloy's primary comprehensive general liability insurer, Reliance, refused defense coverage, and Techalloy then financed its own defense of the suit, which was later dismissed.

Techalloy then sued Reliance, seeking damages for expenses incurred in the defense of the class action suit.

Reliance contended that it should not have to defend Techalloy because, among other things, the alleged contamination caused by the TCE was not "sudden and accidental" and thus was not covered by the policy.

The lower court dismissed Techalloy's complaint, saying that no actual personal injury was alleged in the original suit and, therefore, Techalloy was owed no coverage under the CGL policy. It did not rule on the pollution exclusion issue.

However, the Superior Court said that the original complaint did allege personal injury, but that Reliance did not owe a defense because of the pollution exclusion.

According to the court, the Reliance policy excluded from coverage "personal injury or property damage arising out of the discharge...release or escape of...toxic chemicals...or...waste materials or other irritants, contaminants or pollutants into...any water course or body of water," unless such discharge was "sudden and accidental."

Techalloy contended that Reliance could not invoke that pollution exclusion unless Reliance was certain that the facts of the original class action complaint could not support the contention that the alleged contamination was sudden and accidental.

But, the court said Reliance's use of the exclusion was valid and that at best, Techalloy would be able to prove from the underlying facts only that the discharge was accidental, but not sudden.

"That alone, however, would not substantiate their position, since the language of the policy unambiguously states that there will be no coverage for toxic discharge into the environment unless that discharge is both sudden *and* accidental," the court said.

In the underlying complaint against Techalloy, the plaintiff did not allege a sudden event but rather contamination that occurred over the past 25 years.

"The allegations disclosing the circumstances and nature of the chemical discharge explicitly negate any potential for finding a sudden event in order to render the exclusion inapplicable," the court added.

"Furthermore, despite the early dismissal of Techalloy's complaint, there are sufficient facts on record to support a determination that the water contamination did not occur suddenly.'

An attorney for Techalloy said the company has not decided whether to seek a review by the state Supreme Court.

According to Jan DuBois, an attorney for Reliance with the Philadelphia firm of White & Williams, the court looked to the facts of the underlying complaint against Techalloy and determined that pollution could be accidental but not sudden.

This case is in contrast to some other decisions that have "emasculated" the words "sudden and accidental" to mean unintended and unexpected, he added.

However, in the Waste Management decision, the state Court of Appeals in North Carolina ruled that the pollution exclusion clause did not bar a waste collection and transportation service from receiving defense coverage from its insurers.

The suit originated when the federal government sued Flemington Landfill in New Hanover County, N.C., seeking reimbursement of costs arising out of groundwater contamination allegedly caused by Flemington.

Flemington and others, in turn, sued Waste Management of Carolinas Inc., doing business as Trash Removal Service Inc. That suit sought indemnity and contribution if the landfill were found liable in the government suit.

Flemington alleged that TRS "contributed" to the contamination and was "careless and negligent" in not exercising proper care to prevent the deposit of hazardous chemical wastes when delivering solid wastes.

TRS then sought defense coverage from its two insurers—Peerless Insurance Co. and Pennsylvania National Mutual Casualty Insurance Co.—both of which denied coverage.

Peerless insured TRS under a manufacturers' and contractors' liability insurance policy from August 1974 through Aug. 12, 1979, and Penn insured TRS under a CGL policy from June 17, 1979, through June 17, 1980.

In June 1982, TRS sued the insurers, seeking a declaratory judgment on its rights to coverage under the liability policies.

The trial court granted summary judgment for the insurers, in effect, saying they had no duty to defend because of the pollution exclusion clauses that were contained in the policies.

The appellate court, however, ruled that the insurers owed TRS defense coverage and that the pollution exclusion clause did not bar coverage.

The court said that an ambiguity was created by the definition of "occurrence" under the policies and the definition of "sudden and accidental" under the pollution exclusion clause.

The policies defined "occurrence" as an accident including continuous or repeated exposure to conditions resulting in bodily injury or property damage "neither expected nor intended from the standpoint of the insured," the court said.

The pollution exclusion clause, however, requires that the pollution be "sudden and accidental" for there to be coverage.

The court noted that these definitions can conflict.

"Under the coverage provisions, if an event happens over a period of time, causing bodily injury or property damage unexpected or unintended from the standpoint of the insured, then it is an "occurrence" and the insurer should defend the insured in the event of suit based on it," the court said.

"Yet if the word 'sudden' (in the pollution clause) means only an 'instantaneous happening,' then the occurrence which happens over a period of time is subject to exclusion from coverage under the pollution exclusion."

The court said that when a policy is ambiguous, the court must resolve the conflict in favor of the insured.

"We find that the word 'sudden' is reasonably susceptible of differing constructions, and we construe it not to mean just 'instantaneous' but also unforeseen and 'unexpected,'" the court added.

"This construction renders the pollution exclusion consistent with the definition of 'occurrence,' in the coverage provisions."

Thus, if the court finds the contamination of the ground water was "sudden and accidental"— unexpected and unforeseen from the insured's standpoint—then the pollution exclusion does not preclude the insurer's duty to defend TRS.

Looking at the facts alleged against TRS, the court noted that two complaints alleged TRS "contributed" to contamination of ground water in the Flemington area and was also "careless and negligent" in not preventing solid and hazardous waste material from being deposited in the landfill.

The court found that use of the word "contributed" establishes a potential that TRS's conduct will be found to be accidental and does not conclusively show that TRS expected or intended the resultng damage to the Flemington ground water.

Moreover, use of the theory of negligence and carelessness creates a potential that at trial TRS will be shown to have accidentally disposed of toxic chemicals at the landfill, without any intent or expectation that they would contaminate the ground water and landfill, the court said.

"Construing the pollution exclusion consistently with the definition of 'occurrence,' we find no allegation of facts in the third-party complaints which shows that the contamination of the ground water was not 'sudden and accidental,' i.e., not expected nor intended from the standpoint of the insured," the court said.

"Indeed, the insurers have stipulated that 'the insured (TRS) neither expected nor intended the resulting claimed damage.' The pollution exclusion accordingly does not apply to any of the complaints.

"We hold that both of the general liability policies as applied to the alleged facts oblige the defendant insurers, Penn and Peerless, to defend TRS in suits commenced by the three third-party complaints."

Peerless has sought review from the state Supreme Court. A decision is expected within two months, an attorney for Peerless said last week.

Officials at Penn could not be reached to comment on the case. ■

Insurers launch joint effort to combat punitive damages

By STEPHEN TARNOFF

Insurers are launching an effort to remove punitive damages from the civil justice system or to at least reform state laws to reduce the amount of punitive awards.

Representatives of the National Assn. of Independent Insurers, the Alliance of American Insurers, the American Council of Life Insurers, the American Insurance Assn., the Health Insurance Assn. of America and Farmers Insurance Group recently worked out an agreement to cooperate in the push for reform.

The group also intends to build a wider coalition by enlisting the support of other affected industries and groups, such as manufacturers, small businesses and pharmaceutical producers.

"Punitive damage awards have grown in recent years to the point where society can no longer afford to ignore their adverse impact on the civil litigation process," the agreement says.

"The most appropriate process for deciding what social conduct is punishable and who should be punished is the criminal justice system and not the civil system."

The insurers rejected the idea of a single model law on punitive damages, deciding that state-by-state reform is a better approach because of differences in legal climates, demographics, political environments and public attitudes.

The coalition will give California a high priority because of its liberal legal system and its reputation as the place where legal precedents begin.

The coalition also will organize an industry effort to enact legislation in 1985 in Arizona, Colorado, Kansas and Montana.

A spokesman for the NAII said these are the states where insurers feel they have the best chance of changing the law on punitive damages.

The industry group said it will first seek limitation or elimination of punitive damages from the civil justice system and, if that cannot be achieved, it will press for a series of reforms.

Six reform measures the participants see as necessary include:

- Setting a maximum amount of punitive damages that can be imposed for a single course of conduct.
- Limiting the type of conduct that can give rise to punitive damages; for example, permitting punitive damages only when the underlying claim involves an intentional act.
- Modifying legal procedures to achieve more fairness, perhaps by holding separate trials to determine liability and assess damages; or by changing the burden of proof in the civil system from the current preponderance of evidence to the stricter test of criminal law—proof beyond a reasonable doubt.
- Allowing affirmative defenses such as acting on the advice of an attorney or a government official or relying on a statute or judicial decision.
- Restricting attorney fees, perhaps by banning contingency fees, which typically consume one-third to one-half of punitive damage awards.
- Paying all or part of punitive damage awards under certain conditions to governmental subdivisions such as school districts or to charitable organizations.

The NAII spokesman said the main obstacle to reform will be the plaintiffs' trial bar, which favors punitive damages.

A spokesman for the Assn. of Trial Lawyers of America said his organization probably will oppose any moves to curtail or restrict punitive damages.

"Without punitive damages, there is a gap between negligent behavior and criminal behavior," for reckless or willful and wanton conduct, said Tom Goddard, state legislative counsel for ATLA.

ATLA believes the civil justice system is correct in filling that gap through punitive damages, he said.

Mr. Goddard added that ATLA sees the effort by insurers as part of a larger effort to undermine victims' rights to compensation and society's rights to punish outrageous or reckless behavior. ■

Cable TV loss-prevention group formed

ARLINGTON, Va.—The American Society for Industrial Security has formed a cable television subcommittee to serve the loss-prevention needs of the cable TV industry.

The subcommittee's goals are:

- Improving the communication of loss-prevention information within the cable television industry.
- Promoting programs that have been successful in combatting theft of service and piracy.
- Enhancing the professionalism and training of security personnel in the cable industry.

To be placed on the group's mailing list, contact one of the panel members. The panel members are Chairman Ronald R. Putnam, group director of security at General Instrument Corp., 212-207-6284; John J. Hanson Jr., corporate director of security at Oak Industries Inc., 213-553-7059; and Patricia B. Tomaselli, corporate security and safety manager at Westinghouse Broadcasting and Cable Inc., 212-307-3163. ■

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Syntex will fight $27 million tort award

By MEG FLETCHER

CHICAGO—Two Syntex Corp. subsidiaries are deciding how to best fight a $27 million verdict handed down by a Cook County jury in a product liability case over a recalled infant formula.

The jury on Feb. 28 awarded $5 million in compensatory damages and $22 million in punitive damages to two 6-year-old boys who sustained brain damage allegedly caused by the removal of salt from the company's Neo-Mull-Soy baby formula.

Punitive damages are not normally insurable under Illinois and California law, attorneys say.

Neo-Mull-Soy is a soybean-based formula fed to infants who are allergic to milk.

The verdict is the largest lump-sum personal injury jury verdict ever awarded in Illinois, although not the largest award received by an individual, according to plaintiffs' attorney John D. Hayes of John D. Hayes & Associates of Chicago.

Syntex strongly disputes the decision and will vigorously contest the award, a company spokeswoman said. The company is considering various legal options, but still has not decided whether to appeal the verdict, she added.

The spokeswoman declined to comment on the company's insurance coverage for the award, except to say that it had substantial self-insured retention and it will be noting the verdict on the 10-Q form it will soon file with the Securities and Exchange Commission.

Syntex's first $5 million umbrella layer is written in London and led by H.S. Weavers (Underwriting) Agencies Ltd., London sources say.

According to court papers filed in a related case, the "Syntex insurance program" in June 1983 included a $5 million self-insured retention and $45 million of excess liability coverage.

Syntex's coverage was brokered in the United States by the San Francisco office of Frank B. Hall & Co. Inc., but Hall spokesmen also declined to comment.

The company spokeswoman said the verdict is "flagrantly inconsistent" with jury verdicts in five other related cases which have gone to trial, in which no punitive damages were awarded. Jury verdicts finding for the company were rendered in West Palm Beach, Fla., Dallas and Birmingham, Ala. A jury verdict of $415,000 in compensatory damages was overturned by a trial judge in Kansas City, Mo., and a new trial has been ordered.

However, the company will pay $400,000 awarded by a jury in a similar case in October 1984, according to plaintiffs' attorneys McKenna, Conner & Cuneo of Washington.

In addition, the company has settled more than 100 cases, the Syntex spokeswoman said. The company's position, she said, is that it is concerned about children who suffer health problems as a result of formula use and it will compensate them. However, it will take responsibility for brain damage suffered by children only if it is proven to have been caused by the formula, the spokeswoman said.

The Cook County jury awarded $3 million in compensatory damages to Timothy Sheridan of West Palm Beach, Fla., and $2 million in compensatory damages to James Duddleston of Chicago. Both boys were fed the formula as infants for about three months in late 1978 and early 1979.

They have been diagnosed as having speech, language and fine and gross motor coordination problems and attend special education programs, according to Mr. Hayes, the plaintiffs' attorney.

'I think the punitive damages are assessed to punish the defendants and act as a severe warning to anyone else,' says plaintiffs' attorney John D. Hayes of John D. Hayes & Associates in Chicago.

Circuit Court Judge Brian Crowe will allocate the $22 million in punitive damages, $13 million of which will be paid by Syntex Laboratories and $9 million by Syntex (USA), subsidiaries of Syntex Corp. of Palo Alto, Calif.

"I think the punitive damages are assessed to punish the defendants and act as a severe warning to anyone else," said Mr. Hayes.

Any company that changes a product designed to sustain infants in their first six months of life without adequately testing the effect of its action is acting with "utter disregard" for children, said Mr. Hayes. "They are playing Russian roulette with these kids," he added.

The company removed salt from the product because of concern over the possibility that salt intake by infants could lead to hypertension in adulthood, the company spokeswoman said. In addition, the company believed that the infants would receive adequate levels of salt from the other ingredients.

Mr. Hayes is representing plaintiffs in 15 to 18 additional infant formula cases, while McKenna, Conner & Cuneo has two cases.

More than 8 million cans of the Neo-Mull-Soy and Cho-Free, a related product, were recalled in August of 1979 after 31 infants were found to suffer from a condition called metabolic alkalosis, with symptoms of failure to gain weight, loss of appetite, lethargy and constipation, according to a U.S. Food and Drug Administration spokesman.

Use of the two products was not considered dangerous if used for a short period of time, or used to supplement mother's milk, according to an FDA release in October 1979. The only infants at risk were those who used the product as their sole food source for more than one month, it stated.

The problems associated with the infant formulas prompted Congress to enact in 1980 the Infant Formula Act, which established minimum levels of nutrients in infant formulas, according to the FDA spokesman. ■

LTD offset rule

Continued from page 2

While the blue book does not carry the weight of law, Treasury Department staff members are guided by it when they draft rules, consultants say.

"This is a big relief," said Edward J. Davey, vp-technical analysis at Johnson & Higgins in New York. "This avoids a mad scramble to get into compliance."

By extending the deadline for compliance until rules are published, the tax committee staff is saying to employers: "Hang in there. Don't panic," said Jack Helitzer, an assistant vp with Metropolitan Life Insurance Co. in New York.

"This has to be viewed positively," said John Hickey, a partner at Kwasha Lipton, a Fort Lee, N.J.-based benefit consultant.

"For those employers who haven't done anything, this gives them time to reflect on what to do."

The integration issue affects employers who routinely offset or reduce LTD benefits by the Social Security disability benefits received by a disabled employee. This reduction is made so that the combined amount of LTD benefits and tax-free Social Security disability benefits do not exceed a worker's pre-disability salary.

Employers offset their pension plans with Social Security so that corporate pension benefits and Social Security benefits together replace a pre-determined percentage of a worker's preretirement income.

Pension plan offsetting or integration recognizes that companies are paying for half of a worker's Social Security benefits and thus should receive credit for these expenditures through lower corporate pension plan costs.

But, companies that fully integrate their pension plans with Social Security cannot offset LTD benefits through a VEBA, according to the conference report accompanying the 1984 tax law, though LTD benefits paid to employees covered by collective bargaining are exempt from this requirement.

If pension benefits are between 90% and 100% integrated with Social Security, a limited amount of offsetting will be allowed in LTD benefits funded through a VEBA. The exact amount of offsetting allowed will depend on the extent of pension plan integration with Social Security.

The delay in the effective date of the integration provision until Treasury Department rules are published means that employers that have fully integrated pension plans and that fund LTD benefits through VEBAs do not face possible severe financial penalities.

For example, a VEBA found to be discriminatory—because the employer has a fully integated pension plan and also offsets LTD benefits with Social Security disability benefits—could be taxed on the investment income earned on trust assets, noted Metropolitan's Mr. Helitzer.

The assets could be taxed at a rate as high as 46%.

Currently, assets held by a VEBA earn interest tax-free.

The congressional blue book also says disabled employees who do not collect LTD benefits before the effective date of the Treasury rules will not be affected by the rules. The rules will only cover those who become disabled on or after the rules' effective date.

Consultants earlier said they weren't sure if the rules would apply to LTD claims incurred after Jan. 1, 1985, or only to benefits paid after that date.

When Treasury Department rules are finally published, employers with fully integrated pension plans that fund LTD benefits through a VEBA still face difficult choices.

Companies with fully integrated pension plans could continue to offset LTD benefits in their VEBAs if they slashed the extent of integration in their pension plans. But doing that could interfere with companies' attempts to provide employees with retirement benefits equaling a certain level of pre-retirement income.

But, if companies with fully integrated pension plans stop offsetting LTD benefits with Social Security disability benefits, disabled employees could possibly collect more in benefits than they made in salary before their disability.

That could happen because Social Security disability benefits are tax-free and because, if employees contribute to their LTD coverage, they are not taxed on the percentage of those LTD benefits to which they contributed.

"A benefit structure that gives workers an incentive not to return to work is not socially desirable," Mr. Helitzer said.

Since the integration provision only applies to VEBAs, employers could switch from a self-insured LTD plan funded through a VEBA to an insured plan.

But, consultants have said that switch would increase employers costs—possibly by as much as 20% annually.

Employers can save money funding benefits through a VEBA—compared with an insured plan—because no state premium taxes are paid on a self-insured plan and because the reserves held by the trust aren't taxed.

Some employers could also consider self-funding LTD benefits on a pay-as-you-go basis, but that option is not open to employers with LTD plans that are partially or fully funded by employees. A provision in the Employee Retirement Income Security Act says employers cannot hold onto an employee's benefit contributions in an uninsured arrangement for an extended period of time. ■

Newman named president of The Home

comings & goings: industry

Steven H. Newman has been elected president and a director of New York-based The Home Insurance Co.

In addition, **Marshall Manley** has been elected chairman of the insurer and president of The Home Group.

The new officials replace **Peter C.R. Huang**, 48, who resigned as chairman and president of The Home Insurance Co. and president of The Home Group.

Mr. Huang retains his post as president and chief operating officer of City Investing Co., The Home Group's parent.

The newly elected officials are taking their new posts during City Investing's preparations to liquidate. City Investing is attempting to sell the insurance company as part of the liquidation.

Mr. Newman, 42, had been an executive vp with The Home. Mr. Manley, 44, is a co-managing partner in the New York law firm of Finley, Kumble, Wagner, Heine, Underberg, Manley & Casey. He will retain that position.

Other insurer changes:

Several executives have been promoted at Wausau Insurance Cos. in Wausau, Wis. **Ronald C. Retterath**, vp and actuary since 1979, becomes senior vp and actuary; Richard J. Byron elected vp and associate general counsel; **Delores A. Clancey** elected vp; and **Mark E. Fiebrink**, assistant vp and associate actuary since 1982, named vp-actuarial.

Lawrence G. Becker named vp and corporate counsel at Mission Insurance Group in Los Angeles. He had been a vp at Bayly, Martin & Fay International Inc. in Newport Beach, Calif.

Other suppliers

Myron A. Soltau elected president of Scott Wetzel Services Inc. in Bremerton, Wash., a provider of claims administration, loss-control and statistical services. Wetzel Services is a subsidiary of City Insurance Co. Mr. Soltau, who joined Wetzel Services in 1972, had been executive vp. He succeeds **E. Scott Wetzel Jr.**, founder of the company, who will remain on the board of directors and serve as a consultant.

Arthur R. Rodriguez, M.D., named vp and medical director of Preferred Health Care Corp. in New York. Dr. Rodriguez previously was national medical director of the Office of Civilian Health and Medical Programs of the Uniformed Services, the Department of Defense's civilian health benefits program.

Reinsurance

Timothy P. Mitchell and **Richard S. Skewes** named vps at General Reinsurance Corp. in Stamford, Conn.

Paul J. Krajeski named vp and national property facultative manager in the New York office of Buffalo Reinsurance Co., a subsidiary of Continental Corp. Mr. Krajeski, who joined the company in 1979, had been an assistant vp.

Agents/brokers

F. Dudley Fulton joins Henderson & Phillips Inc. in Norfolk, Va., as executive vp. Mr. Fulton had been executive vp of First American Bank of Virginia.

Peter J. Durkalski named vp of International Special Risk Services Inc., a wholly owned subsidiary of Arthur J. Gallagher & Co. in Rolling Meadows, Ill. Mr. Durkalski, who joined Gallagher in 1973, most recently was an area vp.

The Crump Cos. Inc. in Memphis, Tenn. announced several appointments at subsidiary Crump/Warren & Sommer Inc. **W.J. Creedon Jr.**, executive vp, promoted to president. Mr. Creedon has been with the company since 1981. **C. Wesley Schoelzel** joined the firm as executive vp. Mr. Schoelzel, previously was president of his own insurance company. **Thomas J. Daly** joined as vp and senior account executive. He most recently was executive vp of Walsh, Moore, Garrett-Bromfield Inc. ■

Bethlehem Steel settles with retirees over benefits

Continued from page 2

retirees were required to pay varied according to whether they were paid by the week or by the hour, Mr. Moot says. "We've now averaged it out."

Plan participants will have 100% hospitalization coverage for the first 150 days per occurrence, but they will have to satisfy a 20% copayment on and after the 151st day for all covered expenses. In addition, pre-certification for hospital stays is required.

All covered expenses under the health care program program are subject to an annual $200 deductible for each participant. After 1985, the deductible will increase every year by one-half of the increase in the Medicare hospital deductible, but the Bethlehem deductible cannot increase more than 10% in any calendar year.

The 1981 plan paid 100% of all medical costs.

The settlement caps annual out-of-pocket medical expenses per participant at $800 in 1985, $900 in 1986 and $1,000 in 1987, including the deductible.

The limit may be increased after 1987, but it never may be increased by more than $50 in a single calendar year.

After the out-of-pocket limit is reached, the plan reverts to 100% coverage.

Richard Fay, a benefits expert with the Washington law office of Reed, Smith, Shaw & McClay, says the real significance of the Bethlehem case is not the settlement, but Judge Elfvin's original decision.

"I think the decision itself was the warning sign to other employers," he says.

A Bethlehem spokesman says the company decided to settle the case rather than pursue the appeal because it was in the "best interests of all concerned." The retirees will have "greater certainty in regard to their future health care benefits," while the company will have "improved control and prediction of its health care costs."

Attorney Richard E. Moot, of the Buffalo-based law firm Moot & Sprague, which represented the retirees in the case, says, "We're very pleased with it. It has accomplished what we set out to do."

Mr. Moot notes that, in addition to the 18,000 retirees represented in the original suit, the settlement also covers 2,000 so-called "creepers," employees who had been laid off but were awaiting eligibility for retirement benefits as of March 1984. Any workers who retired from Bethlehem beginning in April 1984 after the original retiree health plan changes were announced are covered by the Comprehensive Medical Plan that drew the ire of the pre-April 1984 retirees.

Richard E. Eardman, one of the retirees named in the suit, who left Bethlehem Steel as a project engineer in 1981 after 31 years with the company, says, "It is satisfying to know I'm going to have health insurance and life insurance benefits for the rest of my life."

He adds he is unhappy about the deductible and pre-certification provisions included in the plan, "but you can't have everything, I guess."

He says the retirees' attorneys had advised them that, despite their court victory, it would have been somewhat risky to turn down a negotiated settlement and proceed with the appeal.

Minnesota weighs superfund changes

By ROBERT A. FINLAYSON

ST. PAUL, Minn.—Under pressure from the business community, the Minnesota Legislature is considering easing the personal liability provisions of its hazardous-waste cleanup law.

The Minnesota Environmental Response and Liability Act of 1983, the first of its kind in the nation, was designed to make it easier for people who were injured by the release of hazardous substances to recover damages (*BI*, April 16, 1984).

But, Minnesota business leaders have complained that the law is punitive and opens the door to potentially millions of dollars in personal injury lawsuits. To date, only three such lawsuits have been filed in the state.

Business leaders have complained that the law makes it hard for Minnesota businesses to obtain environmental impairment liability insurance. However, a December 1984 study by the Minnesota Department of Commerce concluded that the problems in obtaining EIL coverage stem more from the overall collapse of the EIL market than from the state superfund law.

In an attempt to answer business criticism of the superfund law, Minnesota legislators are considering a bill that would:

- Delete the law's causation provision, which makes it easier to get a toxic-tort case before a jury.
- Remove joint and several liability for personal injury claims. However, the bill would leave this strict standard of liability in place for cleanup lawsuits.
- Eliminate the retroactive effect of the law for personal injury claims by stating that only claims stemming from releases of waste deposited after July 1, 1983, could be brought under the law.

Legislative staffers say the the bill to amend the superfund law has been temporarily delayed because some legislators want to tie consideration of the amendments to the passage of a measure that would establish a fund that would provide compensation to victims of exposure to a hazardous substance.

Currently, committees in both the Minnesota House and Senate are considering several bills to establish a such a victim's compensation fund.

Gov. Rudy Perpich, who backs the superfund law, is said to support the proposed amendments and the creation of a mechanism to assist victims of hazardous substance releases. ■

MGM litigation

Continued from page 1

Goldman in the 8th Judicial District for the State of Nevada in Clark County.

The litigation will involve more than 60 attorneys and literally tons of documents and exhibits. Only the litigation between five asbestos companies and more than 75 insurers currently being heard in state court in San Francisco rivals it in size and scope, attorneys say.

The jury trial in the MGM case, which is expected to take about a year, will be conducted in Las Vegas' Thomas-Mack Center at the University of Nevada. The parties in the suit have rented the center for 10 months at a cost of $106,000.

Although a multitude of issues are to be decided in the trial, the main issue is whether the $75 million settlement entered into between MGM and the Plaintiffs Legal Committee included punitive damages that are not covered by the retroactive insurance.

The size of the settlement makes it very clear that it included punitive damages, says Hall Vp and General Counsel Thomas G. O'Brien III.

Hall and Union will seek to prove that MGM agreed to the settlement because it was concerned that if it went to trial the verdict would include punitive damages against them.

Hall and Union also want to prove that the $106 million MGM has paid out so far to fire victims is not a reasonable amount.

MGM was forced to take out bank loans to pay the $75 million settlement that involved 450 fire victims. In addition, more than 2,200 other cases were settled before the $75 million settlement was reached.

Other excess insurers agree with Hall and Union International that punitive damages were involved in the $75 million settlement.

"Our view is that the difference between the reasonable value of compensatory damages and the amount MGM settled for was the settlement of its exposure to punitive damages," said Barry Bunshoft an attorney with the San Francisco firm of Hancock Rothert & Bunshoft.

The insurers he represents have about $20 million of the $35 million second layer of the retroactive coverage.

Mr. Bunshoft said the second-layer excess insurers were told by MGM brokers that the coverage was sought by MGM because it wanted to avoid a qualified financial statement and that there was little chance the second layer would be tapped.

When the $75 million settlement was reached with the final fire victims, insurers attempted to negotiate with MGM to allocate what portion of that represented compensatory damages and what portion represented punitive damages, he said.

However, "we were unable to reach an agreement on an appropriate allocation," he added.

It has been estimated by some of the insurers on the retroactive coverage that compensatory damages owed by MGM for all its liability in the fire should only have totaled around $65 million.

If that were the case, MGM would have had enough coverage to compensate fire victims by tapping only its original $30 million in liability coverage and the first $35 million layer of retroactive coverage.

Mr. Bunshoft said MGM had implied that some of the $75 million settlement was for punitive damages when it offered in Novmber 1982 to pay up to $25 million toward a settlement with the fire vic-

Continued on facing page

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tims if the insurers would contribute $50 million.

The insurers rejected the offer because they believed MGM should contribute more, he said, and once MGM did settle with the victims, it withdrew its offer to pay $25 million.

MGM, however, contends that the $75 million settlement represents only compensatory damages.

William Shernoff, an attorney for MGM, acknowledged that its desire to avoid a trial that could have ended up in it being ordered to pay punitive damages to the fire victims was one of many reasons why it offered to contribute $25 million toward a settlement with the victims.

However, there was no question the $75 million paid to the Plaintiffs Legal Committee was for compensatory damages only, he said.

MGM intends to show at trial that the insurers, particularly Union International and the second-layer insurers, decided early on to delay payment and came up with "bad faith excuses" for nonpayment, Mr. Shernoff said.

He points out that the $75 million settlement was approved in court as compensatory damages, making the insurers' arguments that settlements were too high and represented punitive damages "ridiculous."

"We intend to show at trial that they knew they owed money and were buying more time with this lawsuit," charged Mr. Shernoff, who is of counsel to the law firm of Wyman, Bautzer, Rothman, Kuchel & Silbert of Los Angeles, which represents MGM.

At the heart of Union International's failure to pay, he said, was the payout agreement it had with General Reinsurance Corp. to whom Union International ceded 100% of its liability on the retroactive policy.

Under that payout arrangement, General Re was not obligated to pay Union International any money until 1984. Payments of $7 million were due in 1984 and 1985 and additional payments were to be stretched out until 1990, Mr. Shernoff said.

When the settlement was reached with the fire victims in January 1983, the payout schedule was consequently renegotiated with General Re to accelerate its payments. But, because of the accelerated payout and Gen Re's loss of use of the money, the amount of the payments from General Re to Union International was reduced, Mr. Shernoff pointed out.

Before it stopped indemnifying MGM shortly after the $75 million settlement was reached with the Plaintiffs Legal Committee, Union International had paid out $11.4 million for indemnification and defense costs related to the fire.

MGM is seeking a total of more than $100 million in compensatory damages from the retroactive insurers to cover the $75 million settlement with the fire victims, the interest MGM had to pay on money it borrowed to pay the settlement and attorneys' fees for the coverage and fire litigation, Mr. Shernoff said.

MGM also is asking for punitive damages for the insurers' bad faith, delay of payment and other wrongful activities. These could amount to double or triple the actual damages sought, he added.

Meanwhile, insurers on the third excess layer of the retroactive coverage are charging that the second-layer insurers should have agreed to contribute $50 million when MGM offered in 1982 to pay $25 million toward a settlement with the fire victims. The third-layer insurers wrote a $25 million layer excess of $100 million.

According to Robert N. Schiff, an attorney with the San Francisco firm of Fisher & Hurst, if Union International and the second-layer insurers had settled for $50 million the third-layer insurers would not have been tapped.

If Union International and the second-layer insurers acted in an unreasonable manner in failing to settle, then to the extent that MGM recovers from the third-layer insurers, "We contend we can can recover from the second-layer insurers, said Mr. Schiff. He represents Insurance Corp. of Ireland Ltd., which wrote $5 million of the third layer and $3 million of the fourth layer.

However, Hall's Mr. O'Brien said there was not a genuine opportunity to settle the case with MGM for $50 million, and, he added, the second-layer insurers were very adamant about not paying such a settlement.

Another undecided question is which insurers will pay the $14.1 million in defense costs MGM paid in the fire litigation.

Earlier, Union International contended and Judge Goldman ruled that Granite State Insurance Co., as primary insurer for Del Webb Corp., was liable for $8.6 million in defense costs that Union International had paid to MGM.

On rehearing, however, Judge Goldman left open the question of how much Granite State and Union International would have to pay.

The reason Granite State must contribute to defense costs is because MGM was named as an additional insured on Webb's liability policy.

Webb, which was responsible for the design, construction and alteration of additions to the hotel that were under construction at the time of the fire, was named in hundreds of lawsuits by fire victims.

However, Granite State vigorously disputes that it should pay defense costs.

"Our contention is that we should have only a minute share of the defense costs, if any," said Michael E. Bradford, Granite State's attorney with the Phoenix firm of DeBus, Bradford and Kazan.

Union International, however, contends Granite State should pay the full $8.6 million Union has already paid to MGM for defense costs.

Union also contends that Webb's excess insurers should pay the limits of their policies to indemnify MGM for its losses before any of the excess retroactive insurers must pay. Webb has about $150 million in liability insurance.

The Union agreement with MGM provided that Union would insure MGM but only as to its "ultimate net loss" payable after deducting recoveries and other "valid and collectible insurances," Mr. O'Brien said.

"We believe the Webb policies are valid and collectible insurance and must pay MGM before the Union policy does."

However, Webb's excess insurers contend that they only have to pay under their policies to MGM for Webb's negligent acts or omissions on work done at the hotel for which MGM is found to be vicariously liable.

"If Webb was not negligent in connection with that work then Integrity pays nothing," said David Clark, an attorney for Webb's first-layer excess insurer, Integrity Mutual Insurance Co.

Mr. Clark is with the Los Angeles law firm of Chase, Rotchford, Drukker & Bogust.

"We feel comfortable that our only exposure for indemnity would be if there were proof Webb's acts and/or omissions actually caused a death or injury," added Clifford L. Schaffer, an attorney for four Webb excess insurers with the Los Angeles firm of Pachter, Gold & Schaffer.

Mr. Schaffer also said that under the construction agreement between Webb and MGM there is a $2 million cap on the amount that Webb's insurers have to pay for liability claims. ■

Fidelity bonds

Continued from page 1

McLennan Inc. in New York.

"The client's greatest concern at the moment is getting the coverage and capacity his company needs."

"Of the capacity that is left, many (underwriters) are wondering if they should stay in this class of business in the future," added Merrett's Mr. Burnhope.

"The entire fidelity market has tightened up," said Carroll J. Fitzgerald, vp of the commercial insurance department of Fidelity & Deposit Co. of Maryland in Baltimore. "For the financial institutions, there is a drastic tightening."

The buyers that will be most affected by the loss of capacity are the 15 to 20 largest U.S. banks, market observers in the United States and London agree.

These banks last year could purchase up to $300 million in fidelity insurance, say experts, who add banks will probably have to settle for a lot less coverage in the future.

"Today, putting together $100 million is incredibly challenging," said M&M's Mr. Tomenson.

One of the reasons for the contraction, observers say, is an unprecedented number of fidelity claims.

U.S. fidelity insurers posted a composite combined ratio of 122.3% in 1983, according to A.M. Best Co., compared with combined ratios of 113.5% in 1982 and 99% in 1981. Statistics for 1984 are not yet available.

One London underwriter, who asked not to be named, said three bank fidelity losses reported in the past six months exceed $50 million each, while a half-dozen others exceed $10 million a piece.

Notice of two large fidelity claims, totaling $155 million, have been filed recently by San Francisco-based Bank of America.

The first notice was for the $95 million loss reported by the bank because of its involvement with allegedly fraudulent mortgage-backed securities (*BI*, March 11).

However, it's doubtful whether fidelity insurers will have to pay that claim. Bank of America says that although it has notified its fidelity insurers of a possible claim, the coverage is not applicable because employees have not been accused of dishonest acts. Instead, the bank has sued its directors and officers liability insurers to pay the loss.

Twenty-four hours after fidelity underwriters were notified of a possible claim stemming from the mortgage-backed securities scandal, Bank of America filed another notification of claim for a $60 million employee dishonesty loss in Paraguay, according to a London source.

A spokesman for Bank of America confirmed the bank had notified its fidelity insurers of loan-related losses in Paraguay that occurred between 1982 and 1984. The bank believes the losses "resulted from malfeasance of a former em-

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Commercial Consumers

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Vice-presidents, general managers and other administrative personnel ... 2,573

Financial:
Chief financial officers and vice-presidents of finance 2,168
Secretaries, treasurers, controllers and other financial personnel 7,167

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,206

Sub-total 22,627
Associations 1,081
Government, unions and educational systems 944

Commercial Consumers
Sub-total 24,652
Insurance agents and brokers 9,524
Insurance companies 5,867
Financial institutions 556
Actuaries, attorneys, adjusters, appraisers and consultants 3,265
Others allied to the field, ... 1,143

TOTAL 45,007

* Source: Business/Occupational breakdown of qualified circulation, Nov. 5, 1984 issue, as submitted to BPA for Dec. 1984, BPA Publisher's Statement.

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The Dunlap Agency

Continued from facing page

ployee," said the spokesman, who said he did not know the size of the claim.

These losses have already been written off by the bank, the spokesman said, adding "the claim with Lloyd's will have no negative impact on future earnings. Any proceeds from the claims will contribute directly to the bank's earnings."

Bank of America has more than $95 million of fidelity coverage, the first $10 million of which is written by Lloyd's syndicates managed by Merrett.

Bank of America's fidelity coverage renews in May, the spokesman said. Risk management officials from the bank were in London last week to discuss the renewal and could not be reached to comment on the bank's coverage.

Although increased losses have helped to cut the London market's capacity for financial institution fidelity risks, the weakness of the British pound against the U.S. dollar has sharply reduced Lloyd's of London syndicates' capacity to write coverages whose premiums are paid in U.S. dollars (*BI*, Jan. 21).

Capacity at Lloyd's alone has shrunk by 30% to 35% because of the currency problems, other London market observers note.

Capacity cuts in London affect not only the direct coverage written for banks by London underwriters, but also the capacity offered by U.S. fidelity underwriters since the U.S. market depends upon London for reinsurance support.

"The capacity situation is much less than it was six months ago and this is brought on by the London market cutting back on its capacity," said Mr. Fitzgerald of Fidelity & Deposit Co. of Maryland. "Everything that happens in London has an effect here for insurers who lay off their reinsurance directly to London."

In the United States, markets like Fireman's Fund, U.S. Insurance Group and Shand, Morahan have pulled out of the financial institution fidelity risk market altogether.

Fireman's Fund announced last Monday it would withdraw from the financial institution fidelity insurance market "effective immediately" and limit the amount of fidelity coverage it writes for other types of policyholders to a maximum of $500,000.

Notices to terminate coverage were to be mailed to policyholders late last week.

"Fidelity exposures have grown beyond the point where underwriting vigilence and pricing alone can adequately compensate," said Patrick S. O'Flynn, executive vp in charge of specialty insurance for Fireman's Fund.

"We believe we cannot write this business at a reasonably consistant profit in the future," Mr. Flynn added.

About 1,500 policies are affected by the insurer's decision, a significant portion of which are financial institution policies, says a Fireman's Fund spokesman. The company was not able to provide premium volume figures or loss statistics.

Fireman's Fund's decision to withdraw from the market follows its decision last October to cut the limits it offers to $10 million from $50 million.

U.S. Insurance Group in Basking Ridge, N.J., a Crum & Forster unit, stopped writing fidelity bonds for financial insitutions at the beginning of the year, said USIG Chairman and President William S. Price.

USIG mainly wrote primary layers for small to medium-size banks with limits of $1 million per occurrence, he said.

This business generated about $15 million to $20 million in premium last year, he said, noting that the business has produced combined ratios of 200% to 300% in the last two to three years.

"With deregulation beginning in the banking industry and mergers taking place that bring out claims, we did not see any opportunity (for profit) on a long-term basis," Mr. Price said.

Evanston, Ill.-based Shand, Morahan stopped writing financial insitution fidelity insurance at the beginning of the year, notes James Willis, a senior professional at Shand and former assistant vp for financial institutions. He said the decision was made "for underwriting reasons."

"The book of business was not that large and the amount of time and effort it would take to correct that book of business (from losses) wasn't in our best interest," Mr. Willis said.

The coverage was written through Evanston Insurance Co., which is managed and partly owned by Shand.

Shand could not say how much financial institution business it had written.

Shand's withdrawal follows its decision in October to cut the limits it offered to $5 million from $30 million.

The underwriters that will continue to write fidelity coverage are raising rates and deductibles and tightening conditions of the policies they write.

For example, Merrett's Mr. Burnhope will soon send his policyholders a list of guidelines he plans to follow when coverage is renewed.

"Premiums will go up in multiples, not percentages," he explained. "If they don't like it they can lump it.

"...Right now, the banks spend more on advertising than on insurance policies, so now they are going to learn," he added.

Specifically, Mr. Burnhope said that:

- Within the next 12 months, major U.S. banks will see their deductible increased to between $10 million and $25 million from $3 million to $5 million.

These huge increases in deductibles are attracting the attention of the banks' board of directors, Mr. Burnhope said, which is his intention.

"Risk management has little influence on operations," he said. "Until you can get to the board-of-directors level, it is difficult to communicate your needs."

Now, presidents and chief executive officers are visiting London underwriters themselves to find out more about why deductibles are increasing, he said.

- Coverage terms will be changed.

Currently, fidelity bonds are written on an "each and every loss" basis with no aggregate limit, he said, adding that most are written for three-year terms. Mr. Burnhope says he wants to shorten the policy period to one year and write limits on an aggregate rather than a per-occurrence basis. That means bonds would only cover one or two major losses instead of an unlimited number.

Similar fidelity coverage changes may also occur in the United States.

The Surety Assn. of America in New York is currently reviewing the wording of the financial institution bonds written by its members for U.S. banks and thrift institutions.

Like Merrett, the SAA is considering changing the current per-occurrence limits to aggregate limits, says Frank LeMunyon, the association's vp.

"Changes may be announced by the summer, but that may be optimistic," Mr. LeMunyon says.

Associate Editors Michael Bradford in New York and Steve Taravella in Los Angeles also contributed information to this story.

Brokers optimistic about '85 profit picture

Continued from page 1
increases will have a duration of more than one or two years because of the capital situation of the primary writers," adds Joan Zief, vp at Merrill Lynch Capital Markets in New York.

All of the publicly held brokers that have so far released their 1984 results reported an increase in revenues both in the fourth quarter and for the entire year.

In addition, all of these brokers—with the exception of Frank B. Hall & Co. Inc.—reported profit increases from continuing operations in both the fourth quarter and the entire year. Marsh & McLennan Inc. and Corroon & Black Corp. reported declines in net income—the brokerages' bottom line—during 1984, but the declines were attributed to extraordinary charges rather than to continuing operations.

Alexander & Alexander Services Inc., which will not report its 1984 results until the end of the month, says it will post a fourth-quarter loss because of its recent decision to sell several underwriting units and increase the units' loss reserves (*BI*, March 11).

The earnings decline at Marsh & McLennan was triggered by a $110 million pretax charge to the broker's first-quarter results stemming from the brokerage's losses from unauthorized bond trading in 1983 and early 1984 (*BI*, June 25, 1984). Reflecting this charge, net income for the year fell 37.4% to $58.7 million from $93.8 million in 1983.

However, M&M's net income for the fourth quarter increased by 123.5% to $26.6 million from $11.9 million in fourth-quarter 1983.

"Marsh & McLennan's fourth-quarter results, if analyzed, were maybe a hair below what we had expected," said Mr. Wilson. However, he added that they were good nevertheless.

M&M's operating income for the year totaled $217.2 million, up 9.3% from 1983. Fourth-quarter operating income rose 33.7% to $47.8 million from $35.8 million.

Marsh & McLennan made a bit of brokerage history in 1984 when it became the first brokerage to generate more than $1 billion in revenues. For the year, M&M reported revenues of just more than $1.1 billion, an increase of 14.7% from 1983. Fourth-quarter gross revenues jumped 20.8% to just more than $281 million.

A spokesman for M&M says the brokerage believes that it will post even better results in the future.

"We (M&M) feel we're very well-positioned to operate in the current reinsurance environment, and will be for a few years. We have made a number of adjustments in the last two to three years to position ourselves so that we would be ready for the market change, so we are well-prepared," he said.

Marsh & McLennan generated earnings per share of $1.62 in 1984, down from $2.65 for 1983. Despite the decline, Mr. Rosencrants, Mr. Wilson and Ms. Zief all recommend the purchase of M&M stock, which was trading at about $64.50 per share last week.

Although Hall's gross revenues increased 5.3% to $372.8 million in 1984, the nation's third-largest brokerage reported an 87.7% decline in net income to $1.5 million from $12.5 million.

In the fourth quarter, Hall reported a $440,000 net loss, compared with a $1.5 million gain in the fourth quarter of 1983. Fourth-quarter 1984 gross revenues rose 5.3% to $94.692 million.

Hall's results for 1984 can be attributed to a variety of factors, among them a $16 million aftertax

Continued on facing page

Mission to get $75 million in new capital

Continued from page 2
sion's workers compensation liabilities as of March 31, 1985, a total of about $158 million.

That transaction will result in about $37.5 million in additional capital for Mission, the company says.

In a second transaction, about $34 million in assets now held by Transport Indemnity Co., a Los Angeles unit of American Financial, will be transferred to Mission Insurance Group. Transport Indemnity's liabilities will then be fully reinsured by Transport Insurance Co., another American Financial unit based in Dallas, says Norris Clark, chief of the financial analysis division of the California Insurance Department in Los Angeles.

The transaction will effectively close Transport Indemnity, another Insurance Department official explains.

In addition, Mission will receive an additional $3.5 million in capital through related transactions.

In return, Mission will give American Financial a subordinated note for $37.5 million, bearing 13.5% interest and due in seven years. It will also transfer to American Financial cash and securities worth about $120.5 million.

American Financial would also receive a warrant to purchase Mission stock. Upon exercise of the warrant, American Financial would increase its ownership in Mission to a minimum of 62% and a maximum of 91.3%, according to a Mission statement.

Securities analysts singled out Carl H. Lindner, American Financial's president and a member of Mission's board, for the rescue.

"He could have let it go and cut his losses, but instead he chose to support it," says Michael Lewis, vp-insurance stocks analysis at E.F. Hutton Group Inc. in New York.

"The infusion of capital is certainly good, and suggests that American Financial is giving the company the support many suspected it would. Without that capital, the company probably would have had trouble surviving," observes Denis J. Callaghan at Paine Webber Inc. in New York.

"The real question is whether that capital will be enough," Mr. Callaghan adds.

Mr. Lewis concurs: "If their losses continue for any length of time, or if the recovery takes longer than expected, they may need additional capital."

The $75 million injection comes after Mission reported the worst annual results in its history.

Mission's reported a $198.1 million net loss in 1984, compared with a $15 million loss in 1983. The company reported assets in 1984 of $979 million, down from $1.02 billion in 1983 (*BI*, Feb. 25).

Efforts to improve the company's financial situation include closing its reinsurance operations, implementing substantial rate increases and beefing up loss reserves.

"All of us at the Mission Insurance Group are deeply concerned regarding last year's results and have taken, are taking and will continue to take every action necessary to put our company back into a solid financial operating position as quickly as possible," says a March 4 letter Mission sent to all state insurance commissioners.

Mission Insurance Group recently closed its Mission Reinsurance Corp. underwriting unit (*BI*, Feb. 4). Mission is canceling its facultative reinsurance business and letting treaty business expire at renewals.

Mission is also implementing rate increases. According to the letter sent to the insurance commissioners, Sayre & Toso Inc., the group's wholesale underwriting management division, has been obtaining rate increases upon renewal that in some instances exceed 200%.

In addition, Mission's risk-bearing units implemented rate hikes of about 75% in January, following increases of about 50% in the fourth quarter of 1984 and 38% in the third quarter of 1984, according to the letter signed by Mission President Ray D. Johnson Jr.

Mission also says it added $188 million to reserves in 1984, $70 million of which were added in December after actuarial reviews by Coopers & Lybrands and Tillinghast, Nelson & Warren Inc., the letter states.

"It is our belief that we have now, as a result of these additional reserves, adequately provided for all potential losses," Mr. Johnson states in the letter.

Mission projects its net written premiums this year will drop approximately 21%, to about $340 million from about $430 million in 1984. And, according to the letter, Mission expects its underwriting losses to begin to decline in July. Mission reported a combined ratio of 161.1% in 1984 after policyholder dividends.

Mr. Johnson became president and chief executive officer on Feb. 14, after the resignation of Louis F. Marioni, a 23-year Mission veteran (*BI*, Feb. 25).

The California Insurance Department will begin a routine examination of Mission on March 25.■

update

India hires law firm

Continued from page 2
Jerry Cohen, a Washington attorney and a co-lead counsel in the litigation before the New York court.

Danbury, Conn.-based Union Carbide declined to comment on the Robins, Zelle appointment. Union Carbide is continuing negotiations in hopes of an out-of-court settlement of its Bhopal liabilities by summer, a company spokesman said, noting the company views a settlement as a fairer and faster means of compensating victims than a trial.

Union Carbide Corp. has an estimated $200 million in liability insurance to cover claims from the disaster, although defense costs may be excluded from the coverage (*BI*, Dec. 24-31, 1984).

In a related development, a leak of an acetone-based substance from a Union Carbide Corp. plant in South Charleston, W.Va., was reported last week. The leak caused a misty chemical rain and a fingernail-polish odor, according to David Sweeney, director of emergency services for the city of Charleston, W.Va. Four persons were treated at a hospital but released. Company officials could not be reached for comment on the leak.

Arkansas work comp bill dies

LITTLE ROCK, Ark.—An employer-supported workers compensation reform package, which would make workers compensation the sole remedy through which injured employees could collect benefits, is dead for the session after being stalled in a joint interim committee of the Arkansas Legislature.

The measure—S.B. 405—was drafted in response to court decisions that have allowed injured workers to collect damages through lawsuits against their employers.

The bill also had called for an increase in workers compensation benefits for most injured workers and a decrease in workers compensation benefits for retired workers who receive Social Security benefits. Maximum benefits to injured workers in Arkansas are among the lowest in the country.

The bill was supported by the Arkansas Chamber of Commerce, Associated Industries of Arkansas and the Arkansas Self-Insurers Assn.

Pennsylvania suspends insurer

PHILADELPHIA—The Pennsylvania Insurance Department has suspended underwriting at Transportation Mutual Insurance Co., an 80-year-old insurer, because of "concerns about its financial condition," says a department spokeswoman.

The company had $6.8 million in liabilities and $7.2 million in assets at year-end 1984, says the spokesman. It generated a total of $5.3 million in net premiums written, primarily assumed reinsurance, she said.

A decision will eventually be made as to whether the company will be put into rehabilitation or liquidation, the spokeswoman said. While it is suspended, she said, the company is prohibited from writing new policies, renewing policies, transferring property or paying out any funds without prior written approval of the department. Existing policies remain in effect.

Hawaii work comp bill advances

HONOLULU—Hawaii employers have won one battle in their workers compensation reform fight, but they will have to return to the trenches this week when an amended version of H.B. 463 is scheduled to be discussed by the Senate Labor Committee.

The House Finance Committee amended a "liberalized" version of H.B. 463 on March 11 by restoring two provisions cut earlier this month through the efforts of Rep. Eloise Tungpalan, D-Pearl City, chairman of the House Employment Opportunity and Labor Relations Committee (*BI*, March 11).

The latest draft of the reform measure calls for a waiting period of two workdays after a workplace injury before an injured employee can file a claim, with no retroactivity of benefits. Current law calls for a waiting period of two calendar days and retroactive benefits.

The new draft also reduces employers' burden-of-proof standards in certain occupational disease cases.

Though House members voted 43-8 to send the bill to the Senate March 11, many had approved it with reservations, observers note. A tough fight awaits on the Senate side, the observers added.

Continued from facing page

loss related to discontinued underwriting operations and phenomena involving interest expenses and reserving issues, as well as a $3.2 million gain in the fourth quarter of 1983 generated by the sale of a subsidiary.

Mr. Rosencrants said that Hall's problems are due to two primary factors. First, "They managed to lose money in the fourth quarter. That wasn't easy to do. They have not had the sharp acceleration of earnings like the other brokers have experienced."

The second problem, and the most important one, said Mr. Rosencrants, is that Hall is no longer strictly an insurance broker. "They have written off their underwriting operations, but they also own Jartran Inc.," a truck-leasing subsidiary that is currently in reorganization.

"Jartran's impact on Hall's financial statements thus far has only reflected Hall's investments in the company," Mr. Rosencrants said. "As soon as they pump more money into Jartran. . .to help it emerge from bankruptcy into reorganization. . .the Jartran losses will appear to their full extent in Hall's financial statements."

Mr. Rosencrants added: "Hall's brokerage operations will improve. There's no question about that. But we have no confidence in their stock because of Jartran. Hall (also) has a lot of debts and contingent liabilities. Just as the insurance brokerage price will improve sharply, they will have the unfortunate impact of having to absorb the losses of Jartran."

Stanley Martinez, the broker's senior vp-finance, would not discuss projections of Jartran's anticipated 1985 results, but said: "I think that in terms of insurance services activities, 1985 will be a very good year, as will 1986.

"There is now very good evidence," he continued, "that premium rates are hardening, which is very advantageous to us. We expect rates to go up in 1985 and again in 1986, since insurers cannot raise the rates all at once in a given year" to reach adequate levels.

"Hall's losses surprised us," Mr. Wilson said. "We expected them to make some money in the fourth quarter." He said that Rothschild gives Frank B. Hall's stock a "neutral" rating.

Ms. Zief, on the other hand, said that Merrill Lynch rates Hall's stock as "OK to buy."

Hall earned 12 cents per share in 1984, compared with $1.02 per share in 1983. Last week, Hall stock was trading at about $26.62 per share.

Corroon & Black posted a net loss of just less than $7 million for the entire year and a $13.8 million net loss for the fourth quarter due to the closing of the brokerage's Underwriting Management Group and to a $1.5 million extraordinary charge on settlements arising from C&B's equity interest in Lloyd's broker Minet Holdings P.L.C. (*BI*, Feb. 4).

The company reported net income of $18.3 million for all of 1983 and posted net earnings of $2.6 million in the fourth quarter of that year.

'There is now very good evidence that premium rates are hardening, which is very advantageous to us. We expect rates to go up in 1985 and again in 1986, since insurers cannot raise the rates all at once in a given year to reach adequate levels,' said Hall Senior Vp Stanley Martinez.

"When you isolate the effects of our discontinuing operations, it is apparent there was a significant increase in income from our continuing operations from 1984 over 1983, which was even more significant in the fourth quarter and has created a lot of excitement regarding our stock," said Stephen A. Crane, C&B's senior vp and chief financial officer.

Corroon & Black's income from continuing operations for the fourth quarter of 1984 grew 83.6% to $5.504 million. Operating income increased 8.9% during 1984 to $18.9 million.

The broker also reported a healthy revenue increase. C&B's 1984 gross revenues totaled $199 million, a 20.8% increase. Fourth-quarter gross revenues totaled almost $54 million, a 29.3% increase.

Mr. Crane said: "We're hopeful that, from an accounting point of view, the bad news is behind us. There might be some minor pluses and minuses, but we don't anticipate any big surprises" in 1985.

"We're pretty well situated" for the change in the marketplace, Mr. Crane added. "We didn't cut our staff during the down market, and so we are in good shape to go into this market. . . .We're hoping to introduce some new programs and to get into some new business areas."

Although Corroon & Black experienced a per-share loss of 81 cents in 1984, compared with earnings per share of $2.15 in 1983, Mr. Wilson and Mr. Rosencrants both are now recommending Corroon & Black stock, which traded at about $42 a share last week. Ms. Zief only tracks the results of the three largest U.S. brokers.

Mr. Wilson commented: "Corroon & Black had an excellent quarter. We were very impressed" with their results.

The Crump Cos. Inc. reported a 65.6% increase in net income in 1984 to $4.9 million from nearly $3 million in 1983, the largest profit increase of any of the brokers to report so far.

Fourth-quarter net income rose 96.4% to $886,000 from $451,000.

Gross revenues for 1984 increased 26.5% to $69.6, while revenues in the fourth quarter increased 41.4% to $18.7 million.

"We attribute (our results) to all of our areas of operation, but especially to our E&S group, which began to pick up in the third quarter," Crump's Mr. Power said.

"The momentum is beginning to build in the E&S business, which was slow at the beginning of 1984. We're now experiencing a larger volume of E&S business at higher rates. Our retail business is improving too.

"We have been trying to bring our group of operations into a cohesive unit, and I feel we have done that over the last few years," Mr. Power said. "This is a market for the real professionals. I believe we fit into that category. We've made a lot of changes in our operations, and they're beginning to show now."

Mr. Rosencrants is recommending the purchase of Crump stock, while Mr. Wilson is neutral in his rating.

Crump earned $1.19 cents per share in 1984, compared with 72 cents in 1983. Crump stock was trading at about $26.62 per share last week.

Arthur J. Gallagher & Co., the most recent broker to go public, also posted a healthy gain in earnings last year.

Gallagher's 1984 net income rose 47.5% to $6.3 million from $4.3 million. Fourth-quarter net income rose 256.4% to $1.2 million from $335,000.

Gross revenues rose 20.3% in 1984 to $64.179 million, while fourth-quarter 1984 gross revenues increased 31.2% to $17.052 million.

"There are two things that made us move: "good new-business development and the change that's taken place in the marketplace," explained Michael J. Cloherty, vp of finance for Gallagher.

Mr. Cloherty said that the industry had seen "the bottom of the trough" in 1984 but is now rebounding. However, he adds, "At the very time that the insurance marketplace can afford to price its products properly, the shrinking capital bases are limiting insurers' capacity to write additional premiums.

"Gallagher's concentration is on risk management," he continued. "The condition of the industry will prompt clients to look into alternatives. As (businesses) look for alternative solutions, more will turn toward self-insurance and risk management. We are in the strategic position to serve that market."

Gallagher's earnings per share totaled 27 cents in 1984, compared with 10 cents in 1983. Mr. Rosencrants recommended the purchase of Gallagher stock.

Mr. Wilson gave the stock a neutral rating, though he noted that "Gallagher's results were excellent."

Gallagher stock was trading at about $38.50 per share last week.

Poe & Associates Inc. narrowed its net losses in 1984 to $642,000, or 23 cents per share, compared with a net loss of $3.5 million, or $1.24 per share in 1983. Gross revenues increased 10.4% to $22.8 million.

In the fourth quarter, Poe reported a $1.7 million net loss, or a loss of 60 cents per share, compared with a fourth-quarter 1983 net loss of $3.1 million, or $1.10 per share. Fourth-quarter 1984 revenues totaled $5.3 million, a 4.4% increase.

The year-end and quarterly net losses are primarily attributable to Poe's Whiting National Insurance Co. subsidiary, whose operations will be discontinued by May 1985.

Disregarding this drag on earnings, Poe reported operating income of $1.371 million at year-end 1984, including a $393,000 loss from the disposition of the broker's investment in Stetzel Thomson & Co. Ltd., a London underwriting subsidiary that closed in October. This contrasts a $976,000 loss on continuing operations in 1983.

According to a Poe spokesman, "We feel we had a pretty good year in 1984. Our continuing operations made money in 1984 compared to our results in 1983. . .although we still had some problems with Stetzel. Our obvious problem was in our (Whiting National) underwriting operations, which continued to show losses.

"We anticipate that our net results will certainly be improved in 1985," the Poe spokesman continued. "Companies' rates are coming back up to where they were six or seven years ago, which means that the brokerage business is going to improve in 1985, 1986 and hopefully beyond."

The spokesman said the broker plans to continue and expand its mass-marketing efforts and is now readying new mass-marketing programs for its agent network throughout the country.

Poe's stock, which was trading at about $8.25 last week, is not widely tracked by market analysts. ■

British Issues

12 March Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	190	N/M	16.9	8.9	190—179	
Genl Accident	555	94.1	28.6	5.1	555—535	
Gdn Royal Exch	678	18.8	36.4	5.4	678—653	
Royal	583	N/M	33.9	5.8	585—575	
Sun Alliance	445	49.4	21.4	4.8	446—440	
Brokers						
CE Heath	630	10.8	30.0	4.8	637—620	
Hogg Robinson	291	16.6	11.6	4.0	294—284	
JH Minet	281	19.8	8.0	2.8	283—273	
Sedg Grp	380	17.7	12.8	3.4	383—370	
Stew Wrightson	605	17.3	24.0	4.0	612—574	
Willis Faber	660	23.6	17.6	2.7	665—641	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

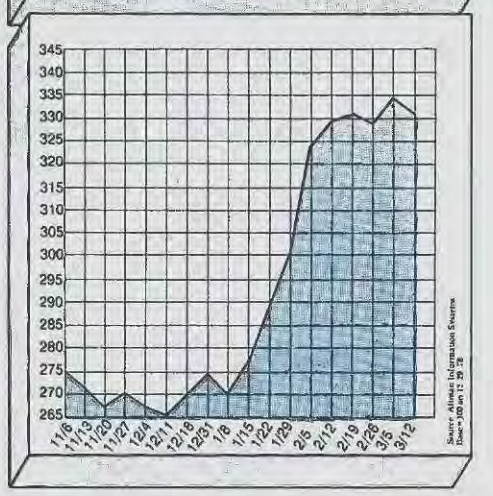
BI Industry Stock Report

March 12, 1985 — 3/6/85 thru 3/12/85

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	30.75	1.7	341.7	1.00	3.3	31.38*	30.00	1,366.4
Baldwin & Lyons Inc	OTC	53.50	0.9	11.0	0.80	1.5	53.50	53.00	2.6
Corroon & Black Corp	NYSE	42.00	-3.7	33.1	1.00	2.4	44.75*	42.00	240.3
Crump E H Cos Inc	OTC	26.63	0.5	22.4	0.44	1.7	27.00*	26.63	128.0
Emett & Chandler Cos Inc	OTC	14.75	0.0	0.0	0.00	0.0	14.75	14.75	1.1
Gallagher Arthur J & Co	OTC	38.00	2.7	23.9	0.28	0.7	38.00	37.00	15.2
Hall Frank B & Co Inc	NYSE	26.63	-0.9	51.2	1.00	3.8	26.88	26.63	147.8
Marsh & Mclennan Cos Inc	NYSE	64.50	0.6	39.8	2.40	3.7	64.50	63.00	216.8
Poe & Assoc Inc	OTC	8.25	0.0	0.0	0.00	0.0	8.25	8.25	7.0
Reed Stenhouse Cos Ltd	OTC	24.63	3.1	35.2	0.60	2.4	25.25*	24.00	816.8
AGENTS/BROKERS	AVERAGE			29.2		2.3			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	41.38	-3.2	14.8	1.28	3.1	42.25	41.38	3,279.7
Anderson Clayton(Ranger/PanAm)	NYSE	38.00	0.7	19.6	1.32	3.5	38.00	37.38	22.2
Armco Inc	NYSE	9.50	-5.0	0.0	0.00	0.0	9.88	9.50	555.8
Berkley W R Corp	OTC	15.00	-4.0	0.0	0.32	2.1	15.50	15.00	22.5
CIGNA Corp	NYSE	49.50	-0.5	450.0	2.60	5.3	49.50	47.88	3,288.8
City Investing Co. (Home Ins.)	NYSE	38.75	1.0	9.3	0.00	0.0	39.00	38.13	1,246.4
CNA Finl Corp (CNA)	NYSE	37.50	-1.0	15.6	0.00	0.0	37.88	37.50	72.1
General Re Corp	NYSE	71.75	-3.9	44.8	1.56	2.2	72.50	71.00	618.1
ITT (Hartford Group)	NYSE	31.38	-2.3	8.5	1.00	3.2	33.38	31.38	3,290.1
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	1.5
Sears Roebuck & Co. (Allstate)	NYSE	35.00	-1.8	8.7	1.76	5.0	35.00	34.75	2,103.4
Teledyne Inc (Argonaut)	NYSE	261.13	-1.4	14.3	0.00	0.0	262.13	259.25	161.3
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.38	0.9	12.7	1.64	5.6	29.38	28.50	266.0
CONGLOMERATES/HOLDING COS.	AVERAGE			21.4		1.7			
Insurers									
Aetna Life & Cas Co	NYSE	41.00	-0.6	25.8	2.64	6.4	41.00	40.25	845.1
American General Corp	NYSE	29.38	-2.9	9.8	1.00	3.4	30.25	29.38	966.7
Amern Heritage Life Invt Co	NYSE	32.25	2.4	9.7	1.08	3.3	32.50*	31.88	5.7
American Incty Finl Corp	OTC	18.00	0.0	0.0	1.12	6.2	18.00	18.00	1.2
American Intl Group Inc	NYSE	71.63	0.4	16.8	0.44	0.6	72.50	69.63	878.9
Aneco Reins Ltd	OTC	1.50	-7.7	0.0	0.00	0.0	1.63	1.50	2.4
Avemco Corp	NYSE	25.63	-4.2	12.4	0.60	2.3	27.00	25.63	6.4
Bitco Corp	OTC	13.50	0.0	0.0	0.40	3.0	13.50	13.50	5.6
Business Mens Assurn Co Amer	OTC	52.25	0.5	6.6	2.08	4.0	52.25	51.88	122.5
Chubb Corp	NYSE	58.75	-1.5	16.7	2.20	3.7	59.25	58.63	191.1
Combined Intl Corp	NYSE	43.75	-2.2	8.8	2.08	4.8	44.00	43.75	264.8
Continental Corp	NYSE	41.00	-2.4	21.2	2.60	6.3	42.00	40.38	413.9
Crown Life Ins Co	OTC	120.00	-4.0	12.4	5.00	4.2	120.00	120.00	0.7
Durham Corp	OTC	40.00	-1.8	7.7	1.28	3.2	40.00	40.00	7.7
Farmers Group Inc	OTC	55.88	-2.4	10.2	1.76	3.1	57.25	55.00	301.2
Fremont Gen Corp	OTC	24.63	-2.0	0.0	0.48	1.9	25.25	24.38	338.4
Great West Life Assurn Co	OTC	350.00	0.0	9.4	14.00	4.0	350.00	350.00	0.0
Hanover Ins Co	OTC	36.00	-2.0	33.3	0.56	1.6	36.75	35.50	23.9
Hartford Steam Boiler Insptn	OTC	70.00	-0.7	31.2	3.00	4.3	70.00	69.00	15.9
Kans City Life Ins	OTC	83.00	1.8	9.5	2.88	3.5	83.00	82.00	7.0
Kemper Corp	OTC	50.50	-2.9	29.4	1.80	3.6	51.63	50.13	237.7
Liberty Corp S C	NYSE	30.38	-2.0	14.6	0.72	2.4	31.50*	30.38	27.4
Lincoln Natl Corp Ind	NYSE	40.88	-3.0	10.8	1.84	4.5	42.13	40.75	177.1
Mission Ins Group Inc	NYSE	8.75	12.9	0.0	0.50	5.7	8.75	7.63	490.1
Monumental Corp	OTC	29.88	-0.8	12.4	1.30	4.4	30.00	29.88	21.9
Northwestern Natl Life Ins	OTC	35.00	1.4	8.2	0.80	2.3	35.00	34.50	90.9
Ohio Cas Corp	OTC	51.88	-1.2	19.5	2.80	5.4	52.25	51.38	173.2
Old Rep Intl Corp	OTC	35.13	0.0	6.8	0.88	2.5	35.25	35.00	55.0
Orion Cap Corp	NYSE	24.38	0.0	270.8	0.76	3.1	24.50	24.38	45.5
Protective Corp	OTC	22.50	2.3	10.5	0.62	2.8	23.00	22.50	157.8
Provident Life & Acc Ins Co	OTC	97.00	2.1	7.0	3.38	3.5	97.00	94.50	29.3
St Paul Cos Inc	OTC	56.00	-1.5	0.0	3.00	5.4	56.88	55.25	827.3
SAFECO Corp	OTC	34.88	-2.1	11.5	1.50	4.3	35.50	34.88	282.9
Sri Corp	OTC	16.13	-5.1	27.3	0.68	4.2	16.75	16.13	138.2
Seibels Bruce Group Inc	OTC	25.75	0.0	0.0	0.80	3.1	26.25	25.50	66.7
Statesman Group Inc	OTC	6.25	-3.8	9.3	0.15	2.4	6.63	6.25	67.1
Tokio Marine & Fire Ins Co	OTC	155.50	-1.9	26.9	1.05	0.7	157.75	154.75	6.5
Torchmark Corp	NYSE	41.38	-1.5	9.9	1.00	2.4	41.75	40.25	365.4
Travelers Corp	NYSE	43.00	-1.4	10.5	2.04	4.7	43.00	42.50	1,079.2
United Fire & Cas Co	OTC	24.00	0.0	0.0	0.80	3.3	24.00	24.00	0.0
United States Fid & Gty Co	NYSE	31.63	-0.8	18.4	2.20	7.0	31.63	31.00	2,632.1
Uslife Corp	NYSE	38.25	-0.6	8.8	1.04	2.7	39.38*	38.13	483.7
Washington Natl Corp	NYSE	27.75	0.0	8.6	1.08	3.9	27.75	27.25	68.1
Zenith Natl Ins Corp	OTC	13.00	2.0	23.6	0.68	5.2	13.00	13.00	62.8
INSURANCE COMPANIES	AVERAGE			15.9		3.6			

System design: Altman Information Systems

BI Insurance Index



The *BI* index of insurance industry stocks slumped for the period ending March 12. The index closed at 331.6 March 12, down 2.5 points from 334.1 March 5. In all, 14 stocks rose, 32 fell and 12 were unchanged. The biggest gains were by Mission Insurance Group Inc., up 12.9%; Reed Stenhouse Cos. Ltd., up 3.1%; American Heritage Life Investment Corp., up 2.4%; Protective Corp., up 2.3%; and Provident Life & Accident Insurance Co., up 2.1%. The largest losses were by Aneco Reinsurance Ltd., down 7.7%; SRI Corp., down 5.1%; AVEMCO Corp., down 4.2%; and Crown Life Insurance Co. and W.R. Berkley Corp., each down 4%. The *BI* index fell 0.7% for the trading period; the NYSE composite fell 1.4%.

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