

# Business Insurance

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## Hall nears settlement of litigation over Union Indemnity collapse

NEW YORK—Frank B. Hall & Co. Inc. last Friday was nearing a settlement of longstanding litigation with the New York Insurance Department over the 1985 collapse of Union Indemnity Insurance Co. of New York.

Hall and the New York department were actively discussing a settlement last week, officials of both sides confirmed. However, representatives of neither side would comment on the negotiations nor on details of the proposal.

*Continued on next page*

## Liberty Mutual pays record fine to N.Y. for rate violations

By DOUGLAS McLEOD

NEW YORK—The New York Insurance Department has levied a \$637,500 fine—the largest in its history—against Liberty Mutual Insurance Co. and Liberty Mutual Fire Insurance Co. for improper rate cutting and other violations.

"This is probably the highest regulatory fine nationwide," a spokesman for the New York Insurance Department said.

In a recent market conduct examination, the New York department found that the two Liberty Mutual companies:

- Failed to file rates and rating plans before putting them into use.

- Knowingly charged rates that represented "major departures" from rating plans and governing standards. Among other things, the insurers improperly manipulated base rates by using unsupported rating modifiers, the Insurance Department found.

- Violated the state's flex-rating law by applying rating credits to ineligible risks, failing to maintain evidence supporting rating decisions and failing to apply rates in a non-discriminatory manner to all eligible risks.

Flex rating, in effect in New York since 1986, allows insurers to adjust rates upward or downward only within specified percentages without seeking prior approval from the Insurance Department.

Generally, insurers are allowed to adjust base rates 15% up or down without prior approval, though allowable fluctuations vary by line of insurance.

Most of the violations involved improper rate cutting on commercial multiperil policies issued in 1987 to small businesses through Liberty Mutual branch offices in New Castle, Pa., and Lynbrook, N.Y., a New York department spokesman said.

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## Court orders PBGC to take LTV's plans

By JERRY GEISEL

NEW YORK—A federal appeals court decision that forces the Pension Benefit Guaranty Corp. to swallow more than \$2 billion in LTV Corp. pension liabilities will not, by itself, lead to yet another increase in the premiums the PBGC charges employers.

But pension experts differ on whether the court decision could trigger a new wave of terminations of hugely underfunded pension plans, saddling the PBGC with billions of dollars in additional liabilities and forcing premiums to spiral once again.

A three-judge panel of the 2nd U.S. Circuit Court of Appeals in New York on May 12 unanimously upheld a lower court decision that the PBGC could not return to LTV three previously terminated pension plans with more than \$2 billion in unfunded liabilities.

The PBGC terminated the plans, which cover about 100,000 participants, in January 1987 after LTV, which filed for protection from creditors in July 1986 under Chapter 11 of the Federal Bankruptcy Act, said it could no longer afford to fund the plans.

But, the PBGC in September 1987 attempted to force LTV to take back the terminated plans after LTV, as part of a collective bargaining agreement with the United Steel Workers Union, established a new pension program to provide certain non-PBGC guaranteed benefits that were lost by plan participants when the original plans were terminated (*BI*, Sept. 28, 1987).

At the time, the PBGC charged that the new "follow-on" plans were an illegal continuation of the terminated plans.

But the appeals court strongly disagreed, describing

the PBGC's decision as "arbitrary and capricious."

The court said it found no evidence in a series of federal benefit laws, including the Employee Retirement Income Security Act of 1974, that Congress ever intended the establishment of new pension programs to be grounds for the restoration of previously terminated pension plans.

While the PBGC argued that Section 4047 of ERISA gives it the right to restore terminated plans, "the legislative history of Section 4047 reveals no indication that Congress intended the establishment of successive benefit plans to be a ground for restoration," the appeals court said.

"Congress' focus in enacting Section 4047 was mandating restoration if there was an improvement in financial circumstances," the appeals court said.

At the same time, the appeals court said employers and unions do have the right to bargain for pension benefits after a pension plan is terminated.

"Collective bargaining agreements can establish a contractual obligation to provide pension benefits, following termination of a plan, in excess of the amounts guaranteed by PBGC. ERISA contains no restrictions on the employees' rights to receive benefits not guaranteed under ERISA," the appeals court said.

While the appeals court acknowledges that an improvement in a company's financial condition is grounds for restoration of pension plans, the administrative record did not support PBGC's finding that LTV's financial circumstances had improved sufficiently to justify restoration.

The problem with the PBGC's restoration decision is

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## Attorneys' fees deplete D&O limits, court rules

By STACY ADLER

SAN FRANCISCO—An appellate court has overturned an unprecedented California trial court decision that found attorneys' fees do not deplete the limits of directors and officers liability policies.

The 4th District Court of Appeals on May 15 reversed what it called an "erroneous" ruling by California Superior Court Judge William Pitt Hyde.

In a March 16 ruling in D&O coverage litigation filed by four directors of Kaiser Steel Corp. against their primary D&O insurer, Judge Hyde had found that the language of the policy was ambiguous and, therefore, ruled in favor of the policyholder that attorneys' fees are not included within the limits (*BI*, March 27).

The language that Judge Hyde found ambiguous, which is standard among D&O insurers, states that policy limits will be reduced by "damages, judgments, settlements and costs, charges and expenses incurred in the defense of actions, suits or proceedings and appeals."

Judge Hyde is one of the first judges ever to rule that defense costs are not included within D&O insurance policy limits.

In overturning Judge Hyde's decision, the appellate court said: "The trial court erroneously found the policy language to be ambiguous with respect to the inclusion of defense costs in the computation of policy limits."

"The language being clear, there was no need to construe it or to consider the expectations of the insured," the appellate court concluded.

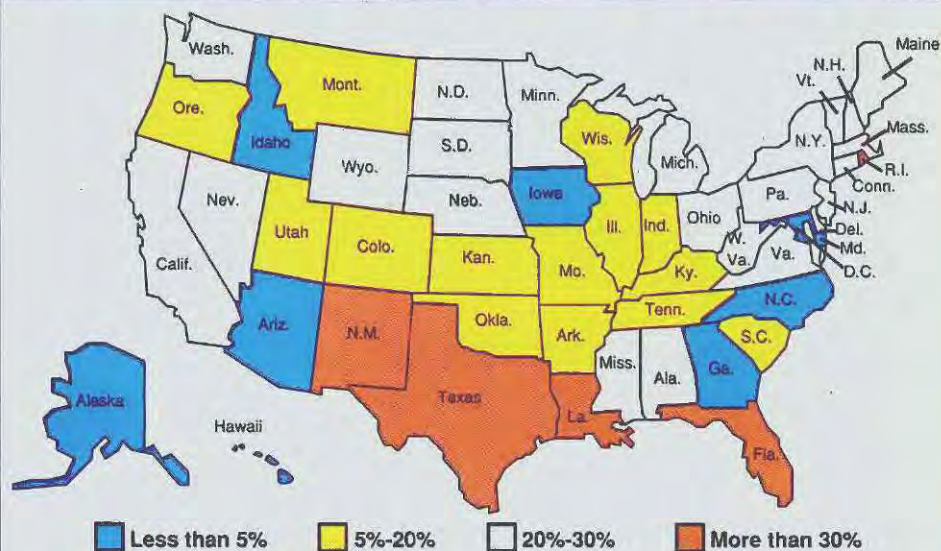
As a result, the appellate court ordered the trial court to vacate its March 16 decision that attorneys' fees to not deplete the limits of the D&O policy.

The directors involved in the coverage litigation had been sued for various alleged financial wrongdoings in connection with their leveraged buyout of Cucamonga, Calif.-based Kaiser in 1984.

The costs of defending this underlying litigation have exhausted the \$5 million primary D&O liability insurance policy under-

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### Proposed work comp rate hikes in 1989\*



\*Based on preliminary NCCI estimates

Source: National Council on Compensation Insurance

Graphic: Holly Seguire

Insurers' requests for workers comp rate increases this year range from less than 5% in some states to more than 30% in others, prompting calls from employers and legislators for reforms in many states that could help hold the line on costs. Stories by Associate Editor Meg Fletcher begin on page 72.

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## Update

## Hall nears Union settlement

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The Insurance Department was preparing to announce a settlement Friday afternoon, but an Insurance Department spokesman said last-minute snags could delay the agreement.

Union Indemnity, a former Hall unit, was found insolvent by \$138.5 million as of year-end 1984 and ordered into liquidation in July 1985.

The department sued Hall, 34 Hall affiliates and 29 Hall and Union Indemnity directors and officers in March 1987, charging they were responsible for Union Indemnity's insolvency.

The suit, which sought \$140 million in damages, also named Touche Ross & Co., Union Indemnity's auditor (*BI*, March 16, 1987).

The department's complaint and other litigation relating to the Union Indemnity failure have caused Touche Ross, also Hall's auditor, to qualify the brokerage's financial results in recent years.

## Sheraton settles fire claims

SAN JUAN, Puerto Rico—Sheraton Corp. finalized a \$36 million out-of-court settlement last week with plaintiffs in litigation stemming from the Dec. 31, 1986, fire at the San Juan Dupont Plaza hotel in Puerto Rico.

Neither Sheraton—the former owner of the hotel—nor the Plaintiffs Steering Committee, which represents all plaintiffs in the litigation, would comment on the settlement, the terms of which were to remain confidential under a San Juan District Court order.

The settlement includes a contribution from an American International Group Inc. unit that wrote excess liability insurance for Sheraton (*BI*, May 15).

Earlier this month, corporate and individual owners, operators and alleged affiliates of the Dupont Plaza hotel and AIG reached what could amount to a \$108 million settlement in the litigation. Two AIG units wrote a \$1 million liability policy for the hotel. As part of that settlement, AIG will assume ownership of the hotel.

After these settlements, Judge Raymond Acosta, who is presiding over the litigation, consolidated proceedings against approximately 80 remaining defendants that provided products or services to the hotel. The trial is set to resume on June 27.

The hotel fire killed 97 people and injured more than 100 others (*BI*, Jan. 12, 1987; Jan. 5, 1987).

## Piper loss may trigger cash call

LONDON—A Lloyd's of London syndicate may ask its members for "substantial" amounts of cash this year to cover outstanding claims stemming from the loss of the Piper Alpha North Sea oil rig—only one year after the disaster and two years before the account closes.

Rose, Thomson, Young (Underwriting) Ltd., manager of marine syndicate 255, warned members' agents in a letter dated May 17 that the syndicate's 1988 account has a solvency deficiency of 35.9 million pounds (\$59.6 million)—129% of the syndicate's 1988 gross premium capacity. The letter notes, though, that "at present the syndicate is well within its reinsurance protections."

Lloyd's American Trust Fund and "Lloyd's solvency regulations require that dollar liabilities be covered by dollar assets," the letter says. "This may result in a substantial cash call shortly. However, the agency is at present endeavoring to ascertain ways to mitigate the situation."

This would be the first cash call related to the Piper Alpha loss.

## Michigan seeks Maxicare funds

LANSING, Mich.—The Michigan Department of Insurance is seeking dismissal of federal bankruptcy proceedings against Maxicare Independence Health Plan Inc. of Southfield, Mich.

State regulators had been planning to liquidate the health maintenance organization when Maxicare Health Plans Inc., the HMO's Los Angeles-based parent, sought protection from its creditors under Chapter 11 of the Federal Bankruptcy Act on March 16 in U.S. Bankruptcy Court in Santa Ana, Calif. (*BI*, March 27; March 20).

Although Health Alliance Plan of Detroit acquired Maxicare Independence's membership of 125,000 enrollees and other assets in October 1988, the Michigan department was saddled with settling an estimated \$30 million in liabilities still under management by Maxicare, a spokeswoman for the department said.

Maxicare had placed about \$17 million in a trust fund to pay creditors, but the filing has left the department unable to settle the remaining \$13 million in liabilities.

## Court to hear safety rules case

WASHINGTON—The Supreme Court last week agreed to review a lower court decision that limited the authority of the Office of Management and Budget to order changes in federal safety rules.

In 1987, OMB objected to several provisions in hazardous communications standards proposed by the Occupational Safety and Health Administration. Among other things, OSHA proposed that material safety data sheets, which detail the nature of hazardous substances in use, be exchanged among employers at multiemployer work sites, such as construction sites. OMB said this requirement imposed too great a paperwork burden on employers.

But the 3rd U.S. Circuit Court of Appeals last year said OMB did not have the authority to interfere with the rule (*BI*, Sept. 5, 1988).

Separately, the Supreme Court declined to hear appeals from the construction and feed grain industries that they should be exempt from the hazard communications rules.

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## Errors &amp; omissions

Hannover Reinsurance Co. approves all financial reinsurance transactions underwritten by Bermuda-based Belvedere Insurance Co. Ltd. under their joint underwriting agreement. Belvedere does not have the authority to commit Hannover Re to financial reinsurance transactions, as was erroneously stated in the April 10 issue.

## Walbrook's results

## Reserves increased for U.S. E&amp;O claims

By CAROLYN ALDRED

LONDON—Walbrook Insurance Co. Ltd. is reporting reserves for outstanding claims at year-end 1988 of 231 million pounds (\$418 million), a 57% increase from 147 million pounds (\$276 million) at year-end 1987, according to the company's annual report released last week.

Provisions for losses stemming mainly from professional liability coverage for U.S. lawyers and accountants forced Walbrook, the lead underwriter for H.S. Weavers (Underwriting Agencies) Ltd., and several former Weavers' underwriters to strengthen their loss reserves last year, says the annual report of London United Investments P.L.C., which owns Walbrook and Weavers.

However, how much of the 84 million pound (\$152 million) increase in reserves is related to this reinsurance of U.S. professional liability business written in prior years and how much is attributable to overall business written in 1988 is not reported in the financial statement.

Walbrook wrote net premiums in 1988 totaling 131.7 million pounds (\$238.4 million).

Weavers, which underwrites on behalf of Walbrook and Anglo-American Insurance Co. Ltd., is the largest market in London for U.S. casualty risks. Walbrook underwrites 55% of the Weavers slip; Anglo-American

Continued on page 85

## 3 LUI directors forfeit gains of \$1.25 million

By CAROLYN ALDRED

LONDON—Two directors and a former director of London United Investments P.L.C. have transferred to LUI their previously publicly undisclosed shareholdings in a Michigan-based underwriting agency without taking any payment.

The agency, a reinsurance underwriting manager for U.S.-based insurers, arranged "substantial" reinsurance of its programs with LUI subsidiary Walbrook Insurance Co. Ltd.

The LUI directors' 66.7% shareholding in Southfield, Mich.-based Russell Reinsurance Services Inc., which was transferred last year to LUI, was valued at 525,000 pounds (\$950,250) at year-end 1988.

In addition, dividends of about \$300,000 earned from the shareholdings in Russell Re also were transferred last year to LUI, the company disclosed in its annual report released last week.

The previous owners of the Russell Re shares were: LUI Deputy Chairman Peter Wilson, LUI Chairman Ronnie Driver and former LUI Director H.S. Weavers.

The transfers result in a \$1.25 million gain for LUI, and no profit to the three former Russell Re shareholders from an initial \$10,000 investment 11 years ago.

(Of LUI's 58 million shares, Mr. Driver has 1.29 million shares; Mr. Wilson has 456,072 shares; and Mr. Weavers' holding is not above 5%.)

Continued on page 85

## Steinberg picks A&amp;A's Bell as Hall's chairman, CEO

By LINDA J. COLLINS

NEW YORK—Former Alexander & Alexander Inc. executive Donald R. Bell is taking over as chairman and chief executive officer of Frank B. Hall & Co. Inc., replacing Saul P. Steinberg.

Mr. Steinberg remains chairman of the executive committee of Hall's board of directors. And Peter T. Pruitt remains president and chief operating officer of the New York-based broker.

Mr. Bell, whose appointment was effective May 15, previously was A&A's Eastern regional manager and senior vp. He had been an A&A executive since 1977 and in the brokerage business since 1956. Mr. Bell also had been a Northeast regional director and president of Alexis Risk Management Services Corp. for A&A.

A&A is the retail brokerage subsidiary of New York-based Alexander & Alexander Services Inc., the second-largest U.S. broker. Its Eastern region is "by far the lar-

gest region that A&A has in the world, revenue-wise," according to Mr. Bell.

In an internal letter, Mr. Steinberg told Hall employees that Mr. Bell's appointment "sends a clear message that the distractions" of the recent past are behind Hall. "We are fully positioned to expand our customer base and at the same time increase business retention by providing clients with the highest quality service possible," he wrote.

The letter continued: "As you know, I have worked hard to lay the groundwork for Hall's future. I have a substantial investment, both financial and personal, in Hall."

"My commitment to Hall remains unwavering, and I intend to continue to take an active role in the management of the company."

Mr. Steinberg, who also is chairman and CEO of Reliance Group Holdings Inc., assumed control of Hall in July 1987 (*BI*, Aug. 3, 1987). Reliance Insurance Co. in Philadelphia, a Reliance Group Holdings

Inc. subsidiary, is Hall's major stockholder.

At year-end 1988, Reliance owned 46% of Hall's outstanding common stock. In addition, Reliance could own 64% of Hall if its preferred stockholdings were converted and no other Hall preferred shareholders converted stock.

And, if Reliance converted warrants it held and no other Hall shareholders exercised their warrants, its holdings in Hall would be boosted to 73%.

When Mr. Steinberg became chairman and CEO of Hall, he stated that he planned to remain in that position until he could turn the financially troubled brokerage around (*BI*, Aug. 24, 1987).

At that time, Mr. Steinberg announced immediate plans to:

- Turn pending litigation matters over to corporate attorneys to free Hall's executives to concentrate on core brokerage business.

- Terminate non-productive employees.

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## Inside

✓ Now that there is a lull in the Section 89 debate, employers must lobby for workable welfare benefit non-discrimination rules, says this week's editorial. **PAGE 8**

✓ In Perspectives, third-party administrator Richard H. Wille looks at how employers can control disability costs while providing a fair and meaningful benefit. **PAGE 47**

✓ In Perspectives, Attorney Richard D. Alaniz discusses some employer concerns surrounding drug testing in the workplace. **PAGE 47**

✓ Despite posting an underwriting profit for the first time in nine years, surety bond underwriters need to put their success into perspective, warns an industry exec. **PAGE 67**

✓ A U.S. District Court interpreting Missouri law has ruled that hazardous waste cleanup costs are legal damages and therefore insurable. **PAGE 68**

✓ Double-digit increases in workers comp insurance rates nationwide are rallying employers, legislators and others to demand changes in the coverage. **PAGE 72**

✓ Lloyd's of London's largest syndicate lost nearly \$29 million on its 1985 underwriting account and is leaving the account open for the second year in a row. **PAGE 81**

✓ First-quarter reports were a sober and unneeded reminder that brokers are caught in the grip of the soft market, says stock analyst Leonard Wilson. **PAGE 87**

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# Bracing for change

## Vendors to update Section 89 software to incorporate reforms

By KARI BERMAN

Faced with slumping sales of Section 89 testing software, vendors are scurrying to convince employers that software will keep pace with any proposed changes in the complex welfare plan non-discrimination tests.

Sales have fallen as much as 75% since House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., introduced a bill in April revising the non-discrimination rules for welfare benefit plans, some vendors report (*BI*, April 24).

Approximately 1,800 Section 89 software systems have been installed in corporate employee benefit departments since their introduction in 1988, according to *Business Insurance's* survey of employee benefit information system vendors. However, vendors say they had expected to license double that number by now.

In addition, demand for Section 89 testing services provided by consultants are down because many employers suspended welfare plan non-discrimination testing in anticipation of a congressional overhaul and simplification of Section 89, employee benefit experts say.

But, while an overhaul is considered likely this year since key congressional leaders all back reform of the much-assailed Section 89 (*BI*, May 8), employee benefit experts are warning employers they could face costly tax penalties if they wait too long to begin testing.

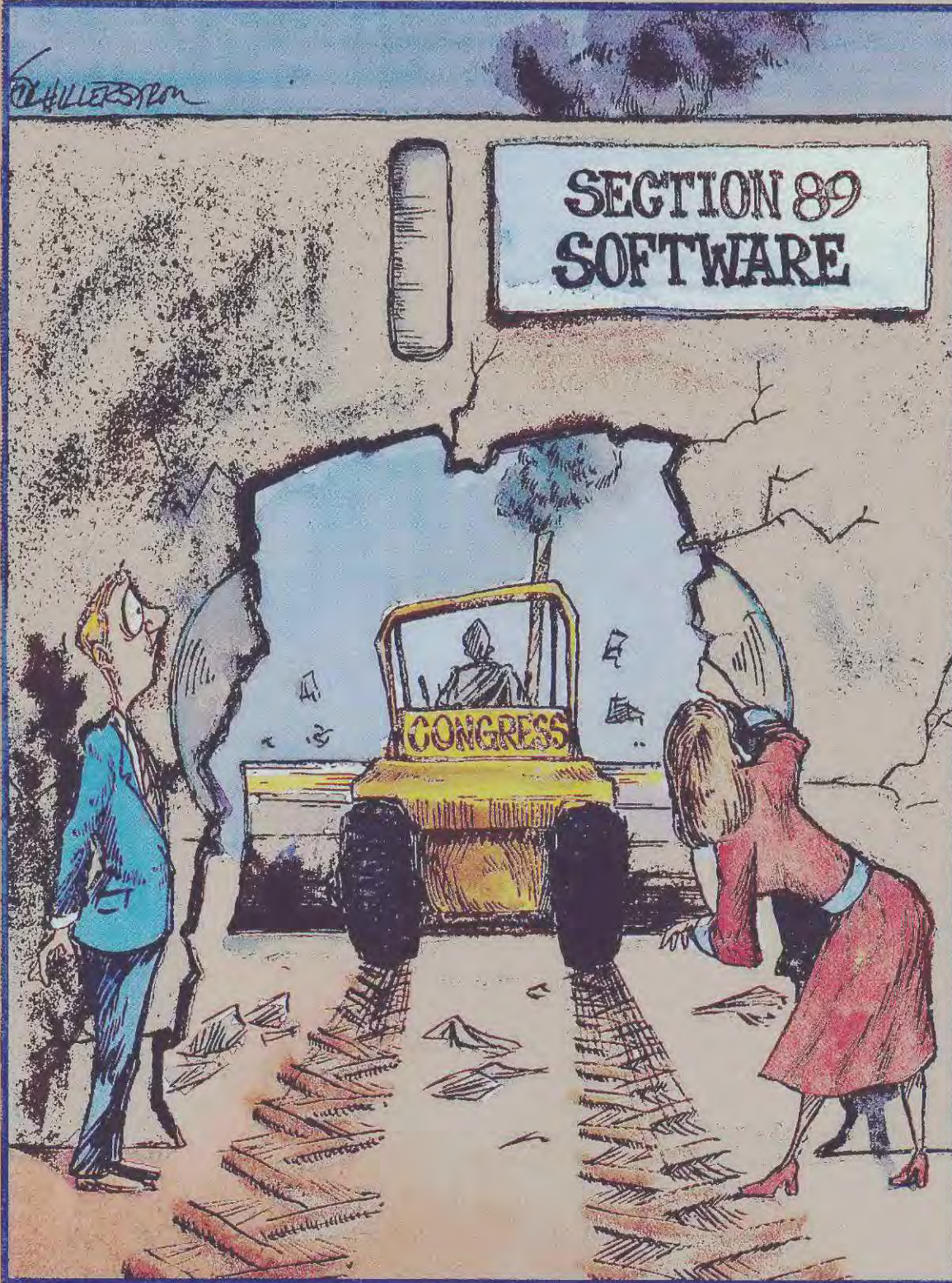
"Sales have slowed in the last month because employers are waiting to see what changes will be made before going ahead with the testing," said Alan H. Williams, president of Houston-based Travis Software Corp., which so far has installed 992 Section 89 testing programs in corporate employee benefit departments.

"The Section 89 software market is extremely dead," agreed Charles Kerr, vp of marketing at Insurance Systems Group Inc. in Raleigh, N.C. "We have watched our sales go down 75% in the last month" from the beginning of the year, when the company began marketing its Section 89 software product.

To date, Insurance Systems has licensed 100 Section 89 testing programs to employers, accountants and third-party administrators, Mr. Kerr said.

"Sales have declined 50% to 75% in the last few months since legislation was introduced," said Ellen Lockwald, manager of market development at Resource Information Management Systems Inc. in Naperville, Ill. RIMS Inc. so far has licensed 30 Section 89 software programs to employers.

*Continued on next page*



## Systems study managed care data

By DONNA DiBLASE

The proliferation of managed care is spurring the development of a new niche in the employee benefit information systems market: managed care information and analysis systems.

Some of these new computerized systems help benefit managers determine whether the premiums they pay to health maintenance organizations fairly reflect the health care cost and utilization experience of their employees.

Other systems help benefit managers evaluate the cost-effectiveness of the preferred provider organiza-

tions with which they contract.

These analyses arm employers with information necessary to effectively negotiate with HMOs and PPOs, say employers, vendors and benefit consultants.

Most of the managed care information systems currently available are sold by firms that specialize in health care information analysis and consulting. The systems usually are sold as modules of these firms' mainframe health care data systems, which generally cost between \$12,000 to \$50,000, depending on many variables like size of the employer and the services provided.

But except for very large employ-

ers, most employers probably will continue to rely on their benefit consultants to analyze and negotiate with HMOs or PPOs on their behalf, some vendors and employee benefits consultants predict.

Many employers will find purchasing such systems is prohibitive, not only from the cost standpoint but also because many benefit managers lack the time and expertise to perform their own complicated analyses of managed care programs, some consultants say.

"Right now, we've found that given the amount of understanding a user needs to perform these analyses, it's more effective for us to do

this in a consulting mode" as opposed to leaving the employer to work alone with the system, explained Alex Hutchinson, a vp at Corporate Health Strategies, a Westport, Conn.-based consulting firm that specializes in health care data analysis and providing employers with benefits analysis software. CHS is a subsidiary of Metropolitan Life Insurance Co. of New York.

Still, many firms have developed these specialty computer software products for employers.

HMO information and analysis systems are particularly important to some employers because most do

*Continued on page 10*

### EBIS wish lists

Employee benefit managers dream of affordable systems that would let employees update their own benefit data and simplify pension calculations. Page 19

### GIC capacity in doubt

Capacity may be strained for guaranteed investment contracts purchased by sponsors of defined contribution plans, some market observers say. Page 25

### PC systems gain popularity

Employee benefit information system software vendors are designing more programs to run on personal computers, giving small employers more options. Page 33

## Spotlight report

## Section 89

Continued from previous page

"Sales have been going down, but whatever happens (in Congress), we are prepared," said Denis Mosticchio, director of marketing at WTR Data Services Inc., the software subsidiary of New York-based benefit consultant Williams, Thatcher & Rand. WTR has installed 85 systems so far.

"The whole (Section 89) software market has dried up as a result of pending legislation," said Allan Thibault, a partner at Mayer Hoffman McCann in Kansas City, Mo., which has installed 150 Section 89 programs in corporate employee benefit departments.

Hay Huggins Co. Inc. in Philadelphia also has seen "a hold on sales for Section 89 software," said Kurt H. Fichthorn, assistant to the president. "The legislation has made it unappealing to employers. We've adopted a wait-and-see phi-

losophy," he added.

So far, Hay Huggins has installed 40 Section 89 programs in corporate employee benefit departments.

Confed Admin Services Inc., a subsidiary of Confederation Life Insurance Co. of Atlanta that conducts Section 89 testing for employers, reports seeing a similar trend since overhaul legislation was introduced, said Bryan Parker, group consultant.

"We had a rush of business around January that has decreased significantly," he said.

Robert Inzetta, a senior welfare consultant at W.E. Stanley & Co. in Greensboro, N.C., agreed: "Until recently, we had a lot of calls from employers interested in testing services, but now the phones have stopped ringing and they are waiting for a decision."

The firm, which provides Section 89 testing and other consulting services to 200 employers,

bought Section 89 compliance testing software from Travis Software, but is not realizing the return it expected from the investment.

Although Travis will provide free updates when Section 89 tests are changed, in the meantime, the consultant's hands are tied.

"For a small firm like ours, we made a strong investment in Section 89 and could lose a lot," Mr. Inzetta said. "Profits, of course, are already negatively influenced."

And some employers that already have been compiling the kind of data needed to conduct the complex Section 89 non-discrimination tests on their own aren't interested in purchasing additional software or seeking outside help.

"We have enough data accumulated from the past to perform the tests ourselves," said Jerry Kenefake, director of compensation and benefits at Hallmark Cards Inc. in Kansas City, Mo., which has 23,000 employees.

"All we have to do is a little calculating, and we don't think we'll have much of a problem with compliance," he said.

Meanwhile, other employers are avoiding the Section 89 software market entirely because they are turning to consultants to shoulder their Section 89 testing burden.

For example, Minnesota Power & Light Co. has contracted with the Minneapolis office of benefit consultant Hewitt Associates to conduct Section 89 non-discrimination testing for its health care plans covering 2,150 employees.

"We have already tested with Hewitt, and it worked well for us because they know the demographics of our company," said Roger Krantz, medical plan administrator at the Duluth, Minn.-based utility.

Section 89 software, which generally is designed to operate on International Business Machines Corp. personal computers and

IBM-compatible PCs, operates in two phases.

First, it compiles employee data needed to run the non-discrimination tests, such as salary information and employee benefit selections.

Second, the software runs the following non-discrimination tests on an employer's welfare-type plans:

- The 80% alternative coverage test. Under this test, a plan is considered non-discriminatory if it covers 80% of a company's non-highly compensated employees.

- If the plan fails this test, then the program will run the other, more complicated non-discrimination tests, all of which the plan must pass:

- The 50% eligibility test, which requires that at least 50% of workers eligible for welfare plan benefits be non-highly compensated employees.

- The 90%/50% test, under which at least 90% of an employer's non-highly compensated employees must be eligible for a plan whose value is at least 50% of the most generous plan offered to any highly compensated employee.

- The 75% benefits test, under which the average value of a benefit for non-highly compensated employees eligible for a plan, whether or not they participate, must be at least 75% of the average benefit for highly compensated employees.

In addition to performing the non-discrimination tests, the systems also can be used to collect and maintain extensive personal information, such as number of employees' dependents, their Social Security numbers and birthdates.

To boost slumping Section 89 software sales, vendors are promising to provide employers and other clients—including benefit consultants, accountants and third-party administrators, which make up the bulk of their business—with free maintenance updates that would include any compliance testing changes that a revised law might impose.

And, although some employee benefit experts believe it is premature, some vendors even are speculating about possible revisions that might appear in a new version of Section 89 and already are designing software for administering the new testing procedures.

For example, WTR Data Services already has incorporated testing standards contained in Rep. Rostenkowski's bill into its existing Section 89 software package.

Employers that use WTR Data Services' software, called The Benefits Manager/Discrimination Testing Module, will be able to conduct both the original Section 89 non-discrimination tests and those contained in the Rostenkowski proposal.

"We are making both testing procedures possible and are advising our clients to test both ways and see how they do in each," said Mr. Mosticchio.

He explained that because tests under both the original Section 89 and the Rostenkowski proposal require almost the same amount of data, the original data base module still can be used.

The software, which consists of two modules—one to gather data and the other to perform the testing—costs \$3,500 for a single user.

In addition, the software also can download information on employees from other data sources, such as payroll or human resources computers.

Western & Pacific also has incorporated the Rostenkowski tests into its software package, said Mr. Johnston.

The Western & Pacific system, called "Discrimination Testing/State of the Art," costs \$2,800 for a single user and also consists of two

Continued on page 6

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# KIDS THESE DAYS ARE SPENDING A LOT OF TIME ON THE COUCH.

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The number of kids with mental health disorders is enough to make you sit up and take notice.

Every year 15 million kids under 18 years old will have some kind of psychiatric illness.\*

Add to that the increased cost of their mental health claims—up 27 percent in 1988\*\* alone—and we're looking at some serious growing pains.

At NWNL Group, we're trying to help control these costs. And, do what's best for the kids undergoing treatment and the employers who are paying for it.

To do that, we have a full-time staff psychologist who works with our hospital utilization review program. Together, they help us spot costly and inefficient treatment methods early on.

For example, adolescent confinement in a psychiatric hospital may not be necessary when effective outpatient treatment is available.

In recommending alternative

forms of treatment, we're trying to maximize psychiatric benefit dollars by helping the patient and doctor understand all of the options.

It's true the advice can be aggressive. And that's not what everyone wants from their insurance company. But then, we're not the insurance company for everyone. Nor do we try to be.

The truth is, we work best with companies that are willing to make smart but tough choices in order to control costs.

Our special booklet—10 Ways To Cut Employee Benefit Costs—tells you how we do it. Call or write Rick Naymark, NWNL Group, Box 20, Mpls., MN 55440, (612) 342-7137 for a copy.

It may be just the time to sit back and analyze what your insurance company is doing for you.

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# Opinions

## Now's the time to speak up

**N**OW THAT THERE IS A lull in the debate over the future of Section 89, employers must act swiftly and forcefully to lobby Congress for workable welfare benefit non-discrimination rules.

Employers should not forget they were saddled with the current Section 89 chaos because they ignored the law after it was enacted in 1986—as though ignoring it would make it go away.

Had employers begun to lobby in 1987 and 1988, they probably could have succeeded in amending the law then and averting today's crisis of uncertainty.

Learning from a past mistake, employers now should lobby their congressmen for an entire rewrite of Section 89.

The redraft of Section 89 proposed by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., is better than the existing law for most employers, but is so flawed that it is not the acceptable remedy.

The Rostenkowski rewrite of Section 89 would be devastating to flexible benefit plans sponsored by hundreds of employers seeking to meet the specialized benefit needs of an increasingly diverse workforce (*BI*, May 15). Most flexible benefit plans as designed today would be considered discriminatory, even though employees all are offered the same benefits.

Another significant problem created by the Rostenkowski bill is its method of indexing the allowable maximum amounts employees can be required to contribute to their health care plans. Indexing

the \$10 per week cap for contributions for individual coverage and the \$25 per week cap for family coverage to the increase in the average weekly wage guarantees that employers will cut health plan coverage as medical care inflation outpaces increases in wages.

In addition, employers must oppose the "cliff" effect of the bill's second prong of the eligibility test. As written, if 90% of non-highly compensated employees are eligible for the health plan, the plan passes the test. But if only 89% are eligible, the plan fails and all highly compensated employees are taxed on the value of their health care coverage.

Employers should lobby their congressmen for non-discrimination rules that correct these three major problems with the Rostenkowski overhaul of Section 89. Employers should demand non-discrimination rules that preserve the value of flexible benefit plans. Employers also should insist that the eligibility test be altered to link the permissible increase in employee contributions to health plans to the rise in the medical care component of the Consumer Price Index. And, employers should seek a graduated penalty for falling short of the 90% eligibility test.

With the current Section 89 rules scheduled to take effect Oct. 1 and Congress considering the merits of the Rostenkowski proposal, employers must lobby immediately and persistently to finally obtain workable non-discrimination rules for welfare benefit plans.

## Letters

### OSHA not intended to control losses

To the editor: I take issue with the phrasing of your At Issue question (as well as some of my colleagues' responses) in the May 1 issue of *Business Insurance*. The Occupational Safety and Health Administration is indeed a safety agency, but it has never been intended or authorized to be a "loss control" agency as most professionals view the term.

Given political and budgeting restrictions, both OSHA and the Mine Safety and Health Administration have had significant impact in identifying physical hazards in the workplace. Controlling losses and loss costs is an issue that rests squarely on the shoulders of industry. Come on, guys. Let's call an OSHA an OSHA.

**Lance R. Hall**  
Manager of Insurance and Safety  
Lone Star Industries Inc.  
Greenwich, Conn.

### Membership in RIMS an earned privilege

To the editor: I had the opportunity to attend the Risk & Insurance Management Society Inc. directors meeting at last month's conference in Atlanta. One subject that was discussed concerned the possibility of allowing a law firm to be a RIMS member. At first I was astonished that a RIMS chapter would even consider such an idea.

The more that I thought about it, the more I realized that only one type of law-

yer was really the problem. Any member of the Assn. of Trial Lawyers of America is the enemy of anybody who believes in the concepts of not only risk management but good business practices and ethics. Putting it bluntly, members of ATLA, as a group, are vultures that feed and grow fat off the misfortunes of others.

I suggest that RIMS allow law firms that meet all membership requirements to be members only if they do not have any partners or employees who have been, or are now, or in the future become members of ATLA. No law firm that has any ties to ATLA should be allowed to be a member of RIMS. All ATLA members are the enemy of all the fine things that RIMS stands for.

**William S. Mortimer**  
Risk Management Consultants  
Laguna Beach, Calif.

### Are reinsurers free not to pay claims?

To the editor: Your May 8 article, "McCarran Doesn't Protect Reinsurers, Brief Contends," makes for interesting reading.

In the latest brief associated with the industry antitrust action, the attorneys general assert, in part, "...reinsurance is not related to the...spreading of a policyholder's risk."

If this proves to be so (questions of contract privity aside), could we, as a facultative reinsurer of risk-exposed business, then ignore future demands for claim payments made by our insurance company customers?

**G. Williams Davis Jr.**  
President  
Facultative ReSources Inc.  
Greenwich, Conn.

### Insurance certificates important documents

To the editor: I was rather appalled at the letter written by Peter H. Fleig of Pfizer Inc. in your May 8 issue calling for the abolishment of the exchange of certifi-

icates of insurance between Fortune 500 companies.

Mr. Fleig would be surprised at the number of Fortune 500 corporations that do not have adequate insurance programs.

Mr. Fleig's statement that time could be better spent examining insurance programs of "non-Fortune 500 companies" qualifies as an extremely snobbish statement.

While his main reason for the elimination of this "requirement" is to "avoid unnecessary paperwork," I suggest the effort is one with great merit, if some of the programs we have examined for Fortune 500 companies provides any indication.

Equally important is the need for a "trail" of insurance companies when claims manifest themselves several years hence.

**Paul E. Felsen**  
Felsen Insurance Services Inc.  
Randolph, N.J.

### Policy wording sets surety claim deadline

To the editor: In "New Mutual Fire Rehab Plan Proposed" (*BI*, March 6), you state that "no cutoff date is set in the plan for claims by surety bondholders..."

While technically this might be a correct statement, it could also be misleading to your readers.

While the rehabilitation plan does not treat this matter, the wording of the policy stipulates the time limit on this which the obligee has to report to the surety (Mutual Fire, Marine) any principal's default (60 days) unless the surety agrees in writing to extend the time. Hence, it might have been taken to state that the rehab plan is mute as to presentation of claims for surety bondholders and hence, presumably, the policy conditions apply.

**Alexander Bratic**  
Special Deputy Rehabilitator  
The Mutual Fire, Marine  
& Inland Insurance Co.  
Philadelphia

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## Section 89

Continued from page 6  
age or \$25 per week for family coverage.

Under the second part, known as the benefits test, a plan that is offered to a limited class of employees would be considered non-discriminatory if the cost of the coverage is no greater than 133% of the cost of coverage for a core health plan available to at least 90% of non-highly compensated employees.

• Group term life insurance plans would be exempted from Section 89 testing rules.

• The number of hours an employee must work per week before being counted in the non-discrimination tests would be raised to 25 from 17.5. This increase will make it easier for employers with a high percentage of part-time employees to pass the tests.

But employee benefit consultants

are warning employers that waiting for congressional action before they begin testing could result in costly tax penalties.

"It seems that employers are unwisely postponing the employee benefit testing process until after Congress decides what to do with Section 89," noted Mr. Parker of Confed Admin Services.

While "it is difficult to comply with a law that has 900 exceptions to 1,000 rules and is constantly changing," employers eventually will have to comply, said Mr. Parker.

"It is unlikely that Section 89 will be repealed, and I don't see any way that the data won't be needed for some kind of testing," agreed Wyatt's Mr. Grass.

Insurance Systems Group's Mr. Kerr, agreed. "Section 89 is clearly not going away, so it is best to gather the information (now) and test later when the regulations are clarified." ■

## Managed care

Continued from page 3  
not receive specific health care cost and utilization data from their HMOs.

Most of the current HMO information systems enable employers to use their indemnity plan data, such as employee health costs and utilization experience, to actuarially estimate what their HMO premiums should be. These types of actuarial analyses usually are performed by employee benefit consultants.

RateCheck, which is available from Ann Arbor, Mich.-based MEDSTAT Systems Inc., enables employers to use different HMO enrollment scenarios to estimate HMO premiums, based on their indemnity plan data, said Dennis Bush, a vp of product development for MEDSTAT.

RateCheck, which was introduced in late 1987, is a personal

computer software system that is available as part of MEDSTAT's on-line mainframe health claims data base product. Employers use the software to access their data from the MEDSTAT mainframe computer. The software is compatible with IBM personal computers, he said.

The system on average costs about \$3 to \$4 per employee, with the cost varying depending on the size and analytical needs of the employer, he said. The average MEDSTAT client has 15,000 or more employees, so the total cost of the system on average ranges between \$45,000 and \$60,000.

With RateCheck, employers can categorize indemnity plan enrollees under many demographic groups—including age, sex, class of employee or geographic location—and determine the health costs of enrollees in these demographic groups.

Employers also can factor into

their analysis variables such as projected health care inflation.

The RateCheck software then generates a two-page report that details a monthly HMO premium guideline based on the HMO enrollment scenarios. The report includes a summary of projected HMO rates per employee; a breakdown of rates by employee age, sex and coverage category, such as individual or family coverage; and the effects of HMO selection on the employer's indemnity plan rates.

"The sentiment of employers is to make sure they are paying a fair rate to HMOs. RateCheck sort of levels the playing field between employers and their HMOs. They can use this information as a guideline in their premium discussions with HMOs," Mr. Bush explained.

Los Angeles-based Atlantic Richfield Co. used RateCheck to evaluate its HMO premiums and found that the premiums were fair for the most part, said Susan Armstrong, a senior benefit consultant with the energy company.

"We went through our major HMOs and compared the rates they charged with the costs of similar employee groups in our indemnity plan. We found that aside from Philadelphia, our HMO rates were what they should be for the groups enrolled," she explained. ARCO has 20,000 employees nationwide, about 23% of whom are enrolled in 43 HMOs offered by the company.

"I found the RateCheck study valuable as a cross-check with the costs we have for similar demographic groups in our indemnity plan," she said.

"But, what RateCheck doesn't tell us is the health status or utilization patterns of the employees in HMOs vs. those in our indemnity plan," Ms. Armstrong pointed out.

Trans-World Airlines Inc. in St. Louis used RateCheck "specifically to get a sense" of whether it was paying too much in HMO premiums, said Robert C. Osborne, vp of health and market development for the airline.

"The common concern is that there is a dearth of information from HMOs on utilization and claims. So, we used our indemnity plan information. RateCheck will be used by TWA in the future as we determine both TWA's contributions toward HMO premiums and employees' contributions," he explained.

About 10%, or about 3,100, of TWA's 31,000 employees nationwide are enrolled in 65 HMOs.

"Until HMOs start providing claims data to employers, RateCheck is very helpful. It gives us a good feel for what we should be paying," he said.

Employers can purchase a similar HMO information and analysis system from Minneapolis-based Health Risk Management Inc.

The "HMO/PPO Evaluator" is part of a health care data base product HRM offers. The company builds a mainframe or PC-based software data base with one year of the employer's indemnity plan claims data. The data base then is updated quarterly.

With the system, employers can use their own demographic indemnity claims data plus normative data from HRM to "predict utilization requirements of their group—such as the number of hospitalizations," explained Bruce Kelley, vp of analytical services.

"Then, those costs are translated into projected claims expenses per employee and compared to the premium the HMO is charging the employer," he said.

The system also can analyze HMO premiums based on a comparison of actual indemnity plan expenses for a demographic group vs. the HMO premiums charged for a similar demographic group enrolled in the HMO, he said.

Continued on page 12

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## Managed care

Continued from page 10

The cost of these HMO analyses "is very sensitive to the size of the employer's group, but the average is about \$12,000," Mr. Kelley said.

HRM's system also enables employers to evaluate PPOs based on the negotiated prices with providers; quality of care factors; convenience and accessibility of the PPO's doctors and hospitals; and patient satisfaction, he said.

With the system, employers can analyze the price they pay per case vs. community norms to see whether the PPO is cost-effective.

In addition, the HRM system "can take the client's claims experience from the year prior to introducing the PPO to see what the employer would have paid" had they used the PPO, Mr. Kelley said.

The PPO evaluation costs about \$2 to \$3 per employee per year, he said.

A new PPO information package soon to be marketed by the Health Data Institute of Lexington, Mass., will enable employers to evaluate both existing PPOs in a given metropolitan area as well as hospitals with which employers can build their own PPO networks.

"NetSelect" includes a diskette that is a self-contained data base of information on hospitals in a specific metropolitan area that can be used for PPO network modeling. The system will be available for 40 different metropolitan areas, said Danya Zimmer, manager of HDI's information business. HDI is a wholly owned subsidiary of Baxter Healthcare Corp.

The diskette is used as "a modeling tool that lets you compare up to five hospital networks at a time," she said.

Benefit managers can select the hospitals they want to include in each of the networks, plus they can enter any information they

have from their claims data about the number of employee admissions at each hospital.

Using this information, the diskette provides a variety of on-screen and hard copy reports, such as reports on average total charges for a particular network, facility charges and lengths of stay at each of the five hypothetical networks.

The system also can generate reports on the percentage of employee admissions at hospitals not currently associated with any of the networks.

In addition, a report included in the NetSelect information system package contains information and ratings of hospitals based on such factors as inpatient utilization and charges, outpatient utilization and charges, physician charges, and quality of the hospital's services or medical equipment.

Employers can use NetSelect either to select existing PPOs in their location based on the diskette's

analyses of hospitals that may contract with the PPO or to develop their own PPOs with hospitals.

The information also can be used to negotiate prices with all providers, Ms. Zimmer said.

The first NetSelect package an employer purchases costs \$20,000, but the price for each additional package for other metropolitan areas is discounted. For example, the second package costs \$17,000 and a third package costs \$16,000.

Corporate Health Strategies also provides an information system employers can use to evaluate the effectiveness of PPOs or to select providers to develop their own PPOs, Mr. Hutchinson said.

The CHS personal computer software system, known as "PC CHAP," also allows benefit managers to access their indemnity plan claims data, as well as normative data, from the CHS mainframe computer to enable the user to estimate the effects of plan design

changes.

Most employers that use PC CHAP have at least 5,000 employees. The cost of the information system begins at about \$40,000 but can be more "depending on the capabilities and needs of the employer. There's a great degree of customization," he said.

With PC CHAP, "we can monitor the patterns of services hospitals and physicians are providing to the employer's employees and their dependents. This type of analysis is something employers can do hands-on," he said.

"Employers can use this information to more intelligently select the kinds of providers they want to contract with. They can also get a better idea, in terms of financial negotiations, how efficiently providers in a network are performing," he said.

CHS also performs analyses of employers' HMO premiums, using indemnity plan data. The firm provides these analyses as a consulting service rather than as a software or hands-on information tool for employers, he said.

Some employee benefits consultants predict that despite the interest of some employers in performing their own analyses of their managed care programs, many employers are not in the market for such a specialized product.

"I don't think the benefit manager wants something like this on his desk. He wants to go to an expert and have the services done for him," said Rich Sinni, director of the health management practice of Buck Consultants Inc. in Harmon Meadow, N.J.

Most employers "don't want to incur a major expense for a software package they might use once," he added.

"I think you're going to see a lot more employers coming to companies like Buck for these types of services," Mr. Sinni predicted, noting that Buck offers HMO and PPO analytical services.

Unless a benefit manager feels he works with data enough to be the company's own benefit consultant, the systems may not be cost effective, said David P. Rahill, a principal with A. Foster Higgins & Co. Inc. in Princeton, N.J.

"Most people we see who buy these systems get their data and then give it to a benefit consultant to analyze it for them" anyway, he pointed out.

"If you add up the cost of buying and using the system, plus the cost of staff to operate the system, there are very few companies that can afford to devote what amounts to several hundred thousand dollars a year," Mr. Rahill said.

Indeed, "our experience has been that our clients want our expertise to do something as involved" as HMO and PPO evaluations and negotiations, said Walter R. Wood, a consultant in the Washington, D.C., office of The Wyatt Co.

"There is always an inclination on the part of employers to have a system in-house. But, I have not seen many clients use a data system effectively, so you don't get much value from having it in-house," explained Suresh Malhotra, a principal in the Deerfield, Ill., office of William M. Mercer Meidinger Hansen Inc.

"I feel that people have a tendency to believe that since you have a data system, you can answer all questions. But, this is not so," he added.

Mercer uses its own system to serve clients but also sells and maintains the system for clients that want an in-house system.

Mercer's on-line mainframe data base, known as Comprehensive Health Claims and Management Program, or CHAMP, costs about \$5 to \$6 per employee per year for employers with at least 2,000 employees. Larger employers pay \$1 to \$1.50 per employee per year. ■

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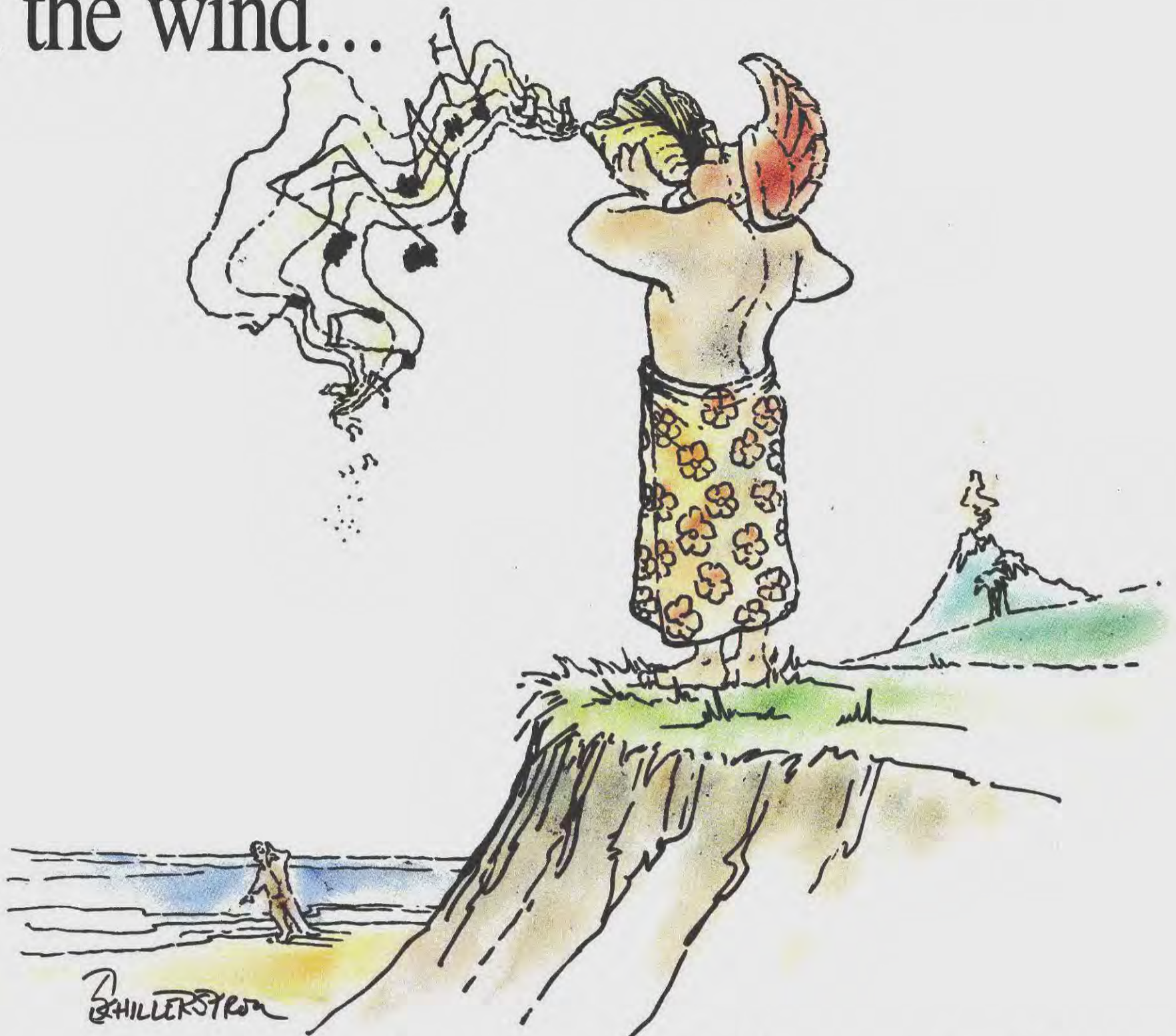
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# Comparative HMO data on the horizon

By DONNA DiBLASE

While most employers have had to rely on actuarial estimates drawn from indemnity plan data to analyze their health maintenance organization costs, that dearth of HMO data may soon end.

A new data base being built from information collected directly from HMOs soon will enable employers to perform the same sophisticated analyses of their HMO cost and utilization experience that they've long been able to perform on indemnity plans.

A prototype of the data base, which is being developed by Ann Arbor, Mich.-based MEDSTAT Systems Inc. at the request of General Motors Corp. and the United Auto Workers union (BI, July 25, 1988), is expected to be introduced this fall, said David J. Chinsky, director of managed care systems at MEDSTAT.

And, although the project was initiated by a request from GM and the UAW, the HMO data base and supporting analytical software products will be available for sale to all employers through MEDSTAT, he said.

**'HMOs will be better positioned. . . if they are able to provide employers with data,' says David Chinsky.**

MEDSTAT also provides an on-line mainframe data base of indemnity plan data that employers can access through the use of personal computers and MEDSTAT software.

The new HMO data base involves MEDSTAT, GM and the UAW working in cooperation with the HMO industry to develop a standard data reporting format that balances employers' HMO data needs with the data reporting capabilities of HMOs, Mr. Chinsky explained.

"Most of our employer clients feel HMOs are doing a superior job. However, I believe that it's primarily a lack of information from HMOs that has fueled employers' loss of confidence in HMOs," he said.

With the development of the data base, "I do believe that we've created a momentum in the HMO community. We really believe that HMOs will be better positioned in the competitive market if they are able to provide employers with data," he added.

So far, only one other major employer—San Francisco-based Pacific Telesis Group—has worked with its HMOs to receive data specific to its employees enrolled in HMOs, benefits experts say.

Development of the MEDSTAT data base began in June 1988, when "GM and the UAW asked us to develop the same capabilities for the managed care environment that we already provide for our clients on the indemnity side. This will enable them to assess HMOs the way they currently assess their traditional health insurance plans," Mr. Chinsky of MEDSTAT said.

MEDSTAT began by meeting with 35 of the largest HMOs serving GM and the UAW to identify both the types of data the HMOs could provide and the types of data employers need to effectively analyze their HMO costs and experience, he explained.

The types of data identified were information on medical diagnoses; information on the process of re-

ferrals from an enrollee's primary care physician to specialists within the HMO; and information on the HMO's methods of provider reimbursement.

"We found that HMOs were very interested in cooperating with health care purchasers on their data needs. And, we found that about 70% of the HMOs had already developed the capabilities to collect data," he said.

MEDSTAT now is holding a second round of meetings with the

HMOs to obtain feedback on proposed data reporting standards.

Then, the company will begin collecting the actual data from the HMOs later this summer. To build and maintain the HMO data base, MEDSTAT will require HMOs to submit data in the agreed-upon standard reporting format on computer tapes, Mr. Chinsky said. This is similar to the method MEDSTAT uses to collect its employer clients' indemnity plan data from claims administrators, he said.

Once the data base is established, MEDSTAT then will develop analytical software modules that employers can buy to perform specific evaluations of their HMO data, he said. For example, the company now is working on a software module that employers could use to analyze the effectiveness of their HMOs' physician referral procedures.

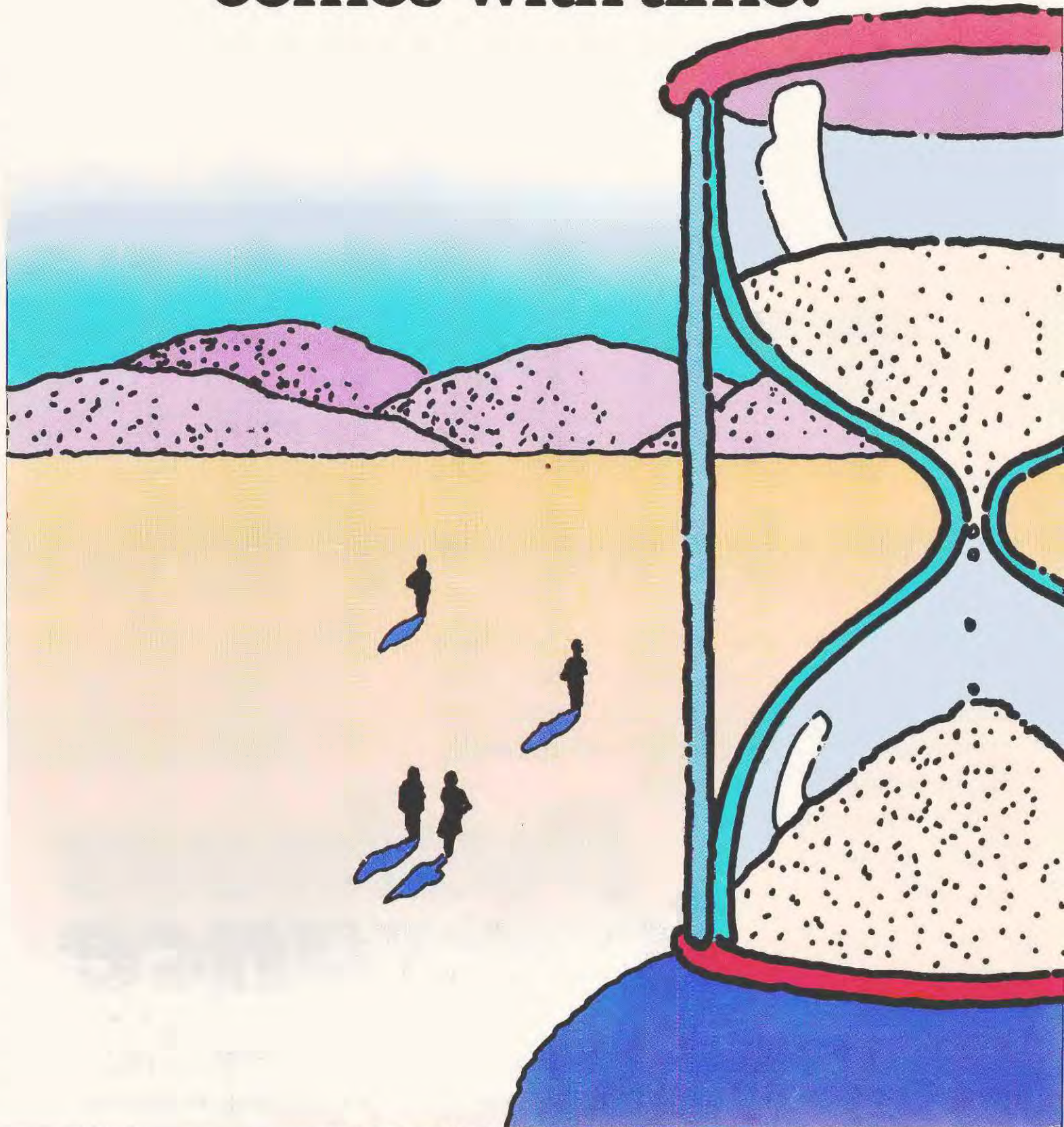
Meanwhile, the Pacific Telesis project is collecting health care utilization data from all 10 of its

HMOs, which the HMOs report on a computer tape and submit to the company's consulting firm, Affordable Health Care Concepts in Sacramento, Calif.

"We had half-day meetings with each HMO and their data people. We explained our data requirements and discussed their reporting capabilities," explained Neil Austin, staff manager-health care cost containment for Pacific Telesis.

*Continued on next page*

## Experience that only comes with time.



# Vendors help employers negotiate provider fees

By MICHAEL SCHACHNER

A trio of Dallas-based health care cost management firms is using health care claims data to help large self-insured companies negotiate lower fees at frequently used hospitals.

In addition, the three vendors are using their extensive health care data bases to help employers develop cost containment pro-

grams tailored to their individual employee populations.

MedicalControl Inc., Libra Information Networks and Health Economics Corp. are just three examples of this new type of cost management firm emerging in the employee benefit information services field.

These companies act as intermediaries between the self-insured employer and the health care provider, using the extensive health care claims data stored in their information systems to negotiate fee discounts with providers and price freezes in line-item charges to insulate employers from the rising cost of specific hospital goods and services.

In effect, by negotiating directly with health care providers, these companies can assemble custom-made preferred provider organizations for employers.

"Our service is valuable because it allows both providers and purchasers to examine where they are going. Our product isn't just compiled data, but it is set up for short- and long-term analysis," explained Charles B. Greitzer, vp-marketing for Libra in Dallas.

"The first solution to a problem such as high health care costs is basing analysis on numbers," said Larry Swayze, vp of MedicalControl, which in addition to negotiating provider discounts and price freezes of line-item costs also processes and administers employers' health care claims.

For example, Dallas-based Southland Corp. recently contracted with MedicalControl to monitor and administer its 45,000 employees' hospital-related expenses (BI, Feb. 6).

Efforts to cut health care costs "have to become more data intensive," echoed Stephen F. Coady, chief executive officer of HEC, another Dallas firm that uses its claims data to help employers better understand where their health care dollars are going.

"Analysis needs to be less subjective and more objective," he said.

Both Libra and MedicalControl negotiate discounts directly with hospitals on behalf of their clients, while HEC uses its health claims data to help employers coordinate plan design, determine which employees should be channeled into PPOs and help establish physician fee schedules.

HEC also supplies hospital cost information to other organizations that negotiate preferred provider arrangements, such as Blue Cross & Blue Shield associations, labor unions and benefit consultants.

The demand for new avenues of cost containment has increased as more and more health care providers—already facing limited payments under the federal Medicare and Medicaid diagnostic related group formulas—shift costs to insurers and self-insured employers, health care experts say.

Employers are desperately seeking ways to reduce their employee health costs, which often are the second-largest expense after payroll, the experts say.

While many self-insured employers have contracted with PPOs and health maintenance organizations as a means of reducing health care costs, they often find that the savings are marginal or short-term at best, asserts MedicalControl's Mr. Swayze.

Other critics say PPOs cannot explicitly demonstrate how savings will be achieved, how clients will know if money was saved and how much was saved.

Continued on next page

HMOs, we think we're pretty much where we were five years ago with indemnity insurers. We had insurers telling us that the data weren't available, that we didn't need it," observed Mr. Chinsky of MEDSTAT.

"But, we think as we develop a set of standard data that purchasers need, that HMOs will develop the capabilities necessary to report data," he said.

However, one consultant observed that not every employer may be able to obtain data from HMOs.

"Not everyone is going to be able to do what General Motors can. The overwhelming majority of companies are not going to be able to go to their HMO and demand data," said David P. Rahill, a principal in the Princeton, N.J., office of A. Foster Higgins & Co. Inc.

Larger employers, who have large numbers of employees enrolled in HMOs, now have more leverage to request data from their HMOs. But, "I think the HMO industry knows they are going to have to provide data to employers" in order to compete, he added. ■

Continued from previous page

Data reporting was one of the requirements of HMOs participating in a bidding process conducted by Pacific Telesis a year ago. The bid process was part of an effort to reduce the number of HMOs the company offered to employees (BI, April 25, 1988).

Pacific Telesis this year reduced to 10 from 20 the number of HMOs it offers to its 45,000 employees. About 70% of its employees are enrolled in HMOs, he said.

"A year ago, some of our HMOs could give us data reports. But, all were willing to work with us. It's just night and day compared to a year ago" in terms of data collection from HMOs, Mr. Austin said.

Some employee benefit consultants say that cooperation between HMOs and employers to establish HMO data bases will increase and that the effort will aid both employers and HMOs.

"In terms of where we stand on collecting data from

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## Hospital fees

Continued from previous page

In addition, HMOs often do not realize their cost containment potential because many employees select other health care options in order to choose from a wider range of providers.

As a result, many self-insured employers are going one step beyond traditional managed care arrangements and are negotiating their own discounts or banding together to purchase health care services as a group.

That's where firms like MedicalControl, Libra and HEC come in. They do much of the legwork for employers and employer groups, in addition to providing detailed computerized claims analyses.

Libra, MedicalControl and HEC use proprietary software to access their enormous data bases of health care claims information from across the country.

The firms use such information as how much a particular employer spent at a certain hospital in a given year, or a comparison of fees for similar services at various hospitals, to give employers clout when negotiating with a health care provider for fee discounts and line-item price freezes.

While MedicalControl is "perceived as a hospital discount company because we work on a national network of hospitals," Mr. Swayze said the company is trying to change that image.

"We're trying to become an information company that can furnish clients and those interested with a wide range of hospital information," he explained.

"The feedback we get is, 'Wouldn't it be nice if one company could do it all?'" he said.

MedicalControl not only obtains provider discounts, but also specializes in negotiating price freezes on line-item costs, wherein a hos-

pital agrees not to raise the costs of some 12,000 line items for a one-year period.

In an effort to expand its services, MedicalControl is about to enter the third-party administration field, as well as market a pre-certification program and physician fee schedules for 183 of the 313 Metropolitan Statistical Areas defined by the Bureau of Census, Mr. Swayze said.

"We're shooting for the global product," he said.

MedicalControl estimates that savings of up to 30% of the average per-employee medical expense of \$2,000—70% of which is paid to hospitals—are possible through frozen line-item prices and provider discounts.

Here is how MedicalControl's system works:

• MedicalControl first requests its client's 1099 medical expenditure form, which is filed with the company's federal tax return, but

looks only at the portion pertaining to hospital expenses. It then compares specific hospital charges with national averages in its data base to come up with a standardized figure to be used for negotiation.

"We can then see what kind of clout we have in each MSA, and more specifically, with each hospital," said Mr. Swayze.

• MedicalControl then sends negotiators to the hospitals that are the source of the client's greatest expenditures to arrange a contract based on volume and costs.

MedicalControl will not negotiate with more than a few hospitals in a given MSA because it wants to avoid becoming a standard PPO, said Mr. Swayze.

Among the line items for which MedicalControl negotiates one-year freezes are room and board charges, intensive care stay rates and thousands of specific, quantified supplies, such as tongue de-

pressors and thermometers.

Hospitals also benefit from the arrangement because they receive increased utilization from the employees of contracted employers, Mr. Swayze pointed out.

MedicalControl focuses on companies with more than 10,000 employees because it can work out the best deals when a hospital can be shown how large numbers of employees will be channeled to it, he explained.

And with the current high rate of empty beds in most U.S. hospitals—estimated at as much as 50% in many urban areas—this is music to hospitals' ears, Mr. Swayze said.

Southwest Airlines Co., which contracted with MedicalControl more than a year ago, saw the system as an alternative money-saving method because contracts with its unionized employees prohibited certain savings methods such as cost-sharing, increased deductibles and larger copayments, said Libby Sartain, director of benefits and compensation for the Dallas-based airline.

"This was a way to save without reducing benefits," she said.

Because the airline has not yet communicated to all of its more than 7,000 employees which hospitals they should use to qualify the company for discounts, an estimate of Southwest Airlines' savings is not available, Ms. Sartain said.

She said Southwest Airlines currently is judging the success of MedicalControl's services based on the quality of the health care providers brought on board, the quality of claims administration and the convenience of the program for its employees in Dallas, Houston and San Antonio, Texas, and Phoenix, Ariz.

When MedicalControl first brought its product to the market in 1988, it required nothing up front from its clients. It started out charging a 40% commission on realized savings with no additional fees.

However, the firm now bills clients \$4.50 per month per employee, because it overestimated the speed at which clients would communicate to their employees which hospitals to use, according to Mr. Swayze.

"We had to get some cash-flow. Clients have been moving at an excruciatingly slow pace. We were suffering from corporate lethargy," he added.

"For the most part, employees so far have made it to discounted hospitals through stumble and bumble. The only way they are treated under the discount is by accident," he said.

However, Mr. Swayze did not rule out the eventual return to a commission reimbursement system if clients could be persuaded to conduct a quicker, more thorough communication program.

Libra, which negotiates hospital discounts ranging from 10% to 18%, claims it can trim 30% to 37% off the average self-insured employer's health care bill through frozen line-item prices, according to Mr. Greitzer.

Libra has direct computer linkage with the hospitals where its clients' employees are treated, he noted. As a result, Libra can download claims information and analyze the line-item billing immediately to determine which hospitals are providing services at the best price, Mr. Greitzer said.

And, using the cost information on many national hospital chains included in its data base, Libra can show both the hospital and the employer how charges compare on a national and regional level, he said.

"We believe that capturing detailed line-item information is not only important in itself, but can lead to freezing costs of those line items," said Mr. Greitzer.

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## Hospital fees

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Libra's computer system reads an entire bill, verifies that the contracted charge agrees with the billed charge, then immediately applies the discount before forwarding the recharged bill to the client's administrator, he explained.

Libra can perform this claims analysis on both inpatient and outpatient cases, said Mr. Greitzer. "This is important considering 40% of health care expenses are paid on outpatient services."

"Libra allows for complete line-item examination," he said. And with hospital inflation of 15% to 20% per year, obtaining a freeze on line-item prices immunizes a client from certain increases, he said.

Libra, which works mostly with health care cooperatives and employer coalitions, is working with the Middle Tennessee Health Care Employers Coalition and a number of employer groups in the Dallas area.

However, Mr. Greitzer admits that Libra does its best business with health care co-ops, which consist of a groups of self-insured

employers that negotiate with health care providers. Co-ops are more formalized than coalitions because they usually have employer funding, he noted.

"We have better success with key members of a coalition who decide to form a co-op and then hire a firm to do the legwork and communicate with us," he said.

"Coalitions are a tough sell" because benefit manager members are less likely to take the risk of upsetting the status quo, Mr. Greitzer said. "They show more concern for making sure benefits are appropriate for their employees than in cutting costs."

But, "it's really a matter of education. We try to convey that this is riskless. We won't take anything if we don't generate savings. If you don't save, you don't pay us," he said.

Libra usually takes an 8% to 12% commission on realized savings depending on the contract and geographical area, he said.

HEC, a subsidiary of Duncan, Okla.-based Haliburton Co., provides claims analysis as part of its claims administration/utilization review services or on a stand-alone basis. HEC processes more than 1 million health care claims per year and provides UR for

more than a half-million people.

HEC's service focuses on surveillance epidemiology and evaluation, with the most important feature being evaluation because that facilitates plan design change, explained Mr. Coady.

Most self-insured firms do not realize that 3% to 4% of their employees account for most of their health care outlay, he said. Evaluation, he explained, can lead to a better grasp of where health care dollars are going.

"We can look at what looks right and what looks wrong," said Mr. Coady. "Most of what we see looks right, but what looks wrong gives employers an opportunity to focus in on outliers."

HEC's claims analysis leads to cost containment methods like physician fee schedules, rate tables for child birth and information on which employees should be steered toward PPOs, according to Mr. Coady.

He said HEC's data base consists of claims information based on the in-house claims analysis it performs, statistical studies performed for others such as business coalitions, as well as records it accesses from various state health departments.

With this extensive data bank, HEC can compare and contrast client-specific statistical information with normative information on a very detailed level.

"It's a snap for us to do FASB projections," Mr. Coady said, referring to the proposed Federal Accounting Standard Board rules that would require employers to recognize retiree health care liabilities on their balance sheets for post-retirement health care benefits (BI, Feb. 20; Oct. 17, 1988).

"All we have to look at is age, sex and probabilities, compare them with the current census figures and recalculate for the future," he said.

HEC has contracts with about 600 clients, most of which are self-insured employers. It caters to companies with at least 500 employees because those with fewer workers have "nothing interesting to recover," said Mr. Coady.

"Our experience has been that companies can reduce their rate of increase for health care by one-half," said Mr. Coady. "We don't promise rollbacks or no increases (in health care costs), nor do we say we can get your costs down to zero." ■

## Keep an eye on big costs: Consultants

Despite the attractiveness of negotiating line-item price freezes with health care providers, benefit consultants caution employers not to lose sight of the forest for the trees.

Such price freezes are a hallmark of a new breed of health care cost management firms (see story, page 15). On behalf of self-insured employers, these firms use extensive health care claims data bases to negotiate fee discounts and price freezes of line-item charges with health care providers.

However, "if you are focusing on one item such as sutures or a tongue depressor, make sure you don't lose sight of composite costs," warns Gino Nalli, a managed care consultant in the Washington, D.C., office of The Wyatt Co.

Richard Sinni, director of health management services for Buck Consultants in Secaucus, N.J., concurred, saying that employers pondering contracts with health care cost management firms must keep an eye on the big picture.

"My only concern is that when you get down to a line item as small as a tongue depressor, the return would not be great enough for even a minimal investment," Mr. Sinni commented.

Wyatt's Mr. Nalli pointed out that there are plenty of new people on the block with many new ideas aimed at curbing health care costs.

"Some will be successful and others won't," he said.

For example, "in the case of DRGs (diagnosis-related groups), inpatient costs were capped, but outpatient costs went sky high," Mr. Nalli said, explaining problems associated with the hospital reimbursement system adopted by Medicare in 1983.

DRGs establish a uniform payment system for health care payers. The system has been adopted nationwide by Medicare and Medicaid programs.

DRG payment systems that apply to all payers were adopted on a statewide basis in Maryland in 1977, New Jersey in 1980, Connecticut in 1986 and in New York last year (BI, March 6).

—By Michael Schachner



# Interactive systems, pension calculators top EBIS wish lists

By MICHAEL BRADFORD

When benefit managers close their eyes and wish for an employee benefit information system, they visualize one that will give employees the ability to routinely tap into frequently updated benefit data.

Such systems not only keep employees aware of changing plan balances and features, but they also take a big chunk of the workload from the benefits department, employers say.

These "interactive systems"—which allow workers to access personal plan information by touching a screen or keyboard or using a telephone hookup—are at the top of benefit managers' EBIS wish lists.

No. 2 on the list of most-requested features of an EBIS are pension calculation systems. Benefit managers want to speed up pension calculations by taking the number crunching away from outside administrators and bringing it in-house.

Because the technology for interactive systems is expensive, few benefit managers say they believe they will see this wish come true in the very near future.

The most costly interactive system houses a computer screen in a kiosk. With such a system, employees touch a screen or a keyboard to display personal benefit data and general plan information.

The kiosk system is "not something you can buy off the shelf," pointed out Keith Alston, managing consultant with A. Foster Higgins Consulting Group in Princeton, N.J. Many employers want them, he noted, but "as soon as it gets down to dollars and cents, the client tends to back off it."

The price for kiosk systems can easily amount to more than \$200,000, according to firms that offer the systems.

With a kiosk-type system, costs can quickly add up, depending on the number of kiosks needed. Each costs around \$10,000, according to Jay Marchant, practice leader for interactive communications for Alexander Consulting Group Inc. in Baltimore, a unit of Alexander & Alexander Services Inc.

But the software, which can add as much as \$200,000 to the bill, is the costly component of the kiosk system, pointed out Alfred J. Walker, a consultant in the New York office of Towers, Perrin, Forster & Crosby Inc.

Less costly to install is a telephone system, whereby workers use a Touch-Tone phone to retrieve data.

With such a call-in system, "you essentially have one piece of hardware—a voice processor. It's usually a PC-based processor," Mr. Marchant explained.

Processors begin around \$15,000 and the installation price goes up depending on the number of phone lines required to handle calls. Altogether, most companies will spend less than \$30,000 on the system, according to Mr. Marchant.

Benefit managers are wishing for interactive systems partly because they feel the quarterly or annual benefit statements sent to employees are too infrequent.

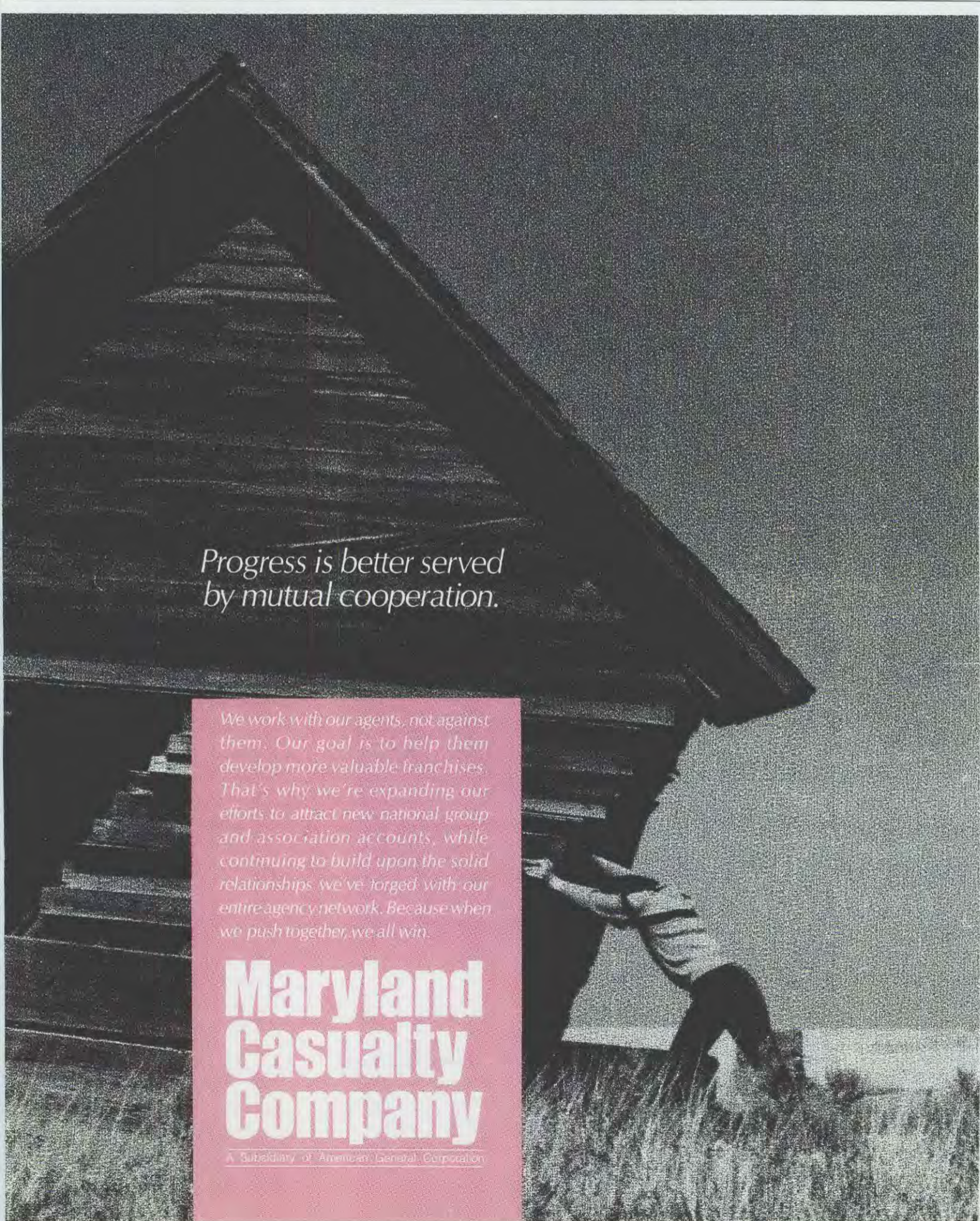
Sara Kelly, senior benefits administrator with Fina Oil & Chemical Co. in Dallas, said she is talking to vendors about installing an interactive system that would give the company's 3,500 employees the ability to monitor their benefit plans instead of relying on yearly statements.

Ms. Kelly said Fina wants a system that will "at least" give employees, via a telephone hookup, the ability to review benefit data that is updated on a monthly basis.

Through such a hookup, workers could retrieve information like amounts of accrued pension benefits and other plan balances, she said.

And, ideally, Fina would like to have an interactive system that

*Continued on next page*



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## EBIS wish lists

Continued from previous page would allow employees to make plan enrollment choices, Ms. Kelly said.

"There are things out there that are being developed, and they would be beneficial to us," she pointed out.

An enrollment feature in an interactive system would be a smart financial move, according to benefit consultants.

For many employers, such a system "at the first open enrollment period pays for itself," said TPF&C's Mr. Walker.

"It eliminates all the data entry by the company," because the job of data input is shifted to the employee, who completes the task by punching numbers on the keypad, Mr. Walker explained.

Keith Wills, compensation and benefit manager at Kerr-McGee Corp. in Oklahoma City, said he

**Kiosk-type systems 'are definitely catching on, but employers are slower to implement them,' says Mr. Marchant. Instead, benefit managers are choosing telephone access systems, and kiosks are 'part of their long-range plans.'**

also would like to get employees in touch with their benefits.

If employees know more about their benefits, they will appreciate those benefits more, according to Mr. Wills. "And, it works both ways. They could also let us know what benefits they would like to have."

Interactive systems also give employees the ability to perform such tasks as changing the number of dependents covered by a plan, re-directing profit-sharing balances or even applying for a loan.

"Why shouldn't an employee be

able to do that directly?" he asked.

"Flex enrollment over the phone is one area that is really exploding," according to Mr. Marchant of Alexander Consulting Group.

Lynn Hein, director of benefits for Hilton Hotels Corp. in Beverly Hills, Calif., also wishes for a way to give employees greater access to benefit information.

"I think we see most of our goals contained in interactive systems," he said.

The hotel chain also would like to get away from the paper-intensive system it now uses to provide

employees with benefit updates, he added.

Hilton already offers interactive system technology to its guests: Some of its hotels have kiosks in their lobbies to provide hotel information, Mr. Hein pointed out.

"So the technology is there," he said.

But Mr. Hein fears that structuring a system for a decentralized organization such as Hilton Hotels could involve logistical problems and great expense.

"Pragmatically and logistically, it may not be possible," he said. "We would have to have a lot of kiosks" or work out schedules that would allow employees to use the systems at certain times to cut down on waiting.

Mr. Hein pointed out that some of Hilton's luxury hotels employ as many as 600 workers, which could mean logjams at the kiosks if scheduling is not precise or if there are too few terminals.

In addition, many employees may not be "computer literate," he said. "Some of our employees may be uncomfortable interacting with computers." Therefore, an educational program for workers might be in order, he said.

Although many companies currently may not be able to afford the kiosk systems, the cost of these systems eventually may fall to more affordable levels as the technology develops, according to consultants.

Mr. Alston of Foster Higgins predicts there will be some off-the-shelf kiosk software products available in about two years.

"If you want a customized system, you can have it today," Mr. Alston noted. But, he cautioned that such a system would be costly because "what you're buying is someone's experience in doing that."

"Typically, you see the larger employers as the first on the block to implement the system," pointed out Richard Johnson, a principal in the Chicago office of benefit consultant William M. Mercer Meidinger Hansen Inc.

But, "as the systems evolve, there will be more and more ways to get them out to more employers in a cost-effective format," he said.

Because of the high cost of kiosk-type systems, most employers are opting for the telephone access systems with an eye toward implementing kiosk systems when that technology becomes less expensive, consultants say.

Kiosk-type systems "are definitely catching on, but employers are slower to implement them," said Mr. Marchant of Alexander Consulting Group. Instead, benefit managers are choosing telephone access systems, while kiosks are "part of their long-range plans," he said.

Edgar M. Spears, director of benefits and payroll at Lowe's Cos. Inc. in North Wilkesboro, N.C., said he too would like "some employee access on an ongoing basis" but that he worries about the way information would be presented to workers.

Mr. Spears is concerned that employees might not be able to understand the benefit information provided either by a kiosk or call-in system.

"There's a real problem of being able to present the data in a readily understandable format," he said.

But Mr. Marchant points out that simplicity is a hallmark of the systems that Alexander has designed for clients.

"That's the value-added we provide," he said. "That's in the quality of the presentation."

In addition, Mr. Spears of Lowe's said "there is a concern about confidentiality and access" by unauthorized individuals.

But, the confidentiality problem can be overcome as well, according to Mike Hager, systems consultant with The Wyatt Co. in Washington, D.C.

He explained that "employees sign up for a card" that authorizes them to access the system with a personal identification number, similar to the procedure for using an automated bank teller machine.

The PIN card is the key to newly developed kiosk systems designed to allow various transactions, including cash withdrawals, Mr. Hager also noted.

"We're seeing an incredible amount of interest in that" type of system, Mr. Hager added.

Besides educating employees about their benefits, interactive systems let benefit managers know which benefit options are most popular with employees, which can help employers control benefit costs, according to Dean Lundgren, a vp with CIGNA Corp. in Bloomfield, Conn.

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## EBIS wish lists

Continued from page 20

Mr. Lundgren said a dilemma that many benefit managers face revolves around the question: "How can I as an employer make decisions that are right for my employees while at the same time controlling medical costs?"

Interactive systems can give workers an open line to the benefit department and allow them to express which benefit options they believe are important, he said.

After interactive systems, benefit managers most frequently are looking for an in-house pension calculation system.

"We've had rocket requests for those," said Mr. Alston of Foster Higgins.

Like interactive communication systems, in-house pension calculation systems can provide better services to employees, he explained. "Employers want to be

**A dilemma that many benefit managers face revolves around the question: 'How can I as an employer make decisions that are right for my employees while at the same time controlling medical costs?' Mr. Lundgren says.**

more responsive to the employee."

Employer demand for pension calculation systems at Foster Higgins "is double what it was last year," Mr. Alston said.

Employers also are interested in pension calculation systems because of the aging U.S. workforce, according to Mr. Alston. "They're starting to expect more of those kinds of services," he said of employees.

Ms. Kelly of Fina Oil & Chemical said Fina is shopping for an in-house system that will calculate pension benefits faster than the

outdated, 10-year-old system the company plans to abandon.

Fina needs a user-friendly system that can be updated instantly, Ms. Kelly added. "We have a substantial payroll, and it is important that (the pension calculation system) be on real time," she said.

"We're looking for something that does (pension plan) discrimination testing and has report-writing capability," Ms. Kelly added. The pension calculations have "to be well-documented."

Because pension calculation systems have been around longer than

interactive systems, benefit managers' No. 2 wish is a little cheaper.

Firms that offer pension calculation systems say prices range from \$15,000 to \$150,000, depending on the size of the employer and the number of pension plans the employer offers.

"It's not a question of the cost of the software, but how many hours it takes to modify it," pointed out TPF&C's Mr. Walker. Although there are plenty of package pension calculation systems, they have to be customized to each employer's specific needs, Mr. Walker explained.

Bill Ward, director of employee benefits at Maytag Co. in Newton, Iowa, called the pension calculation system his company uses "a godsend."

Before Maytag produced its own software nine years ago, pension benefits were calculated manually, he said. "Now, we just punch in the

data, and the machine does the calculations."

DeVerne Schippers, senior programmer/analyst at Maytag, said the system was "more than cost-justified," because it sharply cut the number of man-hours needed to produce the calculations.

Donna D. Taylor, assistant vp and manager of employee benefits at Barnett Banks Inc. in Jacksonville, Fla., said her ideal system would have an in-house pension calculation system linked to the company's payroll system.

"That's a real need," she emphasized, pointing out that the bank plans to eventually bring the pension calculation function in-house. "But whether it will be linked to payroll is a question."

Diane Dolan, manager of benefits for Emery Worldwide in Wilton, Conn., said her company already can do the calculations in-house but that the current system is cumbersome.

Ms. Dolan said she is keeping her eyes open for software that will allow her to calculate pension data for an employee on a single screen rather than having to use several screens to complete the calculations.

Overall, Mr. Ward and Mr. Schippers of Maytag advised benefit managers shopping for employee benefit information systems to put a premium on flexibility.

"This area needs total flexibility to retrieve all kinds of data," Mr. Schippers emphasized. A system should be able to handle tasks as complicated as providing information on various plans to those as simple as printing mailing labels, he noted.

And, information should be easy to access—"all right at the user's fingertips," he said.

"Benefits are more complicated than ever, thanks to our friendly government," Mr. Ward said. As a result, an EBIS has to be capable of handling such intricate demands as administering COBRA benefits and be ready for changes that Section 89 compliance could bring, he said. ■

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## The New PCS

# Medicare cost-cutting projects set to begin

By STACY ADLER

The first of three projects to test the effectiveness of private health care plans' administration of Medicare benefits is scheduled to begin in July.

In addition, the federal Health Care Financing Administration—which administers the Medicare program—is negotiating two other similar projects that could begin in 1990.

Under the "Medicare Insured Group" concept, self-insured employers or unions will administer Medicare benefits to their retirees under a unified program in conjunction with the employers' own retiree health care benefits using managed care techniques.

In return, the employer or union receives a monthly experience-rated capitated premium equal to 95% of what HCFA estimates it would cost the agency to provide Medicare benefits for the group of retirees.

Under the plan, an employer will keep any difference between the amount received from the government and the amount the employer pays in Medicare benefits. However, the employer also is liable if benefit costs exceed the government payment.

Theoretically, employers should be able to administer retirees' claims at a lower cost than the federal government has by implementing cost-containment measures like utilization review and pre-admission certification.

Currently, many retirees receive health care benefits from both Medicare and employer-provided supplemental plans.

This two-tiered system makes it difficult for employers to negotiate discounted rates with providers or to implement cost-containment techniques for retiree health care plans, experts say.

By providing all post-retirement health care benefits under one program, employers will gain more leverage in negotiating with providers and be able to implement cost control techniques, they say.

Retirees also would benefit by receiving all of their benefits from one source. This arrangement would eliminate confusion for retirees about whether Medicare or the supplemental plan pays for a particular benefit, experts add.

While the HCFA is gearing up for its first three demonstration projects, employers are "taking a wait-and-see attitude," said Richard Sinni, a consultant with Buck Consultants in Secaucus, N.J.

However, consultant Elliot Segal, president of Managed Care Options of Bethesda, Md., said some employers are souring on the concept of private administration of Medicare claims.

"There is a lot of red tape, and there is no assurance that the 95% payment won't be cut in the future," Mr. Segal explained.

The first demonstration project, scheduled to begin in July, involves New York-based Amalgamated Life Insurance Co. (BI, Nov. 9, 1987).

ALICO administers 40 Taft-Hartley trusts that provide health care benefits to 500,000 employees and 130,000 retirees who are members of the Amalgamated Clothing and Textile Workers Union.

The ALICO demonstration project will begin in Philadelphia with 11,000 retirees, explained Max Fine of Bethesda, Md.-based Max Fine & Associates, the benefit consultant for ALICO.

Currently, ALICO is attempting to negotiate provider discounts with eight hospitals in Philadelphia.

By participating in the demonstration project, ALICO retirees will receive improved Medicare benefits.

For example, under normal Medicare benefits, physician visits are covered at 80% after a \$75 annual deductible, and hospital care is covered 100% after a \$560 annual deductible.

But, under the ALICO demonstration project, "retirees will receive all the benefits of Medicare without having to pay any deductibles or copayments," Mr. Fine said.

Any money remaining from the government's payment will be put back into the retiree health care plan in the form of improved benefits, Mr. Fine said.

For example, ALICO projects

that savings generated under private administration of the Medicare plan will allow the union to offer vision care, which Medicare does not cover. And, in the future ALICO might be able to offer some type of long-term care benefits for retirees, he said.

The ALICO demonstration project is scheduled to run five years. Each year the project will be expanded to a new city, according to Mr. Fine. However, at most, 20,000 of the 130,000 retirees will participate in the project, he said.

HCFA can spend up to \$600 million annually on three MIG demonstration projects under a provision of the 1987 budget reconciliation act (BI, Feb. 1, 1988).

Another employer eyeing the possibility of conducting a Medi-

care demonstration project is Southern California Edison, according to Sidney Trieger, director of the division of health systems and special studies at HCFA in Baltimore.

Southern California Edison could have its demonstration project up and running this year, but an agreement has not been signed yet, Mr. Trieger said.

Highland Park, Mich.-based Chrysler Corp. also is investigating the viability of conducting a similar demonstration project with some of its retirees, but it, too, has not signed a final agreement with HCFA (BI, March 28, 1988).

The automaker currently is winding up its feasibility study of the MIG concept, which is scheduled to be submitted to HCFA by

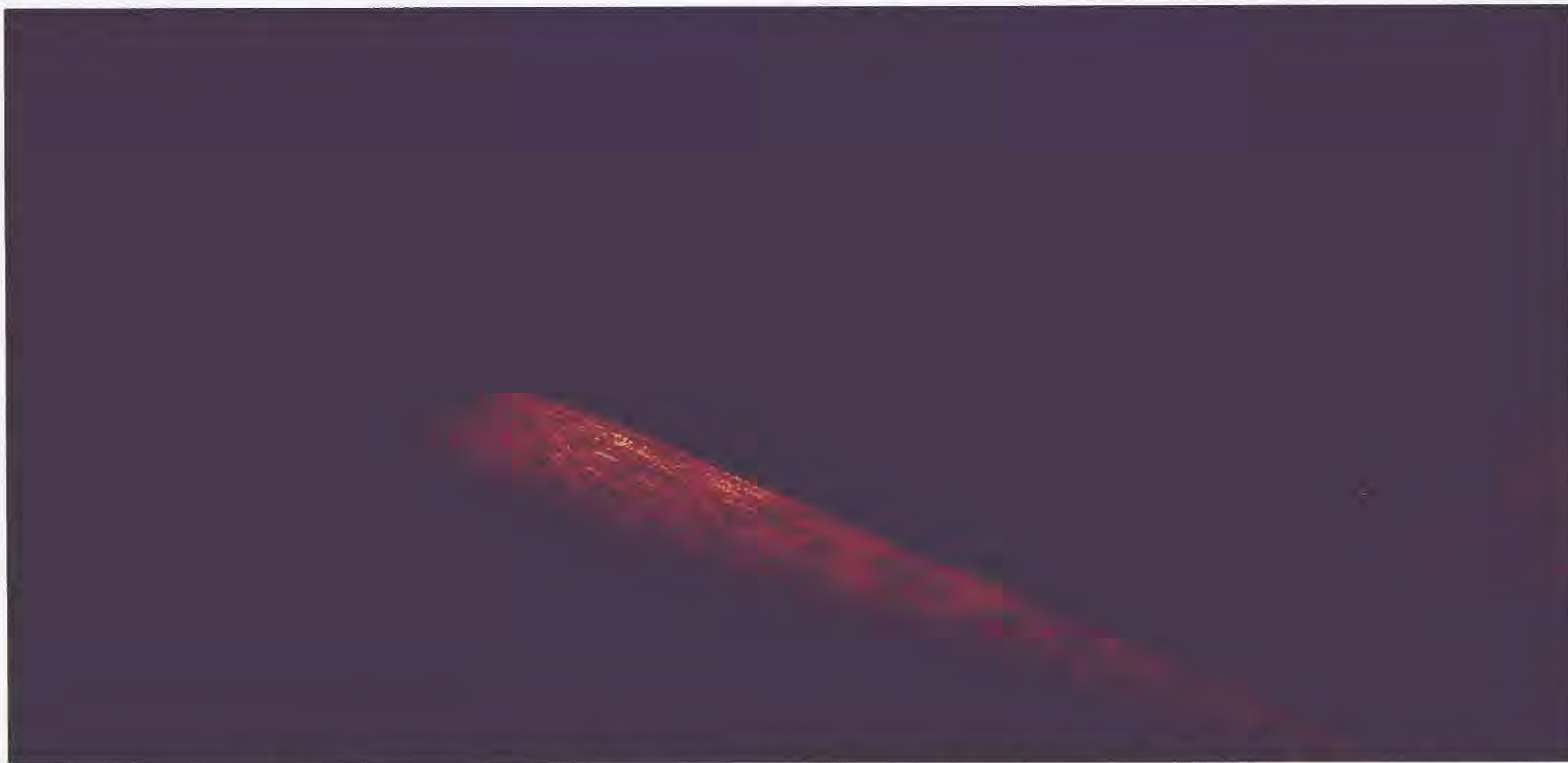
June 1, said Donald Longnecker, manager of finance and planning-health care and group insurance for Chrysler.

If a contract is signed, the project could begin in 1990, Mr. Trieger said.

A spokeswoman for General Motors Corp. said the automaker held discussions with HCFA concerning a Medicare demonstration project but that these discussions "did not bear any fruit."

Detroit-based GM no longer is considering conducting a Medicare demonstration project, according to the spokeswoman.

Similarly, a spokesman from Ford Motor Co. in Dearborn, Mich., said that Ford is not going to participate in the experimental Medicare program. ■



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# GIC demand raises question of capacity

By JUDY GREENWALD

Capacity problems are emerging in the market for guaranteed investment contracts, some observers say.

The limited number of highly rated insurers offering GICs, coupled with the growing demand for the popular investment products, is causing some employers problems in placing contracts in the \$150 billion market, these observers say.

However, others observers, including some major insurers, believe that the currently narrow spreads between GIC rates and Treasury instruments are being misinterpreted as a capacity shortage.

Meanwhile, banks are becoming

**'I think capacity is going to be one of the major issues in the next few years,' says Wyatt's Mr. Boyen. 'There's clearly more players coming in,' but, combined, they would not have quite the impact should one of the major insurers decide to leave.**

increasingly active in the GIC market, which some observers say could ease the capacity crunch somewhat. But, the volume of bank investment contracts written could be reduced by a proposal pending in Congress to eliminate Federal Deposit Insurance Corp. coverage for contracts written by banks (see story, page 30).

Major recent trends that have antee investors a specific rate of return on their invested capital over the life of the contract.

GICs, which account for an estimated 75% to 85% of funds invested in defined contribution pension plans, are popular because they are more secure investments than equities and bonds (BI, May 30, 1988).

developed in the GIC market include:

- A narrowing of spreads between rates offered by GICs and Treasury instruments.
- An inverted yield curve for GICs, with shorter contracts now offering higher rates of return than longer contracts.
- A shortage of good investments available to insurers seeking to invest GIC funds.
- The development of more complex GIC portfolios, including the use of cash "buffers" to fund the withdrawal of money from plans by employees.
- The related emergence of professional GIC investment managers.
- The so-far frustrated search by employers for equally appealing

GIC alternatives (see story, page 30).

But the biggest development concerning some observers are worries over GIC market capacity.

"I think capacity is going to be one of the major issues in the next few years," said Michael Boyen, a consultant in The Wyatt Co.'s Portland, Ore., office.

"There's clearly more players coming in," he said, but combined, they would not have quite the impact should one of the major insurers decide to leave, said Mr. Boyen.

The capacity problems in the GIC market are "very real," agreed Alan Kominz, executive director of Kominz Co. Investment Bankers, based in Marina Del Rey, Calif.

"I think there probably is a capacity shortage," said Bruce Vane, senior vp of Prudential Asset Management Co., a major GIC underwriter that plans to write \$5 billion to \$6 billion in GICs this year. "I think some companies are, in fact, pulling away from the market."

"It may be (for) a variety of reasons," he said. These include: banks' entry into the market have tightened spreads and insurers are not comfortable with writing business at those margins; strains on insurers' reserves; or a shortage of appropriate investment instruments in which to invest GIC funds.

While admitting that there may be "somewhat of a capacity problem," Thomas Keating, who heads the pension group at Travelers Corp., a major GIC underwriter, added that he does not know how serious or how deep it is.

"There's an awful large appetite out there" for GICs, said Mr. Keating, adding that he is not sure insurers can satisfy all of the demand. Banks, however, "might be able to pick up the slack," he said.

"I think there's a capacity problem" for many of the higher-rated insurance companies, said Kenneth L. Walker, president of T. Rowe Price Guaranteed Asset Advisors in Richmond, Va. He said, however, "I think there's still enough supply to meet the demand," and added that banks could help solve capacity problems "tremendously."

"There are capacity problems out there with high-quality carriers," agreed a GIC investment manager for a major corporation who asked not to be identified.

There is a capacity problem "in the sense that it's affecting the rate of return for insurance carriers," said Brian Ternoey, a principal with A. Foster Higgins & Co. Inc. in Princeton, N.J.

Supply equals demand, he said, so it is not a situation where the contracts cannot be obtained, but rather that the yields they offer will be relatively low.

Insurers "don't have the surplus to draw upon that they had in previous years," Mr. Ternoey explained. As a result, in some situations, contracts "just can't be had at a reasonable price."

"I think, to some extent, managers and consultants equate the fact (that) spreads are narrowed with a shortage of capacity," said Judith Markland, a vp at John Hancock Financial Services, a major GIC underwriter.

In fact, she said, the narrow spreads are a marketwide phenomenon that is reflected in the bond and mortgage securities markets as well as the GIC market.

If the spreads between bonds and Treasury securities are low, then spreads between GICs and Treasuries will be low as well because insurers invest their assets in the bond market, explained Felix

Continued on page 27



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## GIC market

*Continued from page 25*  
Schirripa, a vp with Metropolitan Life Insurance Co. in New York, a major GIC underwriter.

Ms. Markland also said observers may have reached the conclusion that there is a capacity shortage because one or two insurers that had reached their sales goals stopped writing GICs at year-end 1988.

But, it "isn't a real problem," said Ms. Markland. "We're not expecting to sell less. In fact we're planning to sell more," she said.

Mr. Schirripa said GIC managers have implied there is a capacity shortage to explain why the managers are needed.

"Certainly we don't have a capacity problem," he said, adding that Met Life is increasing the amount of GIC business it writes.

Met Life is not impacted by surplus constraints either, he said. "We could continue writing quite a bit more business without surplus constraints," he said.

Gordon Dinsmore, senior vp for the Equitable Life Assurance Society of the United States, said Equitable is writing less GIC business to improve its capital ratios.

However, "as far as I know, we're unusual that way," he added. He also said people seem to see a capacity shortage because of the decrease in spreads.

"In general, I don't think there's a real capacity problem," said Chuck Golden, a vp in charge of GIC portfolio management at Boston-based State Street Bank & Trust.

But there are some capacity shortages at smaller insurers that are not as well-capitalized as larger insurers or do not have a large investment staff, Mr. Golden added.

In these cases, the amount of product sold has strained the insurer's surplus, as has the limited number of investment options, because insurers must earn an adequate return on GIC funds. However, "that's not the situation at the larger insurance companies," Mr. Golden said.

In comparing the rates offered by GICs with those offered by Treasury bills, Mr. Golden suggested that observers should take into account that GICs carry a certain amount of risk, while Treasury bills do not.

The "artificially high" spreads once offered by GICs compared with Treasuries will not return, he predicted.

"My understanding is there's no capacity problem. I haven't run into any," said the manager for an employer with \$1.2 billion invested in GICs.

"At a certain price, there's an unlimited capacity," he added.

John Knight, president of Lamberson, Knight GIC Inc., a Short Hills, N.J., GIC brokerage, said he believes the small spreads between GIC rates and Treasury rates may have helped ease capacity problems.

Insurers can now invest GIC funds at "normal" yields and make money, said Mr. Knight. Insurers, for instance, can readily guarantee a 9% rate, then reinvest it at 9.7%. But when buyers expect a spread of 150 to 200 basis points, or 1.5% to 2% between GICs and Treasury instruments, "They can't find something on the other side to make money on."

"I don't really think there's a capacity shortage. I think that there is a profit shortage," commented John Naughton, executive vp of Massachusetts Mutual Life Insurance Co. in Springfield, Mass., which expects to write \$1 billion in GICs this year.

"The profits for GICs are pretty thin right now," he said. More and more organizations are coming into the business, cutting margins and

making the business "tougher for everybody," he said.

But others, like Dan Schukarbt, assistant treasurer at Chicago-based FMC Corp., which has \$194 million in GICs, said: "I don't know whether there is or isn't" a capacity shortage.

While it appears there may be a capacity crunch, there is no clear signal, he said. "All we have is rumors," he said, adding, "The results don't support the rumors at this point."

"I think if you're going to see it, you're going to see it this fall," commented Mark Hanley, a principal with Brentwood Asset Advisers, based in Santa Monica, Calif.

While GICs today are more likely to come due throughout the year, rather than be bunched up at year-end as they once were, any capacity problem will still emerge later in the year, said Mr. Hanley.

Observers say regardless of whether there is a capacity shortage, with few new defined contribution plans being introduced, the GIC market is unlikely to experience any big jumps in growth.

They estimate that with \$150 billion in outstanding GICs, about \$30 billion in new contracts will be placed this year, including contracts that are being rolled over.

"We really see very few brand new companies adding plans," Mr. Ternoey said. "That end of the growth has really flattened out, really peaked."

"There's obviously a lot of money in GICs relative to some of the other options employees have in the savings plans," said Met Life's Mr. Schirripa.

He said, however, he doubted that a lot more money will be shifted to other funds from GICs although, on the other hand, he could see money shifted away as employers introduce new savings plan investment options.

"I don't see a real tremendous growth for the GIC option," said Mr. Schirripa. "I think it will grow still, but not as much as it has in the past."

At the same time, the yield picture has changed. While a year ago, employers were able to obtain higher yields on longer-term contracts, today, with an inverted yield curve, higher yields are available on the shorter, one-to-three-year contracts, say observers.

This phenomena is a reflection of Treasury rates in general, noted Randolph B. Root, a consultant with Fort Lee, N.J.-based Kwasha Lipton.

"The general market has inverted yield rates," said Mr. Ternoey.

One problem facing the insurance industry is a shortage of good investments for its GIC funds, which accounts in part for the narrow spreads.

There is a capacity shortage insofar as good investments are concerned, said Al Sylvain, assistant vp for investment services operations of MONY Financial Services in Purchase, N.Y.

"The entire industry is going through some rather difficult times in terms of the availability of investments to support our GIC business," said Mr. Sylvain. He specifically cited the private placement business, particularly mortgages.

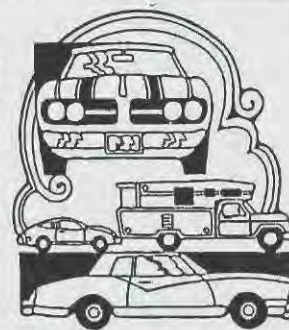
However, "there's some good signs" the problem has been easing of late, he added. As a result, MONY may meet, or even surpass, the \$650 million in contracts it underwrote last year, while originally it had expected to fall short of that mark, he said.

"There are not a lot of high-quality investments out there," agreed Steve Alexander, an underwriter with Principal Mutual Life Insurance Co. in Des Moines.

With more contracts being

*Continued on next page*

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## GIC market

Continued from previous page placed, there is an increasing amount of competition for the same investments, Mr. Alexander said.

"There's only a limited number of investments out there," said Mr. Root.

This is a problem throughout the financial markets, noted Mr. Kominz. "Everybody is looking for the flight to quality."

"It's not much fun. We're all looking for new vehicles and new ways to fund instruments," said John Hancock's Ms. Markland.

Meanwhile, employers' GIC portfolios are becoming more complex.

The two basic kinds of GICs have been window and bullet contracts:

- Under a bullet GIC, one lump sum deposit is accepted by the insurer to be invested for a stated period of time.

**'People are just kind of jumping too fast' on new ideas that have not been tested, Mr. Ternoey says, noting they will rush to take advantage of an attractive yield without first examining its impact on their portfolio over the long haul.**

- Under a window plan, which offers lower yields, the insurer guarantees a return on contributions made over a certain period of time, or an "open window" period.

An increasing number of window contracts now have floors and caps on the amount of money that can be invested, however, to limit insurers' risk, said Kwasha Lipton's Mr. Root.

While floors and caps have always been part of the market, today insurers and banks are either insisting on them, or offering a

premium on the yield if they are part of the contract because "you're taking the risk away from the insurance company or the bank," said Mr. Root.

"We've been doing more of that," said Tom Hardy, assistant vp at MONY, in discussing floors and caps, although he added they still are part of less than half of MONY's window contracts. They are put into contracts that look riskier, he explained.

"I think (floors and caps) are becoming more common, partly because the plan sponsors are more

open to having these things," said Mr. Hardy.

Plan sponsors are starting to realize that by accepting these provisions "sometimes they can get a few more points on their rate," he said.

More insurers also are offering participating contracts, said Mr. Ternoey.

While there are many variations, the common element in these contracts is that there are some risks not covered by the contract that could change the employer's eventual rate of return, said Mr. Ternoey.

Unlike the "true" GICs, "it's not a full guarantee," he said.

"They're passing on all sorts of risks and opportunities for gains and losses" onto the employer with participating contracts, commented State Street's Mr. Golden. He said that while he still is investigating these contracts, to date, he has not recommended any to his

clients.

Employers also are establishing buffer funds consisting of either cash or short-term investments to reduce cash-flow risk in the event employees withdraw their money from a plan, noted James R. Hiner, a partner with William M. Mercer Meidinger Hansen Inc. in Chicago.

These buffers can account for up to 25% of a plan's assets, although most are in the 5% to 15% range, he said.

Another development is investment managers' growing role in the GIC market, say observers. These are firms that, for a fee, manage employers' GIC portfolios.

More and more firms are becoming involved in GIC management, said Wyatt's Mr. Boyen, noting that, to an extent, this is a parallel development with the growing complexity of GIC portfolios.

Previously, he said, employers would invest all their money with one company. Then, they decided to diversify among insurers. Now, he said, employers are becoming even more sophisticated and beginning to treat their portfolios as an investment they structure for maximum returns.

"We expect" GIC managers' "role to increase," although not as dramatically as in the past, said Gordon Maltempo, assistant vp at Aetna Life Insurance Co., a major GIC underwriter.

He estimated that GIC managers now manage more than \$18 billion in funds, compared with about \$4.5 billion in 1984.

"I think their growth will slow down a bit," Mr. Maltempo said, adding, "They offer a very valuable service to plan sponsors" in structuring their portfolio.

Pat Russo, who manages the GIC portfolio of Norwalk, Conn.-based Great Northern Nakoosa Corp., which has close to \$100 million in GICs, says his company uses State Street to help with the complexity of contract language.

"We really don't have the time or the manpower to fully understand each contract," he said.

When Great Northern decided to diversify its funds instead of buying one large contract, it needed help to make sure that plan provisions did not conflict with the contracts, he said.

"All GIC portfolios are managed, even if people don't realize it," said Peter Bowles, president of Fiduciary Capital Management, a Woodbury, Conn.-based GIC management company. "It's really a function of how much attention they're paying to the subject," he said.

On the other hand, FMC Corp., which has offered GICs to its employees since 1982, does not see the need for a GIC investment management firm, said Kenneth J. Morrissey, corporate benefits manager.

"We just felt comfortable in terms of our knowledge of the guaranteed investment contract market" to do without one, he said.

Observers also warn pitfalls may develop when GIC managers propose new, untested types of deals.

"Most people are not doing enough homework," said Mr. Ternoey.

"People are just kind of jumping too fast" on new ideas that have not been tested, he said.

They will rush to take advantage of an attractive yield without first examining its impact on their portfolio over the long haul. "They don't look into the future far enough." They are too concerned with getting an adequate rate of return the next quarter "even though it's a very slow-moving type of investment."

A good example of where this problem develops is with participating contracts, which can offer a more attractive rate going in, but which also carry greater risk, Mr. Ternoey said. ■

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# FDIC changes could hurt bank products

By JUDY GREENWALD

A controversy is brewing over how banks participating in the guaranteed investment contract market will fare if Congress eliminates Federal Deposit Insurance Corp. coverage for their GIC-type products.

Some observers predict that removal of FDIC coverage for bank investment contracts will stunt banks' emergence as a major force in the \$150 billion GIC market.

But others say taking away the government-sponsored insurance coverage will have no impact on banks' success in the GIC market because plan sponsors and investment managers focus on banks' underlying creditworthiness anyway.

BICs are a form of bank deposit that, though technically different from GICs, operate similarly. Both are offered as investment options for defined contribution pension plans (BI, Sept. 19, 1988).

A House Banking subcommittee amendment to the savings and loan bailout bill would impose a two-year moratorium on FDIC coverage for bank investment contracts, retroactive to April 6.

The amendment would prohibit the FDIC from extending

the \$100,000 basic coverage warranty to individual participants choosing BIC options for investing their pension or profit-sharing funds, which is known as pass-through coverage.

The amendment was introduced as a result of efforts by the American Council of Life Insurance, which believes the banks now enjoy an unfair competitive advantage, said Gary E. Hughes, chief counsel-securities at the ACLI.

The two-year moratorium incorporated into the House bill includes 18 months for the Treasury Department to study the federal deposit insurance program, and an additional six months for Congress to review the findings of the study.

The Senate version of the bill, however, does not call for a moratorium of FDIC coverage for BICs. Instead, it includes only an amendment calling for the issue to be studied for six months.

A conference committee is expected to resolve differences in the two versions of the bill shortly.

"It's extremely iffy whether the \$100,000 bank coverage is going to be there or not" when the legislation is approved, commented Randolph B. Root, a consultant with Fort Lee, N.J.-based Kwasha Lipton. "It's real cloudy right now."

While observers say BICs account for less than 5% of the outstanding GICs on the market, the presence of BICs has been increasingly felt in writing new contracts in the past year.

This year, BICs have accounted for as many as one-quarter to one-third of the new GIC contracts written, said Steve Alexander, an underwriter with Principal Mutual Life Insurance Co. in Des Moines.

About a year ago, only about a handful of banks were writing BICs, said Peter Bowles, president of Fiduciary Capital Management, a GIC management company in Woodbury, Conn.

But now, Fiduciary Capital has identified 22 banks that are either definitely or "rumored to be" in the BIC market, he said. "That's been a dramatic event."

"Banks are coming out of the woodwork," said a GIC manager for an employer with \$1.2 billion in GIC contracts. "It is unbelievable the capacity these banks have. In short-term (contracts), they go gangbusters over any of the insurance companies."

"If they decide to go whole hog, they could become a very

Continued on page 32

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## Alternatives to GICs eyed by employers

Some employers are searching for alternatives to guaranteed investment contracts.

"There's a need for alternative products," said David Rubin, senior managing director at Charles, Dunhill, Rubin & Co. in Beverly Hills, Calif.

With pricing in the GIC market weak, "there're going to be other products created to meet the demand at the right place," he said. "We're seeing a real need for higher yields and the need for alternative programs that will meet those requirements," he said.

"I don't think it's just a function of the flat yield curve," said John Allen, a consultant with Hewitt Associates in Chicago, discussing the search for GIC alternatives. He pointed to the large number of defined contribution plans and the growing base of assets.

"We are looking at GIC alternatives," said Ron Ingham, senior consultant at E.I. Du Pont de Nemours & Co. in Wilmington, Del., which has about \$4.2 billion in GIC contracts.

Du Pont is uneasy about having so much money invested with insurers, he explained. "It's just an awful lot of money to have in one industry," he said.

Du Pont would like to have its investments insulated from any potential insurer solvency problems, he added. "We're looking at diversification alternatives," he said, although he added that currently "there's not much to look at."

Other observers also say an investment as appealing as a GIC may be hard to find.

Earlier this year, the GIC industry was relieved when the Financial Accounting Standard Board's emerging issues task force put the issue of book value accounting on its agenda, but did not take any action.

Book value accounting allows GICs to guarantee principal and interest at certain set rates. Other investments, such as stocks and bonds, are reported at market value.

With a GIC, the insurer is willing to guarantee book value and absorb the risks associated with that, said Judith Markland, a vp at John Hancock Financial Services. With any other vehicle, the sponsor would have to be willing to underwrite this risk. "Typically, that's the problem."

"I don't see that many alternatives on the horizon," commented Gordon Maltempo, assistant vp at Aetna Life Insurance Co.

There is no need for alternatives, said David Salvin, assistant vp at Bankers Trust Co. "I believe that banks and insurance companies can easily meet the demand." ■



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## EBIS vendors

Continued from previous page  
ministration programs should run on minis or mainframes," he said.

"The area a mainframe works best in is number crunching high-volume claims," agreed Ellen Lockwald, manager-market development at Resource Information Management Systems Inc. in Naperville, Ill.

Most vendors say that an employer with 200,000 or more lives in their data base should consider a mainframe EBIS.

Employers should consider several factors when choosing between a mainframe and a PC-based EBIS, according to Theresa Tanton, senior vp-marketing/communications of Atlanta-based Computations Inc./Dyer, Wells & Associates Inc.

For example, PC-based systems can require more physical administration and checking than main-

**'The corporate market is opening up to self-administration, but when they see the prices of the largest systems with all the different billing modules, they say, "That's too much for us,"' says Ms. Lockwald of RIMS Inc.**

frame systems, and those duties usually fall to benefits department personnel rather than data processing departments, which generally are in charge of mainframe functions.

Also, PCs are a higher security risk because "hackers" can more easily break passwords and codes to gain access to a PC data base, she said.

However, maintaining a more powerful system requires a large data processing staff, which many companies do not have and are not willing to hire, said Denise Henry,

manager-product development at RIMS Inc.

Mr. Whitman of Kwasha Lipton agreed. "Over the last four or five years there has been a lean and mean attitude in corporations," he said.

"They've cut staffs, and that has put a lot of pressure on the human resource individual to streamline activities."

"The corporate market is opening up to self-administration, but when they see the prices of the largest systems with all the different billing modules, they say, 'That's

too much for us,'" said Ms. Lockwald of RIMS Inc.

"People just aren't willing to spend the money on mainframe systems, support and maintenance and upgrades," Ms. Lockwald said. "Every time you want to add to the system it can cost you \$500,000 to \$1 million."

Therefore, RIMS Inc. has added a personal computer division to develop PC-based software products. "There is a lot of interest in this because hardware costs are so exorbitant for mainframe systems," she said.

As part of RIMS Inc.'s new personal computer strategy, the company now offers QicClaim II, a PC-based version of its minicomputer-based QicClaim Health Claims Management System.

Both systems offer "basic claims administration system along with cost containment reporting" capabilities, Ms. Lockwald explained. The systems administer health,

dental, vision, drug, and long-term and short-term disability claims.

The new PC-based software sells for \$40,000, approximately \$20,000 less than the vendor's minicomputer-based system, which starts at \$60,000 for the software only.

The PC version handles claims administration for employers with 500 to 5,000 employees, Ms. Lockwald said.

However, if an employer expects rapid growth, the minicomputer version would probably be more suitable, she said.

In addition, the company has updated its minicomputer QicClaim version to allow users to generate more detail on types of medical procedures and their health care expenses, Ms. Henry said.

The minicomputer system is suitable for employers with 1,000 to 150,000 covered lives.

"We've modified a lot of reporting functions which address the managed care area," she said.

This year, the minicomputer QicClaim system includes "reasonable and customary schedules" that flag and can even deny claims that are considerably more expensive than the norm.

Reports identify high-cost providers or utilization trends.

Many of the upgrades decrease the need for in-depth analysis by claims processing personnel, according to Ms. Henry.

For example, the modified minicomputer QicClaim version contains what Ms. Henry calls a "decision tree." Similar to artificial intelligence, the decision tree helps eliminate errors in claim adjudication that result when a processor inputs incorrect reimbursement information.

For example, a claims processor previously would have to review a claim and determine the benefit level. But, the upgraded QicClaim system makes that decision now to help eliminate adjudication errors.

"The operator still has to know some medical terminology but doesn't need the high level of claims analysis to pay a claim," Ms. Henry said.

RIMS Inc. has been offering its QicClaim health claims administration product to employers since 1982. The minicomputer software has been purchased by 27 corporate clients.

Computations/Dyer Wells also is marketing a new PC-based version of its health claims administration system to employers. FASTRAK/PC has been available for about a year to employers that want to self-administer their health care claims but cannot afford a mainframe or a minicomputer EBIS system.

Like the company's mainframe system, the PC-based system administers health, dental, vision, drug, life, and long- and short-term disability claims.

"It's an ideal system for companies with 500 to 1,000 employees, because their needs and claims volume aren't as great," Ms. Tanton explained.

So far, 10 employers have purchased the system, which sells for approximately \$60,000.

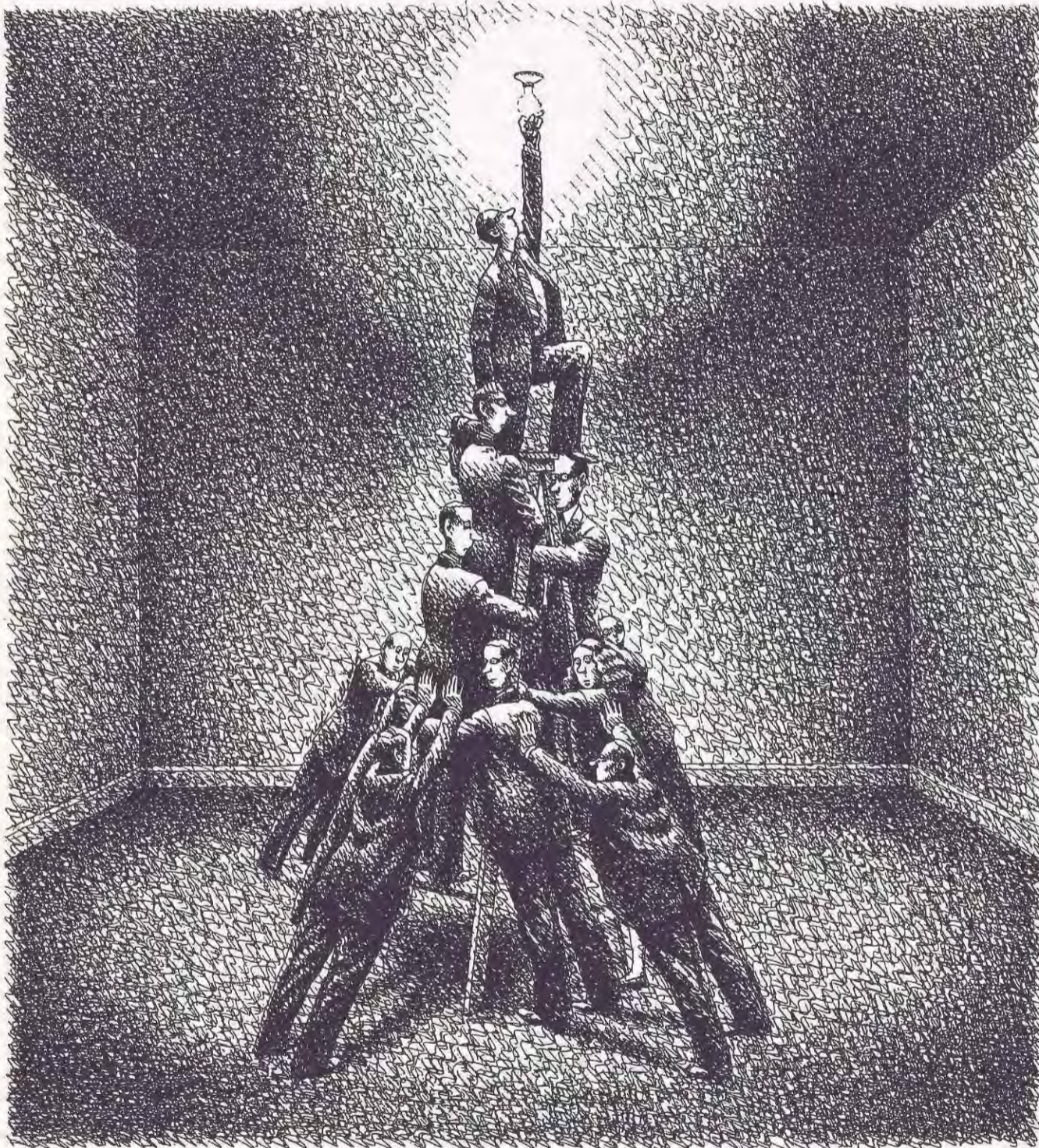
Computations/Dyer Wells' mainframe FASTRAK, which sells for approximately \$200,000 and runs on an IBM mainframe computer, is among the most popular health claims administration systems with benefit managers, according to a *Business Insurance* survey of vendors. Since 1981, 20 employers have purchased the system.

There are some differences between the two systems, Ms. Tanton pointed out.

For example, the mainframe version has some complex duplicate checking criteria that can automatically flag identical claims.

The PC version also will alert benefits personnel of a possibility of a potentially duplicate claim,

Continued on next page



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## Vendors

Continued from previous page  
but manual checking by claims processors is necessary to determine whether the claims are, in fact, identical.

Depending on the number of lives in the employer's data base, the number of different benefit plans available to employees and the amount of number-crunching desired to generate detailed reports, large employers may be better off investing in a larger, more powerful system such as a mainframe or minicomputer system, vendors say.

For example, Nashville, Tenn.-based manufacturer Heil Quaker Corp. self-administers its self-insured benefits plan with a Computations/Dyer Wells mainframe system.

"The complexity of our medical plan didn't lend itself well to the PC," said Ralph Shinbaum, director-compensation/benefits.

Heil Quaker previously processed health care and dental claims manually for 3,000 employees manually. Since implementing the system in 1987, Heil Quaker now gets detailed reports that enable human resource personnel to pinpoint health care spending.

Also, the turnover time for claims processing has dramatically decreased.

"With the manual system, it took a minimum of two weeks, depending on the backlog of outstanding claims, to process a claim. Now our claims processors key claims in on the system, it automatically adjusts deductibles, processes at night and cuts the checks for the employees the next day," explained Ronnie Grimes, human resources/benefits manager.

The most popular mainframe system among employers is Tesseract's Benefit Plan Administration System, according to the *Business Insurance* survey.

Seventy-four employers have purchased the mainframe system since its first installation in 1982. The system, which costs between \$100,000 and \$200,000, administers health, dental, vision and prescription drug claims, flexible benefits and COBRA claims.

Tesseract's client base is 90% corporate employers and 10% TPAs and insurers, according to Tesseract's spokeswoman.

She said Tesseract clients are looking for ways to put a ceiling on their benefit costs and are asking for "richness in the amount of information a system will provide, because their No. 1 goal is cost containment."

In addition, users want the ability to extract information and manipulate it to do in-depth analysis of claims data, she said. "Our users are companies with 1,000 to 3,000 employees and above," she said.

Because of their size, most of Tesseract's clients are best suited to a mainframe EBIS, she pointed out.

ASA also markets one of the most popular health claims administration systems, the ASA/CAS II Claims Administration System, which currently is available only as a mainframe-based system. It administers health, dental, vision, drug and disability claims.

Since its first installation in 1982, CAS II has been sold to 23 employers.

Facts Services Inc., formerly called C.G. Data Corp., offers FACTS Claims to employers for an average cost of \$80,000. Since the first installation in 1982, the vendor has sold the system to 38 employers to administer their health, dental, vision, drug and disability claims.

Facts Services Inc. sells the system and hardware bundled, offering mainframe, minicomputer or personal computer options depending on the client's needs.

Mr. Graham said the majority of his clients are third-party administrators; only 40% are employers.

SW Systems offers a health claims administration system, ClaimsWork, that administers health, dental, vision and prescription drug claims and runs on mainframe, minicomputers or personal computers.

The system, which sells for approximately \$80,000, has been purchased by 18 employers since the company began marketing the system in 1980.

Mr. Whitmore said some employers that are too small to justify

self-administering all of their group health care claims, still can justify the cost of self-administering dental plans.

"The important thing is that you have access to the data," Mr. Whitmore said, pointing out that when employers have control over their own information and reporting, they can more effectively pinpoint ways to cut costs.

California Interactive Computing Inc. of Northridge, Calif., offers GenMed, formerly called DiMed, a health claims administration system that sells for approximately \$200,000, including

software, hardware and services.

The system, which runs on mainframe, minicomputers or personal computers, has been purchased by 14 employers since its first installation in 1980.

"Whether it runs on a PC or a mini makes no difference, except you have to recognize the capacity" of a system to handle an employer's claims activity, said Al Erickson, marketing/communications director at CIC.

Jerry Buckley, the firm's president, agreed, emphasizing that customers should be able to buy software first and then buy hard-

ware that meets their needs and will continue to meet their needs.

"If you buy hardware-dependent software and you grow out of capacity, you've got to buy new hardware and software," he cautioned.

Adaptability also has been the motivation behind enhancements to New York-based Erisco Inc.'s ClaimFacts health care claims administration system, according to Bruce Kaurane, senior director of health management systems at Erisco, a unit of Dun & Bradstreet Corp.

Continued on next page

## 1988 Results **RLI** Even Stronger

### Consolidated Statutory Financial Information

#### RLI Insurance Company and Mt. Hawley Insurance Company

##### STATUTORY SURPLUS (000 Omitted)

1983	— \$12,238
1984	— \$16,739
1985	— \$37,037
1986	— \$53,063
1987	— \$57,243
1988	— \$60,024

##### COMBINED RATIO

1983	— 94.9
1984	— 97.0
1985	— 99.7
1986	— 84.1
1987	— 84.2
1988	— 97.1

5 YEAR  
COMBINED RATIO: 90.8  
(1984-1988)

##### ASSETS (000 Omitted)

1983	— \$ 35,156
1984	— \$ 48,719
1985	— \$105,993
1986	— \$159,568
1987	— \$168,859
1988	— \$176,876

##### LOSS RESERVES (000 Omitted)

1983	— \$ 4,985
1984	— \$ 9,150
1985	— \$22,784
1986	— \$46,243
1987	— \$59,712
1988	— \$71,091

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# Directory of benefit system vendors

## A

### Advanced System Applications Inc.

1 ASA Plaza, P.O. Box 385, Bloomington, Ill. 60108; 312-893-9055

**Year founded:** 1977.

#### Software products:

• **ASA/CAS II Claims Administration System:** Unbundled hardware and software; mainframe; year of first installation, 1982; 30 total installations, 23 in employee benefit departments; functions include health claims administration, multiple claim edits, benefit payment calculation, dental claim

processing; generates correspondence; can be used to administer claims under COBRA.

• **ASA/CAPS Claims Administration and Payment System:** Unbundled hardware and software; mainframe; year of first installation, 1978; 41 total installations, one in an employee benefit department; functions include administration and adjudication of claims covered under medical, dental and vision plans; administers cost containment programs, including pre-certification, second surgical opinion, concurrent review and PPO programs.

• **ASA/CAPSule Health Claims Reporting System:** Unbundled hardware and software; mainframe; year of first installation, 1983; 18 total installations, one in

an employee benefit department; functions include group health claims reporting, including client, cost containment and management reports.

**Staff:** 690 total staff members, 575 professional staff members.

**Clients:** Nine total clients, three employee benefit department clients.

**User support:** User groups and meetings, telephone assistance available 15 hours per day, client newsletter, user advisory board.

**1988 gross revenues:** \$48.7 million total; \$3.1 million from employee benefit information systems; 31% from sale of software, 69% from services.

**Branch offices:** Atlanta; Marina del Rey, Calif.

**Principal officers:** John W

Blaney, chairman/chief executive officer; William J. Beurin, executive vp/chief financial officer; Robert Hoyt, vp-research/development; K. Michael Allen, vp-sales/marketing; Lee Zausner, senior vp-operations.

### The Alexander Consulting Group Inc.

125 Chubb Ave., Lyndhurst, N.J. 07071; 201-460-6600

**Year founded:** 1898 (parent company).

**Parent company:** Alexander & Alexander Services Inc.

#### Software products:

• **Flexible Spending Account Management System:** \$10,000; unbundled hardware and software; personal computer; first installa-

tion, 1988; one total installation in an employee benefit department; system maintains records of employee and employer contributions to flexible spending accounts; records nature and amount of reimbursement requests; generates checks, management reports and explanations of benefits; can be used to communicate benefits to employees.

• **COBRA Compliance Software 2.1:** \$1,595; unbundled hardware and software; personal computer; first installation, 1986; 600 total installations; 500 employee benefit department installations; system is used to administer claims under COBRA and can be used to communicate benefits to employees.

• **First Resource:** \$11,600; un-

*Continued on next page*

## Vendors

*Continued from previous page*

"We've had to make ClaimFacts capture more information, do more with it and identify trends through claims experience" so employers can pinpoint what cost containment methods will work best for them, Mr. Kaurene said.

The system, first installed in 1980, runs on a mainframe or minicomputer and administers medical, dental and disability plans.

The price of the system varies, depending on the type software and hardware purchased.

The upgraded version of ClaimFacts includes an expanded claims record to handle more information from providers regarding what procedures were performed.

"We used to only have six lines of service data, now we have 18 lines," Mr. Kaurene explained.

Other vendors also offer "multiple options systems" that administer claims from a full range of health care providers, focusing on provider reimbursement and various levels of managed care.

Erisco also has designed modules to enhance ClaimFact's alternative provider processing capabilities. For approximately \$100,000, employers can add a "triple option" module that responds to various contracts employers have with health care providers.

For example, when an employer offers employees a choice in providers, for instance an HMO, PPO or private physician, at various reimbursement rates, the system automatically adjudicates the claim with the appropriate payment.

Another enhancement Erisco is offering is a batch adjudication module, which sells for \$75,000.

Mr. Kaurene said Erisco's batch processing module most likely would be used by large employers or TPAs for high volume, low-cost claims, primarily so claims personnel can be free to pursue more complicated cases.

The system takes billing information from a computer tape, loads it into the claims administration system and kicks out a check and an explanation of benefits.

"It's just like the old way, only there is no claims person and no paper—you still get the same output," Mr. Kaurene explained.

If the system denies a claim, a report is generated to show why.

Many employers are requesting such "batch processing" capabilities from their EBIS vendors.

Renee Baderman, director-claims/administration at Ryder Systems Inc. in Miami, chose ClaimFacts to process health claims for the company's 100,000 covered individuals. "In the future there has to be more in the way of batch processing so you can bypass the claims processor inputting a claim that has a known consequence," she said.



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*Continued from previous page*  
bundled hardware and software; personal computer; first installation, 1984; more than 300 employee benefit department installations; system processes information on employee benefit plans and personnel and can be used to administer claims under COBRA; can be used to communicate benefits to employees.

**Staff:** 1,800 total staff members, 956 professional staff members.

**Clients:** More than 500 software clients.

**User support:** User groups and meetings, telephone assistance available eight hours per day, classroom training and consulting.

**1988 gross revenues:** \$160 million total.

**Branch offices:** 50 offices in the United States.

**Principal officers:** A. M. D'Alessandro, chairman/chief executive officer; C. Douglas Preston, president/chief operating officer; Donald Cleveland, president/chief executive officer-Alexander & Alexander Benefits Services Inc.

**ALTA Health Strategies Inc.**

2610 Decker Lane, Salt Lake City, Utah 84119; 801-973-7300

**Year founded:** 1960.

**Software products:**

• ACT/Flex: \$500,000; unbundled hardware and software; mainframe; year of first installation, 1980; two total installations; system administers medical, dental, flexible benefits and utilization review programs.

• PC COBRA: \$2,500; unbundled hardware and software; personal computer; year of first installation, 1986; 320 total installations, all in employee benefit departments; system administers claims under COBRA.

**Staff:** 1,193 total staff members, 350 professional staff members.

**Clients:** 31 total software clients.

**User support:** User groups and meetings, telephone assistance available nine hours per day.

**1988 gross revenues:** Not reported.

**Branch offices:** Albuquerque, N.M.; Atlanta; Baltimore; Boise, Idaho; Boston; Dallas; Denver; Houston; Milwaukee; Philadelphia; Phoenix and Tucson, Ariz.; Princeton, N.J.; San Francisco and Santa Ana, Calif.; St. Louis.

**Principal officers:** W. Terry Nofsinger, president; Robert Shomer and Keith Kinghorn, executive vps; Lane Summerhays, se-

nior vp-finance; Dennis Burge, senior vp-administration; Carvel Whiting, senior vp-information systems/services; Peter O'Donnell, senior vp-national accounts; Carole Kennedy, senior vp-managed care operation.

**Apex Data Systems Inc.**

6464 E. Grant Road, Tucson, Ariz. 85715; 602-298-1991

**Year founded:** 1977.

**Software products:**

• Cognac \* Plus: \$7,500-\$25,000; unbundled hardware and software; personal computer; year of first installation, 1988; 20 total installations, five in employee benefit departments; system adjudicates health claims including flexible benefit and cafeteria plans, verifies eligibility, generates letters, analyzes cost containment methods, administers claims under

COBRA, generates management reports; can be used to communicate benefits to employees.

**Staff:** Eight total staff members, four professional staff members.

**Clients:** Two total clients.

**User support:** Telephone assistance available nine hours per day, on-site support available.

**1988 gross revenues:** Not reported.

**Principal officers:** Dwight Babcock, president.

**Armada Software Inc.**

13017 Artesia, Suite D234, Cerritos, Calif. 90701; 213-926-0553

**Year founded:** 1984.

**Software products:**

• RVS-Industrial Medical Bill Review: \$15,000 and up; unbundled hardware and software; mini-computer or personal computer;

year of first installation, 1984; 12 total installations, one in an employee benefit department; functions include medical bill review.

• Medical Claims Manager: \$28,000 and up; unbundled hardware and software; minicomputer or personal computer; year of first installation, 1984; two total installations, one in an employee benefit department; functions include medical cost reviews; can be used to communicate benefits to employees.

**Staff:** Five total staff members, all professionals.

**Clients:** Three total clients.

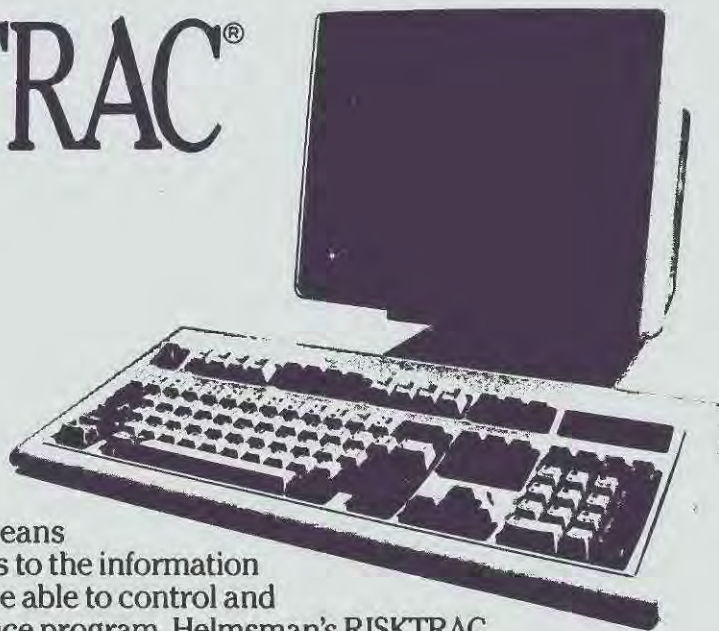
**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** More than \$110,000 total; 100% from sale of software.

**Principal officers:** C. Arndt, B. Stein and Dave Watford.

*Continued on next page*

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## How to use directory

The directory of employee benefit information systems lists companies that produce and supply proprietary software products to employee benefits personnel in response to their information system needs.

Companies that produce and supply software products used to communicate benefit programs to employees are also included.

Each listing begins with the year the company was founded and its parent company, if any.

Information on software products follows. Included are the average completely installed price, whether the software and hardware are bundled or unbundled, the type of hardware needed (mainframe, minicomputer or personal computer), the year of the first installation, the total number of installations to date, the number of installations to date in corporate employee benefit departments and the functions the product performs (including whether the product can be used to communicate benefit programs to employees and whether it is capable of administering claims under the Consolidated Omnibus Budget Reconciliation Act of 1985).

Information on staff, clients who purchased software systems in 1988, continued user support, locations of branch offices and 1988 gross revenues follows. Names and title of principal officers complete the listing.

The directory is published as an editorial service; there is no charge for companies to be included. However, to be listed companies were required to complete a questionnaire provided by Business Insurance.

Although every effort is made to publish complete and accurate information, Business Insurance is unable to verify the data supplied by vendors.

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**B**

**BASI (Business Administration Services Inc.)**

16 Knight St., Norwalk, Conn. 06851; 203-853-6584

**Year founded:** 1984.  
**Software products:**

- BASI The Administrator: \$8,000; unbundled hardware and software; personal computer; year of first installation, 1985; 100 total installations, approximately 65 in employee benefit departments; system administrators defined contribution plans; can be used to communicate benefits to employees.

- BASI The Legal Administrator: \$10,000; unbundled hardware and software; personal computer;

year of first installation, 1987; 12 total installations; system administrators defined contribution plans for law firms; can be used to communicate benefit plans to employees.

**Staff:** 12 total staff members, 10 professional staff members.

**Clients:** Eight total clients.

**User support:** Telephone assistance available nine hours per day, on-site training and support, programming and system modification.

**1988 gross revenues:** Not reported.

**Principal officers:** Burton Stevens, president; Gary Oberst, vp.

**Benefit Concepts Systems Inc.**

396 Wampanoag Trail, East Providence, R.I. 02915; 401-438-7100

**Year founded:** 1986.

**Software products:**

- BCMS-Benefit Continuation Management System: \$1,995; unbundled hardware and software; personal computer; year of first installation, 1986; 200 total installations, 190 in employee benefit departments; functions include administration of claims under COBRA, including compliance, tracking and billing.

- RAMS-Reimbursement Account Management System: \$2,995; unbundled hardware and software; personal computer; year of first installation, 1987; 35 total installations, 25 in employee benefit departments; functions include administration and enrollment for flexible spending accounts; can be used to communicate benefits to employees.

- FBMS-Flexible Benefit Management System: \$7,495; unbundled hardware and software; personal computer; year of first installation, 1988; four total in-

stallations, all in employee benefit departments; functions include administration and enrollment for flexible benefit plans and flexible spending accounts; can be used to communicate benefits to employees.

**Staff:** 15 total staff members, six professional staff members.

**Clients:** 94 total clients; 80 employee benefit department clients; 10% with gross revenues less than \$200 million, 50% with \$200 million-\$500 million, 30% with \$500 million-\$1 billion, 10% with \$1 billion-\$3.5 billion.

**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** 90% from sale of software, 10% from services.

**Principal officers:** John W. Hoder, president; F. Jay Hoder III, vp.

**Benefit Plan Systems Corp.**

15012 Redhill Ave., Suite H, Tustin, Calif. 92680-6525; 714-259-1552

**Year founded:** 1986.

**Software products:**

- COBRA EAS: \$1,595; unbundled hardware and software; personal computer; year of first installation, 1987; functions include administration of claims under COBRA.

- COBRA EAS NON COBRA: \$995; unbundled hardware and software; personal computer; system includes billing and accounting functions for non-COBRA retirees, performs rate calculations based upon variables.

- COBRA EAS Administrator: \$9,995; unbundled hardware and software; personal computer; year of first installation, 1987; approximately 50 total installations; functions include COBRA administration, claim eligibility and account billing.

**Staff:** 18 total staff members, seven professional staff members.

**Clients:** Approximately 400 total clients.

**User support:** Telephone assistance available eight hours per day, 90 days initial support with extended support available, updates, on-site training.

**1988 gross revenues:** Not reported; 80% from sale of software, 20% from services.

**Principal officers:** Leonard B. Wierzba, president; Rea Kennedy, vp/corporate secretary.

**BeneSoft Inc.**

P.O. Box 3530, Bethany, Conn. 06525; 203-393-0320

**Year founded:** 1982.

**Software products:**

- BeneSoft's FlexibleSoftware: \$10,000 per year and up; unbundled hardware and software; personal computer; year of first installation, 1987; 29 total installations, 27 in employee benefit departments; functions include flexible benefits administration and enrollment, eligibility reporting, premium calculations, payroll interface, COBRA administration, Section 89 compliance; can be used to communicate benefit programs to employees.

**Staff:** Nine total staff members, seven professional staff members.

**Clients:** 35 total clients; 33 employee benefit department clients; 30% with gross revenues less than \$200 million, 50% with \$200 million-\$500 million, 20% with \$500 million-\$1 billion.

**User support:** User groups and meetings, telephone assistance available 24 hours per day, off-site training, implementation support and consulting.

**1988 gross revenues:** Not reported, 100% from sale of software.

**Principal officers:** F.A. Saleh, president.

**Buck Consultants Inc.**

2 Pennsylvania Plaza, New York, N.Y. 10121; 212-330-1000

**Year founded:** 1916.

**Software products:**

- Bucks Social Security: Unbundled hardware and software; mainframe and personal computer; year of first installation, 1978; system calculates Social Security benefits.

- BENCAL: Unbundled hardware and software; mainframe and personal computer; year of first installation, 1970; system calculates retirement benefits under defined benefit plans; can be used to communicate benefits to employees.

- LOANS PLUS: Unbundled hardware and software; mainframe; year of first installation, 1984; functions include loan administration for defined contribution plans.

Continued on next page

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Continued from previous page

• **Recordkeeping Plus:** Unbundled hardware and software; mainframe; year of first installation, 1987; functions include recordkeeping and reporting for defined contribution plans.

• **IDP:** Unbundled hardware and software; available on a time-sharing basis; year of first installation, 1970; functions include manipulation and editing of benefits data.

• **ACTVAL:** Unbundled hardware and software; available on a time-sharing basis; year of first installation, 1970; functions include actuarial valuation of defined benefit plans.

• **Buck Tax Exclusion:** \$1,200; unbundled hardware and software; personal computer; year of first installation, 1987; system determines taxable and non-taxable portions of pension payments under Internal Revenue Code Section 72, determines annuity variations, generates reports; can be used to communicate benefits to employees.

• **Buck Section 89:** Unbundled hardware and software; mainframe and personal computer; year of first installation, 1989; system performs discrimination testing of employee welfare plans in accordance with Section 89, performs collection review and maintenance of data used in testing; can be used to communicate benefits to employees.

**Staff:** 1,150 total staff members, 860 professional staff members.

**Clients:** Not reported.

**User support:** Telephone assistance available during business hours.

**1988 gross revenues:** \$109 million total.

**Branch offices:** Boston; Columbia, Md.; Detroit; Dallas; Houston; San Francisco; Los Angeles; Atlanta; Chicago; Denver; Fort Wayne, Ind.; Honolulu; Pittsburgh; Secaucus, N.J.; Washington, D.C.; Toronto; London; Brussels, Belgium; Sydney, Australia.

**Principal officers:** William E. Giegerich Jr., president/chief executive officer; John Seltzer, chairman.

**1988 gross revenues:** Not reported.

**Principal officers:** Jerry C. Buckley, president; Ralph Flygare, vp; Dorothy Payne, director.

#### Cantor & Co.

9348 Civic Center Drive, Beverly Hills, Calif. 90210; 213-859-7277; 800-553-7267 outside California

**Year founded:** 1982.

**Software products:**

• **PCMS:** \$9,700; unbundled hardware and software; year of first installation, 1985; 180 total installations; functions include tracking disability benefits and patient care, optional three-dimensional graphics.

• **Riskmap Risk Financing:** \$1,950; unbundled hardware and software; personal computer; year of first installation, 1983; more than 100 total installations; functions include determining benefit

funding mechanisms and budgeting.

• **Riskmap Loss Forecasting:** \$1,500; unbundled hardware and software; personal computer; year of first installation, 1984; more than 20 total installations; functions include forecasting of frequency, severity and total cost of benefit programs.

• **HMO Membership/Claims Management System:** Bundled or unbundled hardware and software; functions include management of membership and claims for HMOs. **Staff:** Five total staff members, four professional staff members.

**Clients:** 350 total clients; 25% with gross revenues less than \$200 million, 60% \$200 million-\$500 million, 10% \$500 million-\$1 billion, 4% \$1 billion-\$3.5 billion, 1% exceeding \$3.5 billion.

**1988 gross revenues:** Not reported.

**Principal officers:** Alan B. Cantor, president.

#### Cascade Technologies Inc.

393 Old Country Road, Suite 201, Carle Place, N.Y. 11514; 516-333-7650

**Year founded:** 1985.

**Software products:**

• **PRO CAS:** Unbundled hardware and software; personal computer; year of first installation, 1986; 120 total installations, 10 in employee benefit departments; functions include defined contribution plan recordkeeping and administration; can be used to communicate benefit programs to employees.

• **CAS Voice:** bundled hardware and software; personal computer; year of first installation, 1989; one total installation in an employee benefit department; system is an interactive voice response and communications system and is used to communicate benefit programs to employees.

**Staff:** 10 total staff members, all

of whom are professionals.

**Clients:** 20 total clients.

**User support:** User groups and meetings, telephone assistance available nine hours per day, documentation, programming.

**1988 gross revenues:** Not reported; 90% from sale of software, 10% from services.

**Principal officers:** Vigdis Austad, president; William E. Colgan, vp-applications, Frank Joicy, vp-technology.

#### Commons

##### Management Group

10420 Little Patuxent, Columbia, Md. 21044; 301-997-9292

**Year founded:** 1981.

**Parent company:** Parkside Health Management Corp.

**Software products:**

• **Caseplex Business System:** \$9,000-\$18,000; unbundled hardware and software; personal com-

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**Spotlight report**

*Continued from previous page*  
puter; year of first installation, 1986; 36 total installations, 25 in employee benefit departments; system analyzes utilization patterns; can be used to communicate benefit programs to employees.

• PRISM: \$5,000-\$15,000; unbundled hardware and software; personal computer; year of first installation, 1987; 12 total installations, six in employee benefit departments; system is designed to aid in the selection of preferred provider organizations; can be used to communicate benefits to employees.

• Caseplex Hospital Systems: \$12,000-\$25,000; unbundled hardware and software; personal computer; year of first installation, 1984; 53 total installations; system provides an analysis of physician practice patterns.

**Staff:** 23 total staff members, 15 professional staff members.

**Clients:** 16 total clients; 50% with gross revenues less than \$200 million, 31.3% \$200 million-\$500 million, 12.3% \$500 million-\$1 billion, 6.3% \$1 billion-\$3.5 billion.

**User support:** Telephone assistance available eight hours per day, on-site consultation.

**1988 gross revenues:** Not reported; 25% from sale of software, 75% from services.

**Branch offices:** Park Ridge, Ill.  
**Principal officers:** Ed Wristen, president.

### Computations Inc./Dyer, Wells & Associates Inc.

2500 Windy Ridge Parkway, Suite 1400, Atlanta, Ga. 30067; 404-952-7854

**Year founded:** 1977.

**Parent company:** Computations Holdings Ltd.

**Software products:**

• Response Plus: \$225,000; bundled hardware and software; minicomputer; year of first installation, 1983; 42 total installations, 11 in employee benefit departments; functions include health claims and flexible benefits administration.

• FASTRAK: \$200,000; unbundled hardware and software; mainframe; year of first installation, 1981; 45 total installations, 20 in employee benefit departments; functions include health claims processing.

• FLEXTRAK: \$150,000; unbundled hardware and software; mainframe; year of first installation, 1987; 13 total installations, seven in employee benefit departments; functions include flexible benefits and COBRA administration; can be used to communicate benefits to employees.

• FASTRAK PC: \$60,000; bundled hardware and software; personal computer; year of first installation, 1987; 15 total installations, 10 in employee benefit departments; functions include health claims processing.

**Staff:** 150 total staff members, 110 professional staff members.

**Clients:** 23 total clients; 15 employee benefit department clients; 40% with gross revenues less than \$200 million, 30% \$200 million-\$500 million, 30% \$500 million-\$1 billion.

**User support:** User groups and meetings, telephone assistance available 24 hours per day, maintenance agreements.

**1988 gross revenues:** \$11.7 million total; \$6.3 million from employee benefit information systems; 5% from sale of hardware, 60% from sale of software, 35% from services.

**Branch offices:** Los Angeles, Chicago, Dallas.

**Principal officers:** Robert Bramston, president; Jay Hillebrand and Ken McKenzie, executive vps; Theresa Tanton, senior vp; Michael Jenkins and Michael Robertson, vps.

### Coopers & Lybrand-Actuarial, Benefits & Compensation Group

400 Renaissance Center, Detroit, Mich. 48243; 313-446-7346

**Year founded:** 1961.

**Parent company:** Coopers & Lybrand.

**Software products:**

• Benefits Information Line: Unbundled hardware and software; minicomputer; year of first installation, 1988; three total installations, all in employee benefit departments; provides generalized and personalized information on employee benefits plans to employees via touch tone telephone.

• Benefactor: \$25,000, plus \$15,000 yearly fee; bundled hardware and software; personal computer; year of first installation, 1989; one installation, in an employee benefit department; system functions as a database to support

defined benefit, defined contribution and welfare plans; can be used to communicate benefit programs to employees.

• COBRATRACKS: \$1,500; unbundled hardware and software; personal computer; year of first installation, 1986; 89 total installations, all in employee benefit departments; system administers group medical plans in accordance with COBRA; can be used to communicate benefit plans to employees.

**Staff:** 838 total staff members, 610 professional staff members.

**Clients:** 14 total software clients.

**User support:** User groups and meetings, telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported.

**Branch offices:** Atlanta; Boston; Chicago; Columbus, Ohio; Dallas; Houston; Los Angeles; Louisville, Ky.; New York, Syra-

cuse and Albany, New York; Philadelphia; Pittsburgh; San Francisco; Stamford and Hartford, Conn.; Newark, N.J.; Minneapolis; Tampa, Fla.; Charlotte, N.C.; Cleveland.

**Principal officers:** Jerome Y. Halperin, vice chairman.

### Corporate Health Strategies

2 Whitney Ave., New Haven, Conn., 06510; 203-759-2989

**Year founded:** 1981.

**Parent company:** Metropolitan Life Insurance Co.

**Software products:**

• FROACT: Unbundled hardware and software; personal computer year of first installation, 1988; 18 total installations, all in employee benefit departments; system provides monthly monitoring of benefit plans.

• CHAF: Unbundled hardware and software; personal computer; year of first installation, 1985; 45

total installations, all in employee benefit departments; system analyzes benefit plan experience.

**Staff:** Approximately 85 total staff members.

**Clients:** 30 total clients, all employee benefit departments.

**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported.

**Branch offices:** Westport, Conn.; Orange, Calif.

**Principal officers:** Leon Hyman, president; Dennis Dang, chairman.

### Cyborg Systems Inc.

2 N. Riverside Plaza, 12th floor, Chicago, Ill. 60606; 312-454-1865

**Year founded:** 1974.

**Software products:**

• The Solution Series: Unbundled hardware and software;  
*Continued on next page*



Continued from previous page

mainframe or minicomputer; year of first installation, 1974; system provides tracking of Section 89, COBRA, 401(k) plans, pension plans, profit sharing, thrift and savings plans.

**Staff:** 138 total staff members.

**Clients:** 70 total clients.

**User support:** User groups and meetings, telephone assistance available 24 hours per day, on-line documentation, consulting, training.

**1988 gross revenues:** \$14.5 million total; \$7 million from employee benefit information systems; 63% from sale of software, 37% from services.

**Branch offices:** Darien, Conn., Atlanta; Newport Beach, Calif.

**Principal officers:** Michael Blair, president; James Pierce, executive vp; John Kluska, vp-product/service; John McBlain, vp-finance; Gary Tarr, vp-sales.

## D

### Data Management Ventures Inc.

P.O. Box 724258, Atlanta, Ga. 30339; 404-438-9193

**Year founded:** 1985.

**Software products:**

• **FEE FACTS:** \$1,590 annually; unbundled hardware and software; mainframe or personal computer; year of first installation, 1986; more than 200 total installations, 10 in employee benefit departments; system functions as a health, personal injury, workers compensation and cost containment claim reference service.

**Staff:** Five total staff members, three professional staff members.

**Clients:** 100 total clients; 10 employee benefit department clients.

**User support:** Telephone assis-

tance available eight hours per day.

**1988 gross revenues:** Not reported; 10% from sale of software, 90% from services.

**Principal officers:** Richard E. Olson, president.

### Digital Insurance Systems Corp.

1560 Fishinger Road, Columbus, Ohio 43221; 614-457-8336

**Year founded:** 1986.

**Software products:**

• **HCPS:** Unbundled hardware and software; mainframe and mini computer; year of first installation, 1983; 20 total installations; system administers medical, dental, prescription drug and vision plans; can be used to administer claims under COBRA.

**Staff:** 35 total staff members, 30 professional staff members.

**Clients:** Not reported.

**User support:** User groups and

meetings, telephone assistance available nine hours per day, assistance available via modem or on-site.

**1988 gross revenues:** Not reported; 70% from sale of software, 30% from services.

**Principal officers:** Donald Demers, president; Robert Fountain, executive vp; Curg Shields and Frank Reilly, vps.

## E

### EBG & Associates Inc.

70 E. Lake St., Suite 1400, Chicago, Ill. 60601; 312-580-2250

**Year founded:** 1978.

**Software products:**

• **PensionMaker DB:** Unbundled hardware and software; personal computer; year of first installation,

1979; 100 total installations; system is a pension proposal and valuation system; can be used to communicate benefits to employees.

• **PensionMaker DB-Xtra:** Unbundled hardware and software; personal computer; year of first installation, 1986; 20 total installations; functions include calculation of ancillary benefits, FASB 87 compliance, report generation; can be used to communicate benefits to employees.

• **PensionMaker DC:** Unbundled hardware and software; personal computer; year of first installation, 1979; 100 total installations; system is a proposal and valuation system for profit sharing, 401(k) and thrift plans; can be used to communicate benefit plans to employees.

• **PensionMaker DC-100:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1984; 150 total installations; functions include administration of 401(k) plans, employee stock ownership and defined contribution plans; can be used to communicate benefits to employees.

• **Pension Tax:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1986; 50 total installations; functions include assisting in government filing requirements for pension plans, generation of tax forms.

• **Herbie:** Bundled unbundled hardware and software; personal computer; year of first installation, 1988; system interacts with employees to provide earning projections from their retirement plans.

• **System 89/125:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1989; functions include Section 89 and Section 125 data collection and compliance monitoring.

• **COACH:** Unbundled hardware and software; personal computer; year of first installation, 1989; system functions as a tutorial, reference library and guide to individual plan compliance.

**Staff:** 28 total staff members.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available 10 hours per day, electronic bulletin board, newsletter.

**1988 gross revenues:** Not reported.

**Principal officers:** Emmanuel B. Garcia Jr., president; Dee L. Holt, vp.

### Eastern Benefit Software Inc.

200 Freeway Drive E., East Orange, N.J. 07018; 201-676-3333

**Year founded:** 1983.

**Parent company:** Centennial Financial Group Inc.

**Software products:**

• **Claim/Net:** \$30,000; bundled or unbundled hardware and software; personal computer; year of first installation, 1983; eight total installations, two in employee benefit departments; system is designed to adjudicate claims.

• **Flex/Net:** \$15,000; bundled or unbundled hardware and software; personal computer; year of first installation, 1985; four total installations, two in employee benefit departments; functions as a flexible spending account claims processing system.

**Staff:** Five total staff members, four professional staff members.

**Clients:** Two total clients.

**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported.

**Principal officers:** William Vogel, chief executive officer; Antonio T. Lim, president.

Continued on next page

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**Erisco**

1700 Broadway, New York, N.Y.  
10019; 212-765-8500

**Year founded:** 1968.

**Parent company:** Dun & Bradstreet Corp.

**Software products:**

• **ClaimFacts:** Bundled or unbundled hardware and software; mid-range computer or mainframe; year of first installation, 1930; 131 total installations, 56 in employee benefit departments; system functions as a health claims management system for the administration

of medical, dental, disability and triple option plans.

• **CertiFacts:** Bundled or unbundled hardware and software; mid-range computer or mainframe; year of first installation, 1986; 13 total installations, one in an employee benefit department; functions as a utilization review system for the administration of pre-admission certification, concurrent stay review and discharge planning; can be used to communicate benefits to employees.

• **ImpleFacts:** Bundled or unbundled hardware and software; mid-range computer or mainframe; year of first installation, 1972; 200

total installations, 190 in employee benefit departments; functions as a recordkeeping system designed to manage defined contribution plans including 401(k), profit sharing, employee stock ownership and savings plans; can be used to communicate benefits to employees.

• **GroupFacts:** Bundled or unbundled hardware and software; mid-range computer or mainframe; year of first installation, 1985; 32 total installations; functions as an administrative system for group life and health insurance, remittance processing, policyholder administration and experience reporting.

**Staff:** 250 total staff members, 225 professional staff members.

**Clients:** 35 total clients.

**User support:** User groups and meetings, telephone assistance available 24 hours per day, client training, consulting and documentation.

**1988 gross revenues:** Not reported; 30% from sale of software, 70% from services.

**Principal officers:** Thomas Barrea, chairman; Patrick D'Amato, vice chairman; Anthony Fiumefreddo, senior vp-operations; Anthony Bellomo, senior vp-products; Jeff Sauerhoff, chief financial officer; Louis D'Andrilli, vp-sales/marketing.

**F****FLX Corp.**

1523 McDaniel Drive, West Chester, Pa. 19380; 215-696-6600

**Year founded:** 1985.

**Software products:**

• **FLX Recordkeeper Series II:** \$20,000; unbundled hardware and software; personal computer; year of first installation, 1985; more than 50 total installations, more than 25 in employee benefit departments; functions include flexible benefits and flexible spending account administration; can be used to communicate benefit programs to employees.

• **FLX Discriminator:** unbundled hardware and software; personal computer; year of first installation, 1989; functions include Section 89 compliance.

• **FLX COBRA:** unbundled hardware and software; personal computer; year of first installation, 1989; functions include COBRA compliance.

**Staff:** Six total staff members who are professionals.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available nine hours per day, modem support.

**1988 gross revenues:** Not reported, 100% from sale of software.

**Principal officers:** Ed Hughes, president; Karen Fitting, director-marketing.

**Facts Services Inc.**

1575 San Ignacio, Penthouse,  
Coral Gables, Fla. 33146;  
305-284-7400

**Year founded:** 1989 (Facts Services Inc. purchased all software rights from C.G. Data Corp. in 1988 and began operations in 1989).

**Software products:**

• **Facts Claims:** \$80,000; Bundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1982; 80 total installations; functions include administration of health claims, billing, claims payment and reporting; can be used to administer claims under COBRA; can be used to communicate benefits to employees.

• **Facts 125:** \$10,000; Bundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1987; 33 total installations; functions include administration of cafeteria plans; can administer claims under COBRA; can be used to communicate benefits to employees.

**Staff:** 38 total staff members.

**User support:** User groups and meetings, telephone assistance available nine hours per day.

**Principal officers:** Robert S. Graham Jr., president.

**Fell Business Systems Inc.**

P.O. Box 159, Winnetka, Ill. 60093;  
312-441-5577

**Year founded:** 1984.

**Software products:**

• **Medical Benefits:** \$500; unbundled hardware and software; personal computer; year of first installation, 1988; one total installation, in an employee benefit department; system processes and issues checks to employees and dependents, checks against deductibles, copayments and coinsurance.

**Staff:** One staff member.

**Clients:** One client with gross revenues less than \$200 million.

**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported, 100% from sale of software.

**Principal officers:** Joe Fell.

*Continued on next page*

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Continued from previous page

G

**Genelco Inc.**1600 S. Brentwood Blvd., Suite 500,  
St. Louis, Mo. 63144; 314-962-2040**Year founded:** 1973.**Parent company:** General American Life Insurance Co.**Software products:**

- Health Benefit Management System: Bundled or unbundled hardware and software; minicomputer; year of first installation, 1985; system provides adjudication and administration of medical, disability, dental, vision and prescription drug claims, including data collection and reporting.

- Benefit Administration & Reporting System: Bundled or unbundled hardware and software; minicomputer; year of first installation, 1987; functions include administration of individual and group insurance plans, billing and collection functions, eligibility information for medical claims administration, overpayment tracking, multiple rating options, reporting.

**Staff:** 156 total staff members, 29 professional staff members assigned software services.**Clients:** Not reported; 25% with gross revenues less than \$200 million, 25% with \$500 million-\$1 billion, 50% with \$1 billion-\$3.5 billion.**User support:** Telephone assistance available nine hours per day, maintenance agreements, on-site training.**1988 gross revenues:** \$12.7 million total; \$7.4 million from employee benefit information systems; 6% from sale of hardware, 64% from sale of software, 30% from services.**Principal officers:** David B. Johnson, president; Russell E. Korte, executive vp/treasurer; Ben C. Allen Jr., senior vp; Larry M. Amundsen, vp-software systems sales/marketing.**Genesys Software Systems Inc.**5 Branch St., Methuen, Mass.  
01844; 508-685-5400**Year founded:** 1981.**Software products:**

- Flexible Benefits: \$150,000; unbundled hardware and software; mainframe; year of first installation, 1988; four total installations; system administers flexible benefit plans; can be used to communicate benefits to employees and to administer claims under COBRA.

- Defined Benefits: \$150,000; unbundled hardware and software; mainframe; year of first installation, 1987; 44 total installations; system administers pension plans; can be used to communicate benefit programs to employees and to administer claims under COBRA.

- Defined Contributions: \$150,000; unbundled hardware and software; mainframe; year of first installation, 1986; 62 total installations; system administers 401(k) plans; can be used to communicate benefits to employees and to administer claims under COBRA.

**Staff:** 150 total staff members, 120 professional staff members.**Clients:** 30 total clients, all benefit departments; 10% with gross revenues less than \$200 million, 25% with \$200 million-\$500 million, 25% with \$500 million-\$1 billion, 25% with \$1 billion-\$3.5 billion, 15% with more than \$3.5 billion.**User support:** User groups and meetings, telephone assistance available 24 hours per day, annual users' conference, maintenance, consulting, data center for clients, disaster recovery programs, client training.**1988 gross revenues:** Not reported.**Branch offices:** Atlanta; Dallas; Chicago; Long Beach, Calif.; Hackensack, N.J.**Principal officers:** Lawrence J. Munini, president; Robert R. Pomerleau, senior vp-finance/treasurer; Linda M. Koski, vp/corporate clerk.

H

**John Hancock Financial Services**P.O. Box 111, Boston, Mass. 02117;  
617-421-6000**Year founded:** 1862 (parent company).**Parent company:** John Hancock Mutual Life Insurance Co.**Software products:**

- ICAs: Unbundled hardware

and software; personal computer; year of first installation, 1987; functions include analysis of medical claims experience.

- Star-View: Unbundled hardware and software; personal computer; year of first installation, 1986; 18 installations, all in employee benefit departments; functions include providing benefit information to employees.

**Staff:** 16 total staff members, 10 professional staff members.**Clients:** Not reported.**User support:** Telephone assistance, electronic mail communication.**1988 gross revenues:** Not reported.**Branch offices:** Detroit and Kalamazoo, Mich.; Cleveland and Columbus, Ohio; Indianapolis; Rochester and New York N.Y.; Philadelphia and Wayne, Pa.; Manchester, N.H. Washington, D.C.; Chicago Milwaukee Minneapolis. Atlanta Dallas; Houston;

Greensboro, N.C.; Fort Lauderdale, Fla.; Nashville, Tenn.; San Francisco and Los Angeles.

**Contact:** Susan Dayno, director-client consulting; Alex Malcolm, director-strategic systems.**Hartzler Enterprises**9525 Georgia Ave., Suite 206,  
Silver Spring, Md. 20910;  
301-589-3372**Year founded:** 1985.**Software products:**

- Health & Welfare Claims Processing: \$15,000; unbundled hardware and software; personal computer; year of first installation, 1982; one installation in an employee benefit department; functions include health claims processing.

**Staff:** Three total staff members, two professional staff members.**Clients:** One employee benefit department client with gross revenues less than \$200 million.**User support:** Telephone assistance.**1988 gross revenues:** \$146,000 total.**Principal officers:** Gary J. Hartzler, partner.**Hay/Huggins Co. Inc.**229 S. 18th St., Philadelphia, Pa.  
19103; 215-875-2569**Year founded:** 1911.**Parent company:** Saatchi & Saatchi P.L.C.**Software products:**

- Pension Valuation Language (PVL): \$25,000; unbundled hardware and software; available on a time-sharing basis; year of first installation, 1980; 24 total installations, 20 in employee benefit departments; functions include funding and expense calculation for defined benefit plans, gain and loss analysis and projections.

- Pension Individual Calcula

Continued on page 52

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# A difficult balance

## Drug tests weigh employee privacy against safety issues

By Richard D. Alaniz

**SUBSTANCE ABUSE**—the “misuse” of drugs—is one of the most talked about problems of our time. Drugs, their harmful effect on individuals, organizations, nations and on humanity, in general, is a subject of worldwide concern.

A major obstacle to U.S. efforts to successfully wage war on illegal drug use is the conflict created when individual rights clash with society's rights. And nowhere is this conflict more evident than in the workplace.

Screening for drug use has become a leading employment issue and many companies have implemented or are considering implementing drug testing programs. Yet controversy abounds. There are concerns regarding the accuracy of tests, applicable laws and liabilities, and the desirability of testing for drugs itself.

Since drug testing is rather new to the workplace, concerns like these have yet to be conclusively resolved by the courts. These concerns are worth examining.

In an attempt to create a drug-free working environment, increasing numbers of employers are turning to medical tests as a means of detecting and preventing substance abuse in the workplace. In 1982, fewer than 5% of the nation's largest firms tested employees for drug abuse. By June 1988, a Gallup Poll revealed that the percentage had risen to around 30%—nearly a six-fold increase.

This rapid increase should come as no surprise. Employers, after all, have a lot at stake. The success of their businesses in large part depends upon the capabilities of their workers.

Studies indicate that employees who abuse drugs have more work-related injuries and file five times

more workers compensation claims than non-abusers. And, though estimates vary, it is generally accepted that substance abuse accounts for upwards of \$110 billion in lost productivity per year.

Additionally, it has been estimated that 20% of workers age 20 to 40 used illicit drugs during 1988. Furthermore, the National Institute on Drug Abuse reports that approximately two-thirds of individuals entering the workforce have used illegal drugs at least once.

But, instituting a drug-testing program is fraught with peril for employers.

The law on drug testing in the private sector is still in its formative stages and employers face a host of common law and statutory limitations on blood and urine testing, the most commonly used testing methods. Critics of drug testing programs have challenged these tests, claiming they violate an individual's right to privacy.

How do they violate an individual's rights? It would take several pages to list all the reasons that have been cited, but major ones include:

- The tests are intrusive and embarrassing to employees.
- The tests can't indicate when drugs were ingested, thus they can't prove an employee was impaired while working.
- Indiscriminately administered, the tests violate the principle of “probable cause.”
- The tests invite inaccurate readings or mislabeling of samples—mistakes that can cost an employee his job and irrevocably damage his reputation.

Employers with unionized employees face additional hazards in implementing drug-testing programs. Unions may file an unfair labor practice

complaint with the National Labor Relations Board claiming the employer failed to bargain in good faith before beginning the program. Unions may also file a grievance challenging a particular employee's drug-related discharge, or a grievance claiming that the entire program is unreasonable.

Under present circumstances, providing a drug-free environment for employees is an extremely difficult task for employers. The question remains: How can employers implement and administer a drug-testing program without jeopardizing themselves?

Here are some guidelines they can follow:

- Thoroughly investigate the importance of a drug-testing program in your workplace. Be certain the program will benefit your organization. Courts and juries can more easily understand the necessity of detecting substance abuse among employees involved with public safety and dangerous jobs.

If you do decide to implement a testing program, require uniform testing of *all* employees, including executives. This practice will promote a higher degree of acceptance among your workers. Plus, drug-testing programs that include management are viewed more favorably by courts and juries.

*Continued on next page*

*Richard D. Alaniz is a partner in the Houston law firm of Alaniz & Schraeder, which represents management in all areas of labor relations, including union matters, discrimination claims and workplace disputes. This article is meant to provide general information, not specific legal advice. Individual circumstances may limit or modify this information.*



# Disability benefit abuse abounds

By Richard H. Wille

**A BURGLAR ENTERS** your office in the dead of the night and steals equipment valued at thousands of dollars. That's theft and you demand action.

A highway bandit stops a truck and takes \$500,000 in cargo. That's hijacking and you contact law enforcement officers to take immediate action.

A trusted employee diverts corporate funds into a Swiss bank account and sends you a postcard from somewhere in the South Pacific. That's embezzlement and you ask for extradition and retribution.

An underground organization coerces you to pay \$1 million for special protection or else you suffer the consequences. That's extortion and you turn to the authorities.

In each of these instances you take action.

Yet corporations routinely pay \$1 million or more per year in unnecessary disability benefits and no one raises an eyebrow. It's not extortion or hijacking, it's just that disability benefits are not managed effectively. Action is needed!

The grim scenario above is adapted from a speech given by D. Kenneth Mitchell and Donald E. Schray of

### Speaking out

National Industries Rehabilitation Corp. They effectively illustrate what's wrong with employers' approach to managing disability expenses.

Disability has become a big-ticket item. Disability costs are estimated to be approximately \$150 billion a year, up 30% from \$115 billion in 1975. In comparison, health care costs in the United States total about \$450 billion annually and the national defense budget is about \$300 billion a year. Health and defense costs receive tremendous coverage in the press. No one, however, appears to be paying attention to today's disability costs.

While 80% of disability claims present no problems, the other 20% need to be looked into. That 20% can represent 80% of the total cost of disability benefits. Employers can no longer afford to overlook opportunities to examine disability programs to get at the problem claims. Employers and insurers alike face the simple, yet difficult-to-answer question: What can be done to effectively control disability costs while providing fair and meaningful benefits?

In an effort to find some answers to

this question, let's look at some of the key elements of an effective disability plan.

For a start, employers must have a disability plan manual. An updated policy and procedures manual covering disability claims processing is an absolute necessity.

Administrators often do not have accurate and detailed policies and procedures in writing. This can lead to mistakes or overlooked opportunities for savings in disability administration. Any organization handling disability claims—whether the employer or a third party—needs these guidelines.

They should include instructions on how to handle such situations as appeals of claim denials, letters from attorneys, how to follow up on cases in which it is difficult to confirm disability, how to use telephone calls, on-site visits and rehabilitation specialists and dozens of other issues.

But watch your plan language. If the plan document is vague or too broadly worded the employer may wind up paying excessive amounts.

For example, most plans poorly define eligibility requirements for disability benefits and have no

provisions for rehabilitation review or individual federal tax information. If an employer or trustee plan correctly defines disability benefits, few questions will arise and most cases can be handled easily.

Eligibility requirements are basic. Waiting periods should be definitely spelled out in the plan's language (longer waiting periods lead to lower costs). For any plan, the duration of benefits should be clearly indicated and understood.

The plan document should clearly outline all facets of a disability plan, such as entitlement, pre-existing conditions, rehabilitation, job modification, Social Security and fraud.

Let's look at how each of the elements mentioned above play a role in containing disability plan costs:

- Entitlement. To determine disability entitlement, a disability

*Continued on next page*

*Richard H. Wille is executive vp of Thomas L. Jacobs & Associates Inc., a Chicago-based third-party administrator.*



## Employee drug testing

*Continued from previous page*

- Remember, random testing without notice has become a hotly contested issue in the courts. However, mandatory testing—such as associated with annual or pre-employment physicals—is viewed as less intrusive and less arbitrary.

Individualized testing limited to circumstances involving reasonable suspicion of impairment while on the job is most likely to withstand legal challenges.

- Ensure that your written policies on substance abuse clearly state your company's position on drug and alcohol use, including statements that define your company's view of a substance abuse problem.

Your policies should be carefully worded and comprehensive and should state when and how testing will be conducted. They should also identify the penalties to be imposed on employees who test positive.

- Use a certified, experienced testing laboratory to provide the results of your tests. Ensure that the lab provides careful labeling and chain-of-custody procedures. Also ensure that it provides appropriate secondary confirmation tests. Employers that take these steps have a better chance of defending actions against employees who test positive.

- Do not release unconfirmed test results and do not divulge unrelated medical information. This practice will limit the risk of defamation claims against your company.

- Provide voluntary rehabilitation programs as part of your testing policy. Employers that make such programs available—rather than automatically

discharging employees upon first offense—can more easily defend their substance abuse policies.

- Train management personnel, especially first-line supervisors, to detect the presence of drugs and symptoms of intoxication. In addition, train your personnel to document unusual employee behavior, such as frequent absenteeism or tardiness, increased irascibility or conflicts with co-workers, and decreased efficiency. Awareness by management of such behavior should warrant counseling, which often uncovers the cause of the behavior.

Regardless of the guidelines a company establishes for employee drug testing, the risks remain high.

As earlier suggested, the courts are currently divided on the constitutionality of drug-testing programs.

Although most courts have upheld testing conducted for reasons of law enforcement or public safety, some have ruled that drug tests are only justified if there is individualized suspicion of drug use. Thus, even the most carefully considered and constructed testing programs may be subject to harsh judicial review.

Before instituting any drug testing program, an employer should check state and local laws to ensure compliance with applicable statutes. At last count, 13 states had enacted laws regulating drug testing. More states will undoubtedly follow suit as testing becomes more widely accepted.

On the federal level, employers should be aware that alcoholism and drug addiction are protected handicaps under the Federal Rehabilitation Act of 1973. This law applies to employers that have contracts with the federal government, and specifically excludes from protection employees whose "current use of

alcohol or drugs prevents (them) from performing the duties of the job in question or whose employment, by reason of alcohol or drug abuse, will constitute a direct threat to the property or safety of others."

As yet, the duty of employers that contract with the federal government has not been conclusively determined. Many cases are still in litigation, but it appears that federal law requires government contractors to reasonably accommodate employees who voluntarily enter a rehabilitation program.

Since many states also protect employees against discrimination based on handicaps, an employer should evaluate what local accommodations must be made before discharging employees who come forward with their abuse problem.

A good general rule is to follow the accommodation afforded employees under federal law—time off without pay to obtain treatment. Employees who forgo the opportunity or fail to complete treatment are terminated.

In light of the legal debate and controversy still surrounding drug testing programs, there is another step employers should consider. Make your company's drug testing policy an issue of employee rights. The majority of people are non-users; therefore, impress upon your employees that they have a right to work in a safe, drug-free environment. Impress upon them that they, as well as the company, have a lot at stake.

Finally, remember that although drug testing programs—regardless of the care taken with their design and execution—may expose you to legal liabilities, not testing may give rise to greater problems in the future.

## Benefit abuse

*Continued from previous page*

professional must have information ranging from knowledge of the individual's abilities to a complete medical diagnosis.

By definition, total disability entails providing coverage for anyone who becomes totally disabled from his or her job or occupation. Most plans, however, provide coverage for total disability only if an individual is unable to work at "any occupation."

Technically, any occupation must be interpreted as meaning that the individual must be totally disabled for any occupation for which he or she is reasonably qualified. This definition provides protection for both the claimant and the employer.

For example, a truck driver disabled by lower back pain so that he can no longer lift boxes and crates would not be required to take a position as a data processor, even though he could probably perform the physical duties of the job. He might be required, though, to take a job as a dispatcher, a sedentary position for which he probably would be qualified.

In determining entitlement, a complete file with all medical information regarding the claimant must be obtained. Detailed medical questionnaires are quite helpful not only for the disability professional reviewing the claim. Questionnaires also help the claimant's physician understand how objective the process must be to determine disability.

- Medical examinations. Ordering a medical exam requires selecting an objective doctor. Above all, the physician should be board certified in the specialty required for the claimant's examination.

A word of caution, however: If an individual doctor routinely denies or approves cases, that doctor's value in determining disability should be doubted.

When any new individuals enter any type of disability plan, pre-existing conditions must receive attention. In the

past, plans simply accepted anyone.

Today, paying for pre-existing conditions can be very costly in terms of disability and medical benefits.

- Rehabilitation. Rehabilitation involves evaluation of a person's ability to return to work, whether disabled or not. There should be regular follow-up to confirm the degree of disability. If a claimant appears to be recovering, the person handling that case file should know the next appropriate action.

Cases with high potential for rehabilitation should be identified early and work with the individual should begin as soon as possible. It is difficult to handle rehabilitation in cases where the claimant has already been disabled for two or more years. The percentages for individuals older than age 50 returning to work are also very poor. Real opportunities exist, however, if individuals are younger than 50, it appears the individual is motivated to return to work or the medical problem is not of a major magnitude.

Return-to-work programs often are not used effectively. Some progressive companies, however, have developed job modification programs designed to help employees return to work. Federal Express Corp., for example, has developed a program that moves disabled employees to light from heavy work. The company will even go so far as to have the employee fly to another location for work, rather than simply collect disability benefits for being unable to lift bags of mail.

- Social Security benefits. In every disability situation, Social Security benefits should be pursued aggressively. It is in the best interest of the employer, especially in terms of cost savings, to help employees obtain the maximum Social Security benefits possible.

However, if Social Security benefits are denied, the individual's claim of total disability should be open to question.

With proper authorization, Social Security records are available.

- Fraud. Fraud is a big issue. It is

estimated that up to 5% of all disability claims contain an element of fraud or malingering.

A number of indicators can signal a fraudulent claim: Look for documents that are photocopied instead of originals; changes in records; a claim from a new entrant to a plan; a check sent to a post office box or picked up by the claimant; or anyone who is particularly pushy or suggests that an attorney be involved.

There are other potential indicators: A claimant seen by a doctor who has an inappropriate specialty for the stated medical problem; use of a doctor whose name appears on a list of doctors indicted by the federal government for fraud; a vague diagnosis of such things as headaches or stomach pain; or a combination of ailments where there is no definitive totally disabling diagnosis.

On-site interviews with the claimant can be particularly helpful at dispelling or confirming suspicions of fraud. They reflect how an individual's home and surroundings look while the claimant has been totally disabled. It is always interesting to see how much "disabled" people can accomplish once they are no longer at work. A strong, objective medical examination after observation of a claimant who has been very active with household projects will help determine the claimant's abilities.

Investigation of fraud cases often involves the use of surveillance, which requires considerable expertise. Surveillance should only be conducted by professionals experienced with disability cases.

The disability plan administrator also must really understand disability benefits and how to challenge the disability of a claimant using evidence gathered by surveillance. Once a decision has been made to deny a claim, it should be well documented and referred to someone knowledgeable in disability benefits before any actual action is taken.

In view of all of the above information, there are several specific steps that

employers can take to control soaring disability benefit costs:

- An individual or consultant should be assigned the responsibility of coordinating corporate disability programs and policies.

- Internal review boards should be created by the employee benefit department to certify, monitor and evaluate disability cases.

- Disability audits should be developed to assure company management that it is paying for truly disabled employees and not for malingerers who are taking advantage of the disability program.

- Medical examinations and outside vendors experienced in disability management should be used to assist employees' return to work.

- Disability duration guidelines for longer-term disabilities that can be effectively applied by company benefits or medical personnel should be developed and utilized.

- All employees off work for more than seven days should be monitored.

- Local physicians should be informed of the objectives, policies and procedures of a corporate disability program if the employer has a significant employee population in one area.

- Long-term disability plan design changes should include the addition of a mandatory rehabilitation provision, self-insurance and the creation of a disability review panel within the company.

All of the above information illustrates why disability benefits must be managed today—not tomorrow. With approximately 1%-3% of payroll representing long-term disability costs, attention must be focused on their control. Even though 80% of disability costs are not a problem, the other 20% need management attention, using some of the methods and involving some of the approaches detailed in this article.

With the application of proper techniques, the opportunities for disability cost savings are abundant.



# What did you think your first \$200,000 AIDS case would look like?

Some experts predict that by 1991 the U.S. will experience between ten and twenty thousand pediatric AIDS cases alone, with an average of \$200,000 in total medical costs for each child.

For all age groups, the course of the disease varies in almost every case — in diagnosis, in symptoms, in treatment and length of illness. One thing is certain with AIDS: managing an AIDS case as if it were any other illness could have a devastating effect on your healthcare budget.

The unpredictable nature of the illness requires that every case be managed individually to ensure that the patient is receiving the most cost-effective treatment in the most caring manner possible.

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The complexity of AIDS typifies the challenges in medical case management today. And there is no organization better equipped to handle those challenges than Intracorp.

For more information on how Intracorp Medical Case Management can provide high quality, cost-effective care for your employees and dependents stricken with AIDS, call

1-800-345-1075 (in AK, HI and PA call collect at 1-215-889-2600).

-----  
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1205 Westlakes Drive, Ste. #300, Berwyn, PA 19312  
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Company: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_  
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# Theater reviews evacuation procedures

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from the most recent national examination in ARM 55-Risk Control, describes appropriate measures for rapidly evacuating a burning theater (or other assembly) and for evaluating the progress of the rehabilitation of those who may be injured in the fire.

**Q:** When its administrative headquarters burned and some of its employees were injured because they could not leave the burning structure promptly, a major movie theater chain determined that it should do more to prepare its employees to manage the evacuation of persons from any of its theaters in the event of a fire.

• For each of the three life-safety factors listed below, describe two actions the chain might reasonably take to improve the ability of its

## A.R.M. exercises

employees to manage evacuations of theaters:

- ✓ Personal mobility.
- ✓ Density (crowding).
- ✓ Awareness of the fire.

• Other than fire drills, describe two measures through which the chain could periodically monitor the preparedness of its staff for an emergency evacuation.

• Describe five specific tests by which the chain properly could determine whether the employees injured in the fire at its headquarters are receiving appropriate physical and vocational rehabilitation.

**A:** • To indicate the scope of answers that earned full credit in the national examination, the following paragraphs give a greater number of answers than called for in each of the question subparts.

✓ To enhance the ability of patrons to leave the theater promptly, the chain's management can make sure that each theater has sufficiently wide aisles, adequate emergency lighting, a sufficient number of exits (each of adequate width) and special seating areas for impaired persons.

In addition, the manager of each theater should control the maximum number of persons in the theater at any time and should train employees in proper procedures for evacuating patrons.

✓ Crowd density control can be achieved through several of the measures already identified—particularly adequate emergency lighting, ample aisle space, strict enforcement of maximum capacity requirements and providing the proper number and width of exits.

✓ Making patrons aware of a fire without unduly frightening them requires properly designed alarm systems that will both detect and signal the presence of a fire anywhere in a theater building, coupled with a public address system for announcing further information or giving instructions.

A "proper" alarm system here implies one that alerts persons with either visual or hearing impairments. Ushers passing through the aisles or standing at exit doors can also be helpful in guiding patrons.

• To determine whether each of its theaters and their staffs are prepared for an emergency evacuation, the

chain's senior management could ask each theater manager to test the alarm system and the emergency lighting. Moreover, these managers should confirm that each theater has an adequate number of sufficiently wide exits and should test staff readiness for conducting a prompt evacuation, perhaps through dry runs with no patrons present.

• The chain's management can be reasonably confident that injured employees are progressing well in their rehabilitation if none of the traditional danger signals of mismanaged rehabilitation are present.

These signals include: extended hospital stays; frequent changes of physicians; lack of a clear diagnosis and prognosis for each injured patient; uncoordinated medical treatment; physical therapy that lacks specific goals; and the absence of concrete targets for each patient's discharge from the hospital and return to work.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

# Loss from counterfeit check not insured

Did a loss resulting from a policyholder's acceptance of a counterfeit bank cashier's check fall within an insurance policy exclusion for losses resulting from a fraudulent scheme, trick, device or false pretention? A Colorado appellate court concluded that it did.

Computer Works Inc. sold computers and software. It purchased a business account insurance policy from CNA Insurance Cos. that insured it against any accidental direct physical loss of property or income resulting from all hazards with specific exclusions. One such exclusion was a loss resulting from any "fraudulent scheme, trick, device or false pretense" that caused the policyholder to part with the title to or possession of any property. The exclusion did not apply to acceptance in good faith of any post office or express money order or counterfeit U.S. or Canadian paper money.

In 1985, Computer Works sold equipment and was given a bank cashier's check that later proved to be counterfeit. CNA denied the policyholder's claim. Computer Works sued but lost in the trial court.

The appellate court said that a cashier's check issued by a private banking institution did not fall into either classification as a "post office or express money order" and, thus, there existed no basis for concluding that the contract of insurance here covered the loss sustained.

*Computer Works Inc. vs. CNA Insurance Cos.*, Colorado Court of Appeals, May 12, 1988 (BI/02/Feb.-\$10).

## Recreational injury not compensable

A police officer was not entitled to workers compensation benefits for an injury arising out of an off-duty basketball game, even though he was required by the department to keep himself in good physical condition, a California appellate court ruled.

In December 1981, James A. Taylor, a police officer employed by the city of Berkeley, Calif., injured a knee while playing basketball during his lunch break. Off-duty injuries while voluntarily participating in recreational activities were not

## Legal briefs

compensable under the city code, except where the activities were a reasonable expectancy of, or expressly or impliedly required by, employment.

Mr. Taylor's participation in the game was voluntary and not required by the police department. As a police officer, Mr. Taylor was expected by his employer to keep himself in good physical condition. He filed for benefits. While benefits were initially awarded, the appeals board reversed.

On further appeal, Mr. Taylor argued that, as a member of the hostage negotiating team, he was required to meet a higher physical fitness standard than police officers who were not members of the team. Thus, he argued that he played basketball to maintain and improve his physical fitness for that job and for the benefit of his employer.

The court said that where an employer expects employees to participate in recreational or athletic activities to maintain certain standards of physical fitness necessary for performance of their work, it was reasonable to allow the employer to limit its liability for workers compensation to injuries sustained in designated and preapproved athletic activities, as the police department did here. To hold otherwise, the court observed, would in effect render the employer potentially liable for any injury sustained in any recreational or athletic activity if the activity contributed to the employee's physical fitness. The court upheld denial of benefits.

*Taylor vs. W.C.A.B.*, California Court of Appeals, March 3, 1988 (BI/03/Feb.-\$10).

## Change in beneficiary voided by court

The Supreme Court of Washington affirmed a trial court's decision to void a change in beneficiary made by a member of a group life insurance program that violated a court-ordered injunction in a domestic relations case.

William Schwalbe filed a petition for dissolution

of his marriage to Joanne Schwalbe. Shortly thereafter, the trial court awarded Joanne temporary custody of the parties' three children and ordered Mr. Schwalbe to pay child support. The court also enjoined Mr. Schwalbe from changing entitlements of any insurance policies, including life insurance.

Mr. Schwalbe was insured under a group term life insurance policy provided by his employer and issued by Standard Insurance Co. At the time the injunction was issued by the domestic relations court, Joanne was the policy's named beneficiary. In disregard of the injunction, Mr. Schwalbe changed the beneficiary from Joanne to Joanne and Glenda Rae Dent, "equally or the survivor." One month later, Mr. Schwalbe died.

Joanne received one-half of \$62,000, the amount of the insurance. Joanne and Ms. Dent both claimed the remaining half of the insurance proceeds. The insurer sought clarification from the court as to who to pay. The trial court ruled for Joanne, but was reversed by the appellate court.

The appellate court noted that, generally upon the death of a policyholder, the named beneficiary's rights vest and the beneficiary becomes entitled to the policy proceeds, except when a life insurance policy is used as security for the payment of child support. In such cases, the court said, equities arise in favor of the children that preclude the policyholder's right to change beneficiaries.

The court said that it was irrelevant that the injunction here was preliminary to dissolution rather than a final decree as the equities in each instance were similar. The trial court decision was reinstated in favor of Joanne.

*Standard Insurance Co. vs. Schwalbe*, Supreme Court of Washington, May 26, 1988 (BI/04/Feb.-\$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

# THE SOURCE



**Spotlight report**

Continued from page 43

System (PICS): \$25,000; unbundled hardware and software; mainframe or available on a time-sharing basis; year of first installation, 1984; four total installations, all in employee benefit departments; functions include calculation of retirement benefits on an estimated or financial basis; can generate payment forms; can be used to communicate benefits to employees.

• Capital Accumulation Language (CAL): \$10,000; unbundled hardware and software; mainframe or available on a time-sharing basis; year of first installation, 1986; 27 total installations, 14 in employee benefit departments; functions include administration of defined contribution plans; can be used to communicate benefits to employees.

• MediCalc: \$2,500; unbundled hardware and software; personal computer; year of first installation,

1987; four installations, all in employee benefit departments; functions include calculation of liabilities and projection of cash disbursements for post-retirement medical benefits.

• Asset/Liability Projections System (ALPS): \$45,000; unbundled hardware and software; mainframe or available on a time-sharing basis; year of first installation, 1986; two installations, both in employee benefit departments; functions include asset and liability forecasting for defined benefit plans.

• Section 89: \$985; unbundled hardware and software; personal computer; year of first installation, 1988; 12 total installations, all in employee benefit departments; functions include determining Section 89 coverage eligibility, benefit tests, determination of highly compensated employees, allocation of discriminatory excess.

**Staff:** 130 total staff members,

70 professional staff members.

**Clients:** 24 total clients.

**User support:** User groups and meetings, telephone assistance available eight hours per day, client newsletter.

**1988 gross revenues:** \$25 million total; \$5 million from employee benefit information systems; 5% from sale of software, 95% from services.

**Branch offices:** Atlanta; Boston; Los Angeles and Walnut Creek, Calif.; New York; Washington, D.C.; Toronto; London.

**Principal officers:** Kenneth P. Shapiro, president; Kurt H. Fichthorn, assistant to the president.

**Hazlehurst & Associates**

400 Perimeter Center Terrace, Suite 850, Atlanta, Ga. 30346; 404-395-9880

**Year founded:** 1971.

**Software products:**

• Section 89 Testing System: \$8,500; unbundled hardware and software; microcomputer; year of first installation, 1988; 40 total installations, three in employee benefit departments; functions include Section 89 data collection, maintenance, data classification and tabulation, non-discrimination testing and reporting.

• Benefit Calculation System: \$19,800; unbundled hardware and software; microcomputer; year of first installation, 1985; 30 total installations, all in employee benefit departments; functions include determining early, normal and postponed retirement benefits; terminated vested and survivor calculations; Social Security benefit calculations; benefit options; can be used to communicate benefits to employees.

• IRC 415 Limit Testing: \$6,500; unbundled hardware and software; microcomputer; year of first in-

stallation, 1986; 25 total installations, all in employee benefit departments; system allows plan sponsors to monitor employees approaching Section 415 limits; calculates annual additions based on salary and contribution data; individual and summary reporting.

**Staff:** 130 total staff members, 110 professional staff members.

**Clients:** 40 total clients; 35 employee benefit department clients; 20% with gross revenues less than \$200 million, 25% with \$200 million-\$500 million, 25% with \$500 million-\$1 billion, 20% with \$1 billion-\$3.5 billion, 10% with more than \$3.5 billion.

**User support:** Telephone assistance available eight hours per day, consulting.

**1988 gross revenues:** \$500,000 from employee benefit information systems; 50% from sale of software, 50% from services.

**Branch offices:** Seattle, Wash.

**Principal officers:** James G. Pope, president; R. David Parsons, chairman/principal actuary; David M. Gladstone and T. Ray McKinney, executive vps.

**Health Claims System**

14500 S. Forty Outer Road, Suite 502, Chesterfield, Mo. 63017; 314-434-4620

**Year founded:** 1985.

**Parent company:** Benefit Consultants Inc. and William Byrne & Associates Inc.

**Software products:**

• Health Claims System (Version 1.0): \$9,995 for personal computer version; \$14,995 for minicomputer version; bundled or unbundled hardware and software; year of first installation, 1985; five total installations, two in employee benefit departments; functions include health claims administration.

• Health Claims System (Version 2.0): \$14,995 for personal computer version; \$21,995 for minicomputer version; unbundled hardware and software; year of first installation, 1989; one installation, in an employee benefit department; functions as an adjudicated health claims administration and eligibility system.

**Staff:** 20 total staff members, 17 professional staff members.

**Clients:** Not reported.

**User support:** Telephone assistance available 10 hours per day, on-site assistance.

**1988 gross revenues:** Not reported.

**Branch offices:** St. Louis.

**Principal officers:** William Byrne and Alan Lemley.

**The Health Data Institute**

20 Maguire Road, Lexington, Mass. 02173; 617-863-2000

**Year founded:** 1981.

**Parent company:** Baxter Healthcare Corp.

**Software products:**

• Optimed: Unbundled hardware and software; minicomputer or personal computer; year of first installation, 1985; system is designed to support managed care programs, including pretreatment reviews, second surgical opinions, preferred provider channeling; generates reports.

**Staff:** 230 total staff members, 200 professional staff members.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available eight hours per day, on-site technical support.

**1988 gross revenues:** Not reported.

**Branch offices:** Boston, Chicago, Los Angeles.

**Principal officers:** Owen McKenna, vp/general manager; Shelli Williamson, vp/general manager-managed care; Dr. Jeremy Nobel, medical director.

Continued on page 54



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Continued from page 52

**Health Risk Management Inc.**

8000 W. 78th St., Minneapolis, Minn. 55435; 612-829-3500

**Year founded:** 1977.

**Software products:**

- HRM ResultsPLUS Medical Claims Analysis: Bundled hardware and software; operates on vendor-supplied mainframe; year of first installation, 1980; 50 total installations, all in employee benefit departments; functions include analysis of past claims experience to analyze health care costs; also generates reports on hospital utilization and hospital and physician pricing patterns; can be used to communicate benefits to employees.

- HRM BeneCalc: Unbundled hardware and software; personal computer; year of first installation, 1984; system is a data base for access to recent claims data via ad-

hoc reports monitors the performance of utilization review vendors; PPOs and claims administrators; can be used to communicate benefits to employees.

- HRM Health Benefit Modeling: Unbundled hardware and software; personal computer; year of first installation, 1988; system produces benefit plan models and projects future costs using actual data, not actuarial estimates; can be used to communicate benefits to employees.

**Staff:** 250 total staff members, 220 professional staff members.

**Clients:** Total clients not reported; 125 employee benefit department clients; 60% with gross revenues less than \$200 million, 10% with \$200 million-\$500 million, 10% with \$500 million-\$1 billion, 10% with \$1 billion-\$3.5 billion, 10% with more than \$3.5 billion.

**User support:** User groups and meetings, telephone assistance

available eight hours per day, on-site consulting.

**1988 gross revenues:** Not reported.

**Branch offices:** Boston; Shrewsbury, N.J.

**Principal officers:** Dr. Gary McIlroy, chief executive officer; Marlene Travis, president; Norb Krebsbach, vp-corporate sales; Steve Osterkamp, vp-sales/marketing; Terry Booth, vp-sales; Tim Temple and Bruce Kelley, vps.

**Health Systems International**

100 Broadway, New Haven, Conn. 06511; 203-562-2101

**Year founded:** 1968.

**Software products:**

- Clinical Claims Editor (CCE): unbundled hardware and software; mainframe or personal computer; year of first installation, 1983; 37 total installations, seven in employee benefit departments; func-

tions including clinical and DRG validation of hospital claims.

- Medical Claims Monitoring System (MCMS): unbundled hardware and software; personal computer; year of first installation, 1984; 11 total installations, three in employee benefit departments; functions include financial, clinical and DRG review of hospital claims.

**Staff:** 107 total staff members, 89 professional staff members.

**Clients:** 23 total clients; 85% with gross revenues less than \$200 million, 15% with \$200 million-\$500 million.

**User support:** User groups and meetings, telephone assistance available 10 hours per day.

**1988 gross revenues:** \$9 million total; \$1 million from employee benefit information systems; 100% from sale of software.

**Branch offices:** Los Angeles; Orlando, Fla.

**Principal officers:** Ron Bernier,

president; Mike Dylag, vp-finance/administration.

**HealthDecisions Inc.**

198 Western Ave., Suite 200, St. Paul, Minn. 55102; 612-227-5779

**Year founded:** 1986.

**Software products:**

- ClaimsAccess: \$35,000; unbundled hardware and software; personal computer; year of first installation, 1988; three total installations, one in an employee benefit department; system functions as a data base to identify areas of cost savings and cost control strategies.

- ClaimsAnalysis: \$25,000; unbundled hardware and software; personal computer; year of first installation, 1985; 20 total installations, 15 in employee benefit departments; system identifies higher-than-average medical costs and generates reports on disease rates.

- Demographic Estimator: \$15,000; unbundled hardware and software; personal computer; year of first installation, 1987; three total installations, two in employee benefit departments; system compiles age/sex demographic profiles from preliminary data.

**Staff:** 23 total staff members, seven professional staff members.

**Clients:** 10 total clients; four employee benefit department clients; 50% with gross revenues less than \$200 million, 50% with \$200 million-\$500 million.

**User support:** Telephone assistance available eight hours per day.

**1988 gross revenues:** \$420,000 total; \$210,000 from employee benefit information systems; 80% from sale of software, 20% from services.

**Branch offices:** New Haven, Conn.

**Principal officers:** Dr. Richard Huset, president; William Rush, director-research/development; Matt Mackowski, chairman.

**Hewitt Associates**

100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000

**Year founded:** 1940.

**Software products:**

- Social Security Calculator (PC): \$500, \$250 for updates; unbundled hardware and software; personal computer; year of first installation, 1984; 216 total installations, all in employee benefit departments; system calculates Social Security benefits for offset and pre-retirement counseling purposes.

- Social Security Calculator (Mainframe): \$4,000, \$1,500 for updates; unbundled hardware and software; mainframe; year of first installation, 1979; 30 total installations, all in employee benefit departments; system calculates Social Security benefits for offset and pre-retirement counseling purposes.

- Interactive Software: Unbundled hardware and software; personal computer; year of first installation, 1986; 12 total installations, all in employee benefit departments; system allows employees to use a computer terminal to obtain benefit information and make transactions for defined contribution plans, pension plans and flexible benefit plans.

- Telephone Voice Response System: Unbundled hardware and software; year of first installation, 1989; two total installations, both in employee benefit departments; system allows employees to use a touch-tone telephone to obtain benefit information and make transactions for defined contribution plans, pension plans and flexible benefit plans.

- 415Calc (PC): Unbundled hardware and software; personal computer; year of first installation, 1988; 15 total installations, all in employee benefit departments;

Continued on next page

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Continued from previous page  
system calculates Section 415 benefit limits; maintains employee data base and produces documentation, including audit and summary reports.

- 415Calc (Mainframe): Unbundled hardware and software; mainframe; year of first installation, 1988; two total installations, both in employee benefit departments; system calculates Section 415 benefit limits; maintains employee data base and produces documentation, including audit and summary reports.

- Plan Accounting System (Processing Services): Unbundled hardware and software; personal computer optional; year of first installation, 1974; 220 total installations, all for employee benefit departments; functions include recordkeeping for defined contribution plans, including 401(k), profit sharing, savings and employee stock ownership plans.

- Plan Accounting System (Installable): Unbundled hardware and software; mainframe; year of first installation, 1976; 10 total installations, all in employee benefit departments; functions include recordkeeping for defined contribution plans, including 401(k), profit sharing, savings and employee stock ownership plans.

- Pension Administrator (PC): Unbundled hardware and software; personal computer; year of first installation, 1986; 60 total installations, all in employee benefit departments; system administers pension plans, including employee data maintenance, benefit calculations and report writing.

- Pension Administrator (Mainframe): Unbundled hardware and software; mainframe; year of first installation, 1986; eight total installations, all in employee benefit departments; system administers pension plans, including employee data maintenance, benefit calculations and report writing.

- Pension Administrator (Time-sharing): Unbundled hardware and software; personal computer; year of first installation, 1986; 10 total installations, all in employee benefit departments; system administers pension plans, including employee data maintenance, benefit calculations and report writing.

- FlexSystem Timesharing: Unbundled hardware and software; personal computer; year of first installation, 1983; 75 total installations, all in employee benefit departments; functions include enrollment, administration and recordkeeping for flexible benefit programs; can be used to administer claims under COBRA.

- FlexSystem PC: Unbundled hardware and software; personal computer; year of first installation, 1985; 96 total installations, all in employee benefit departments; functions include enrollment, administration and recordkeeping for flexible benefit programs; can be used to administer claims under COBRA.

- Installable FlexSystem: Unbundled hardware and software; mainframe; year of first installation, 1986; 13 total installations, all in employee benefit departments; functions include enrollment, administration and recordkeeping for flexible benefit programs; can be used to administer claims under COBRA.

**Staff:** 2,115 total staff members, 1,425 professional staff members.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available eight hours per day, system updates and documentation.

**1988 gross revenues:** Not reported.

**Branch offices:** Atlanta; Bedminster, N.J.; Boston; Charlotte, N.C.; Chicago; Cleveland; Houston, Dallas and The Woodlands, Texas; Dayton, Ohio; Denver; Detroit; Los Angeles, San Francisco

and Santa Ana, Calif.; Milwaukee; Minneapolis; New York; Philadelphia; Pittsburgh; Phoenix; Rowayton, Conn.; St. Louis; Seattle; Tampa, Fla; Washington, D.C.; Toronto.

**Principal officers:** Peter E. Friedes, chief executive officer.

**A. Foster Higgins & Co. Inc.**

212 Carnegie Center, Princeton, N.J. 08543-5323; 609-520-2500

**Year founded:** 1922 (parent company).

**Parent company:** Johnson & Higgins.

**Software products:**

- BeneNet Administration System: \$70 000; unbundled hardware and software; mainframe, mini-computer or personal computer; year of first installation, 1985; 55 total installations, all in employee benefit departments; functions in

Continued on next page

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New from Brownyard



Continued from previous page  
 clude benefit plan administration; can be used to communicate benefits to employees.

• COBRA Administration System: \$15,000; unbundled hardware and software; mainframe, mini-computer or personal computer; year of first installation, 1987; 18 total installations, all in employee benefit departments; system processes claims under COBRA.

• BeneCalc: \$50,000; unbundled hardware and software; personal computer; year of first installation, 1988; four total installations, all in employee benefit departments; system calculates retirement plan benefits.

**Staff:** 54 total staff members, 49 professional staff members.

**Clients:** 12 total clients; 67% with gross revenues less than \$200 million, 8% with \$1 billion-\$3.5 billion, 25% with more than \$3.5 billion.

**User support:** Telephone assistance available 10 hours per day.

**1988 gross revenues:** Not reported.

**Branch offices:** Atlanta; Boston; Chicago; Costa Mesa, Los Angeles, San Diego and San Francisco, Calif.; Dallas; Honolulu; Houston; Minneapolis; New York; Parsippany, N.J.; Philadelphia; Pittsburgh; Portland, Ore.; Richmond, Va.; Rocky River, Ohio; Seattle; Stamford, Conn.; Washington, D.C.

**Principal officers:** John Feldtmose, president; Robert Phillips, executive vp.

### Insurance Software Packages Inc.

5118 N. 56th St., Tampa, Fla.  
 33610; 813-621-6069

**Year founded:** 1985.

**Software products:**

• Health Benefits Management System: \$38,000; unbundled hardware and software; personal computer; year of first installation, 1986; 25 total installations, three in employee benefit departments; functions include enrollment, claims payment and adjudication, code validation and reporting for health plans.

• Multi-Line Claims Management System: \$12,000; unbundled hardware and software; personal computer; year of first installation, 1986; 21 total installations, six in employee benefit departments; functions include claims entry, validation and payment, accident data entry, reserve tracking, claim inquiry and reporting.

• Medical Fee Schedule Validation System: \$12,000; unbundled hardware and software; personal computer; year of first installation, 1986; 55 total installations, one in an employee benefit department; functions include fee schedule validation, medical bill history, duplicate bill checking and inquiries, reporting.

• COBRA EAS: \$1,600; unbundled hardware and software; personal computer; year of first installation, 1987; more than 300 total installations, one in an employee benefit department; functions include administration of claims under COBRA, including notification, billing and payment history.

**Staff:** 26 total staff members, 23 professional staff members.

**Clients:** 45 total clients; 50% with gross revenues less than \$200 million, 20% with \$200 million-\$500 million, 20% with \$500 million-\$1 billion, 10% with \$1 billion-\$3.5 billion.

**User support:** User groups and meetings, telephone assistance available nine hours per day.

**1988 gross revenues:** \$2 million total; 85% from sale of software, 15% from services.

**Principal officers:** A. Allan Machesney, president; David L. Wellons, vp-sales; George Cannon, vp; Dan Scopes, vp-development.

### K

### Kwasha Lipton

2100 N. Central Road, Fort Lee, N.J. 07024; 201-592-1300; 212-279-6800

**Year founded:** 1944.

**Software products:**

• Int-Act: \$40,000; unbundled hardware and software; personal computer; product developed in 1986; product is used for enrollment in flexible benefit programs; can be used to communicate benefits to employees.

• Custom-Designed, Micro-Computer Benefits Administration System: \$5,000-\$50,000; unbundled hardware and software; personal computer; year of first installation, 1982; 40 total installations, all in employee benefit departments; functions include benefit recordkeeping, Social Security calculations, benefit reports, data transfer and entry.

• Group Benefits Administration System: \$15,000-\$75,000; unbundled hardware and software; personal computer; year of first installation, 1988; product functions as a database for administration of group benefit plans, flexible bene-

fit enrollment, Section 89 testing and Section 125 accounts; can be used to communicate benefits to employees.

**Staff:** 320 total staff members, 30 professional staff members assigned to software products.

**Clients:** 50 total clients; 10% with gross revenues less than \$200 million, 15% with \$200 million-\$500 million, 40% with \$500 million-\$1 billion, 35% with \$1 billion-\$3.5 billion.

**User support:** User groups and meetings, telephone assistance available 10 hours per day, software updates and manuals.

**1988 gross revenues:** Not reported; 60% of information system revenues are from sale of software, 40% from services.

**Principal officers:** Richard C. Sears, chief executive officer; David A. Skovron, chief operating partner; R.T. Whitman, partner in charge of marketing.

### M

### Mayer Hoffman McCann

420 Nichols Road, Kansas City, Kan. 64112; 816-968-2055

**Year founded:** 1954.

**Software products:**

• Cafeteria Plan Management System: \$3,450; unbundled hardware and software; personal computer; year of first installation, 1985; 275 total installations, 75 in employee benefit departments; functions as an accounting system for Section 125 flexible spending accounts; can be used to communicate benefits to employees.

• Cafeteria Plan Proposal System: \$495; unbundled hardware and software; personal computer; year of first installation, 1987; 450 total installations, 50 in employee benefit departments; functions include employee enrollment in Section 125 plans; can be used to communicate benefits to employees.

• Section 89 Analyzer: \$4,950; unbundled hardware and software; personal computer; year of first installation, 1988; 150 total installations, 10 in employee benefit departments; system gathers data and performs discrimination testing for Section 89.

**Staff:** 135 total staff members, 100 professional staff members.

**Clients:** 225 total clients; 40 employee benefit department clients, 100% with gross revenues less than \$200 million.

**User support:** User groups and meetings, telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported, 100% from sale of software.

**Principal officers:** Miles Ross and Alan Thibault, partners.

### MEDSTAT Systems Inc.

777 E. Eisenhower Parkway, Suite 500, Ann Arbor, Mich. 48108; 313-996-1180

**Year founded:** 1981.

**Software products:**

• MEDSTAT On-Line System: Unbundled hardware and software; personal computer; year of first installation, 1983; more than 45 total installations, all in employee benefit departments; system provides employee medical plan design, modeling, monitoring, evaluation, carrier and administrator evaluation, provider evaluation, premium justification.

**Staff:** 95 total staff members, 60 professional staff members.

**Clients:** Not reported; 4% with gross revenues of \$1 billion-\$3.5 billion, 96% with more than \$3.5 billion.

**User support:** User groups and meetings, telephone assistance available 11 hours per day, work-

Continued on next page

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1-800-421-8570 in California  
 1-800-223-4276 nationwide



\*subject to underwriting guidelines.

Continued from previous page shops, consulting.

**1988 gross revenues:** \$7.3 million total; all from software services.

**Branch offices:** Boston, San Francisco.

**Principal officers:** Ernest G. Ludy, chairman/chief executive officer; Laurence J. Hagerty, president/chief operating officer; Dennis J. Becker, vp-marketing; J. Dennis Bush, vp-product development; Ross L. Coffey, vp-client services; Jennifer S. Ponski, vp-finance/administration.

#### William M. Mercer-Meidinger-Hansen Inc.

1211 Ave. of the Americas, New York, N.Y. 10036; 212-997-7171

**Year founded:** William M. Mercer Inc. and Meidinger Inc. merged in 1984; William M. Mercer-Meidinger Inc. and A.S. Hansen Inc. merged in 1987.

**Parent company:** Marsh & McLennan Cos. Inc.

#### Software products:

• **Benefit Calculation System:** Unbundled hardware and software; personal computer; year of first installation, 1986; more than 50 total installations in employee benefit departments; product calculates defined benefit pensions.

• **FlexKey:** Unbundled hardware and software; mainframe or personal computer; year of first installation, 1984; 40-45 total installations, 35-40 in employee benefit departments; functions include flexible benefit program enrollment, administration and reimbursement account processing.

• **Social Security Calculation System:** Unbundled hardware and software; mainframe or personal computer; year of first installation, 1979; 100-120 total installations in employee benefit departments; product calculates benefits under the Social Security law in effect since 1975.

• **MasterKey:** Unbundled hardware and software; mainframe; year of first installation, 1984; functions include administration of defined contribution plans.

• **LoanKey:** \$8,000 or individually priced modules; unbundled hardware and software; personal computer; year of first installation, 1986; 70 total installations, 36 in employee benefit departments; system administers defined contribution plan loans.

• **DataKey:** \$15,000 or individually priced modules; unbundled hardware and software; personal computer; year of first installation, 1987; 10 total installations; system is used to collect and administer data for defined contribution plans.

• **ACPkey:** \$2,000; unbundled hardware and software; personal computer; year of first installation, 1987; 25 total installations, one in an employee benefit department; system performs discrimination tests in accordance with the Tax Reform Act of 1986.

• **Intersection 89:** \$10,000; unbundled hardware and software; mainframe or personal computer; year of first installation, 1988; more than 50 total installations, 15-20 in employee benefit departments; system performs tests for compliance with Section 89 of the Internal Revenue Code.

• **Section 415:** \$15,000; unbundled hardware and software; personal computer; year of first installation, 1988; more than 50 total installations, 5-10 in employee benefit departments; system tests for compliance with Section 415.

• **TouchSource:** Unbundled hardware and software; personal computer, video disk player; year of first installation, 1989; product is an interactive video system for flexible benefit plan enrollment, 401(k) plan modeling, company orientation and employee attitude surveys; product is used to commu-

nicate benefits to employees.

**Staff:** 3,591 total staff members, 1,650 professional staff members.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available during business hours.

**1988 gross revenues:** \$524 million total.

**Branch offices:** Albuquerque, N.M.; Anchorage, Alaska; Atlanta; Baltimore; Birmingham, Ala.; Boston; Charlotte, N.C.; Chicago and Deerfield, Ill.; Cincinnati, Cleveland and Columbus, Ohio; Dallas, Houston and Fort Worth, Texas; Denver; Detroit and Grand Rapids, Mich.; Fresno, Los Angeles, Orange, San Francisco and San Jose, Calif.; Indianapolis; Kansas City and St. Louis, Mo.; Louisville, Ky.; Memphis and Nashville, Tenn.; Milwaukee; Minneapolis; Morristown, N.J.; New Orleans; Philadelphia; Pittsburgh; Phoenix, Ariz.; Portland, Ore.; Richmond, Va.; Rochester and White Plains, N.Y.;

Seattle; Stamford, Conn.; Tampa, Fla.; Tulsa, Okla.; Washington, D.C.; Wichita, Kan.

**Principal officers:** Peter Coster, president; Robert A. Brochu, Joseph Holtzer, Frank Peabody III and Ronald M. Walker, executive vps; Philip E. Carlin, Chester D. Clark, Edward H. Davis, Robert E. Lindgren, Howard F. Lund, Timothy J. Lynch and Daniel C. White, managing directors.

#### Metropolitan Life Insurance Co.-Communications Services

1 Madison Ave., New York, N.Y. 10010; 212-578-8957

**Year founded:** 1869 (parent company).

**Parent company:** Metropolitan Life Insurance Co.

**Software products:**

• MetLife SHOWCASE: Bun-

dled hardware and software; personal computer; year of first installation, 1983; 15 total client company installations, all in employee benefit departments; system communicates personalized benefits information to employees via computer terminals.

• **MetLife BenePhone:** System runs on vendor mainframe; bundled or unbundled personal computer; year of first installation, 1987; six total installations; system communicates personalized benefits information to employees via touch-tone telephones.

**Staff:** 14 total staff members, 11 professional staff members.

**Clients:** 12 total clients.

**User support:** User groups and meetings, telephone assistance.

**1988 gross revenues:** Not reported.

**Branch offices:** San Francisco, Chicago.

**Principal officers:** James Logan, vp.

#### PATH Systems

5600-B Scotts Valley Drive, Scotts Valley, Calif. 95066; 408-438-7284

**Year founded:** 1982.

**Parent company:** Access Centers Inc.

**Software products:**

• **PATH Benefits Administrator:** \$1,900; unbundled hardware and software; personal computer; first installation, 1987; 50 total installations, all in employee benefit departments; functions include plan enrollment, calculation of contributions, flexible benefit administration, administration of claims under COBRA, preparation of benefit statements; can be used to communicate benefits to employees.

Continued on next page

“Six months ago my daughter wouldn't even speak to me.”

Once she was a carefree, friendly girl with a great smile and a terrific backhand. But Lisa suddenly changed. She withdrew from everyone and everything. No one could reach her.

She spent several weeks in the psychiatric ward with no improvement. No one realized that the underlying problem was drugs.

No one, that is, except an HRM case manager. Thanks to case management and HRM's Quality First<sup>SM</sup> approach, Lisa got the help she needed.

Her story illustrates the HRM difference. With us, the quality of care always comes first. That's why our customers keep coming back. What's more, our Quality First<sup>SM</sup> approach reduces costs. By \$45,000, in Lisa's case.

Quality First<sup>SM</sup> is just one reason her mom's employer chose our Managed Mental Health Care

Program. Another is the full range of services available. Besides case management, there's an Employee Assistance Program (EAP) and comprehensive utilization review. The EAP for easy access to help *before* a problem becomes a crisis. *Inpatient* review to make sure hospitalization is appropriate. And *outpatient* review to provide focus for family therapy or individual counseling. It's a full-service Managed Mental Health Care Program that includes price controls. Quality First<sup>SM</sup> means a lot to people like Lisa's mom. She's got her daughter AND her tennis partner back!

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**Spotlight report***Continued from previous page*

• **Time-Off:** \$750; unbundled hardware and software; personal computer; first installation 1938; 40 installations, all in employee benefit departments; functions include administration of various benefit plans for employees' paid time off, scheduling vacations, forecasting accruals and analyzing absenteeism costs.

**Staff:** Six total staff members, four professional staff members.

**Clients:** Not reported.

**User support:** User groups and meetings; telephone assistance available nine hours per day; newsletters for clients, consulting.

**1988 gross revenues:** \$100,300 total; \$20,000 from employee benefit information systems; 75% from sale of software, 25% from services.

**Principal officers:** Fred Cameron, president; Pam Mcrmington, vp-sales/marketng.

**Pentabs**

520 E. Montecito St., Santa Barbara, Calif. 93103-3291; 805-963-8881

**Year founded:** 1973.

**Parent company:** Corbel & Co.

**Software products:**

• **401(k)/Defined Contribution/ESOP System:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1984; 500 total installations; system performs recordkeeping and administration of 401(k), ESOP and defined contribution plans; can be used to communicate benefits to employees.

• **Defined Benefit/Defined Contribution System:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1979; 520 total installations; system administers defined contribution and defined benefit plans; can be used to communicate benefits to employees.

• **Government Forms System:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1986; 160 total installations; system prepares and prints government forms for retirement plans.

• **Trust Accounting System:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1978; 120 total installations; functions include recordkeeping for retirement plan assets; can be used to communicate benefits to employees.

• **Age 70½ System:** Bundled or unbundled hardware and software; personal computer; year of first installation, 1987; 80 total installations; system calculates minimum required distribution for retirement plans to age 70½; can be used to communicate benefits to employees.

• **Data Management System:** Bundled or unbundled hardware and software; personal computer;

year of first installation, 1979; 400 total installations; system creates custom-designed employee reports, including benefit statements; can be used to communicate benefits to employees.

**Staff:** 60 total staff members.

**Clients:** Not reported.

**User support:** User groups and meetings; telephone assistance available 12 hours per day; regional training for clients; on-site training.

**1988 gross revenues:** \$4 million total; 5% from sale of hardware, 65% from sale of software, 30% from services.

**Branch offices:** Flint, Mich.; Cranford, N.J.; Carrollton, Texas; Chicago; Marietta, Ga.; Jacksonville, Fla.

**Principal officers:** Larry DuBcis, president; Robert Cerulle, vp-sales-western region; Bob Mark, vp-sales-eastern region; Kalon Kelley, research/development manager.

**Policy Management Systems Corp.**

One PMS Center, Blythewood, S.C. 29016; 803-735-4330

**Year founded:** 1974.

**Software products:**

• **Group-Comm:** \$250,000; unbundled hardware and software; mainframe; first installation, 1982; 27 installations; functions include administration of group insurance plans.

• **Casewriter:** \$75,000; unbundled hardware and software; mainframe; first installation, 1984; 16 installations; functions include automation of group insurance data.

• **Examiner:** \$200,000; unbundled hardware and software; mainframe; first installation, 1983; 40 installations; functions include adjudication of health claims; can be used to administer claims under COBRA and to communicate benefits to employees.

• **ExClaim:** \$400,000; unbundled hardware and software; personal computer; first installation, 1987; two installations in employee benefit departments; functions include adjudication of health claims; can be used to administer claims under COBRA and to communicate benefits to employees.

**Staff:** 2,700 professional staff members, 200 staff members assigned to employee benefit information systems.

**Clients:** Not reported.

**User support:** Monthly system maintenance.

**1988 gross revenues:** \$217 million total; 50% of employee benefit information system revenues from software, 50% from services.

**Principal officers:** G. Larry Wilson, chairman/president; Robert L. Gresham, executive vp/secretary/treasurer.

**Professional Computer Services**

22010 S. Wilmington Ave., Suite 207, Carson, Calif. 90745; 213-830-1072

**Year founded:** 1964.

**Software products:**

• **Health & Welfare Multi-Employer Remittance:** \$5,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1964; 25 total installations; functions include billings for all types of benefit plans, including accounting, discrepancy and delinquency notifications.

• **Work-History & Eligibility:** \$20,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1964; 25 total installations; functions include calculation of eligibility for benefits; can be used to communicate benefits to employees.

• **Member/Dependent Registration:** \$10,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1970; 25 total installations; system is designed to verify status of benefit plan enrollees and dependents, including personal information, full-time student verification and disability and legal status; can be used to communicate benefits to employees.

• **Claims Adjudication:** \$20,000-\$200,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1975; eight total installations; system is designed to adjudicate medical, dental, disability and other types of claims; generates reports; can be used to communicate benefits to employees.

• **Pension Multi-Employer Remittance:** \$5,000; unbundled hardware and software; mainframe, minicomputer or personal com-

*Continued on next page*

**EMPLOYEE BENEFITS BULLETIN:  
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You spent big dollars last year on your employee benefits program, and your employees are still not happy. Sally is a working mother and would like help with her dependent care expenses. John wishes he had more life insurance for the security of his wife and four youngsters. And you wish you could better meet your employees' needs while containing your own costs.

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Continued from previous page  
puter; year of first installation, 1964; six total installations; functions include billing for pension plans, including accounting, discrepancy and delinquency notifications.

• **Benefit History:** \$30,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1964; six total installations; system administers defined contribution and defined benefit plans, generates reports and can be used to communicate benefits to employees.

• **Annual/Periodic Benefit Notices:** \$10,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1964; six total installations; system generates notification of current and estimated status of pension benefits for employees.

• **Withdrawal Liability Calculation:** \$10,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1980; two total installations; system calculates cost of withdrawal for unfunded vested liability in pension plans, can generate forms and amortization schedules.

• **Pension Payment:** \$15,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1964; six total installations; system calculates monthly pension payments, prints forms and provides government reporting; can be used to communicate benefits to employees.

• **Investment Tracking:** \$5,000; unbundled hardware and software; mainframe, minicomputer or personal computer; year of first installation, 1979; two total installations; system tracks pension investments including comparison of relative performance.

**Staff:** 10 total staff members, four professional staff members.

**Clients:** Eight total clients.  
**User support:** Meetings, telephone assistance available 12 hours per day.

**1988 gross revenues:** \$720,000 total; all from employee benefit information systems; 10% from sale of software, 90% from services.

**Principal officers:** Edna Broman, chairman; J. Patrick Broman, president; Ernestine Givens, secretary.

**R**

**Resource Information Management Systems Inc.**  
500 Technology Drive, P.O. Box 3094, Naperville, Ill. 60566-7094; 312-369-5300

**Year founded:** 1981.

**Software products:**

• **QicClaim Health Claims Management System:** Unbundled hardware and software; minicomputer, or microcomputer; year of first installation, 1982; 350 total installations; functions include automated claims processing, plan design, check reconciliation, automatic eligibility verifications, stop-loss statistics tracking, fund accounting, provider updates, reporting.

• **QicPACE Program for Alternative Care Environment:** Unbundled hardware and software; minicomputer or microcomputer; year of first installation, 1982; 65 total installations; system administers managed care programs, including provider network management, prepayment distribution and managed care administration, report generation.

• **POWERPACT:** Unbundled hardware and software; personal computer; year of first installation, 1988; 30 total installations; system is designed to perform plan analy-

sis and compliance testing for Section 89 of the Internal Revenue Service.

**Staff:** 179 total staff members, 168 professional staff members.

**Clients:** 50 total clients; 80% with gross revenues less than \$200 million, 20% with \$200 million-\$500 million.

**User support:** User groups and meetings, telephone assistance available 11 hours per day, evening support programs.

**1988 gross revenues:** \$17.7 million total; \$16.2 million from employee benefit information systems; 51.9% from sale of hardware, 29% from sale of software, 19.1% from services.

**Branch offices:** Costa Mesa, Calif.; Troy, N.Y.

**Principal officers:** Thomas H. Heimsoth, chief executive officer; Thomas J. Colgan, president; Terry L. Kirch, chief operating officer; Howard P. Downs, executive vp.

*Continued on next page*

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 Title \_\_\_\_\_  
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Continued from previous page

## S

**SBPA Systems Inc.**

14925 A Memorial Drive, Houston, Texas 77079; 713-496-0800

**Year founded:** 1976.**Software products:**

- GBAS/CPS: \$60,000; bundled hardware and software; minicomputer; first installation, 1976; 24 installations; including four employee benefit department installations; functions include claims adjudication, precertification, administration of claims under COBRA, check and report generation.

- Section 125: Minicomputer; product developed in 1988; functions include enrollment and discrimination testing for Section 125 benefit plans, generation of reports

and benefit statements.

**Staff:** 10 total staff members, eight professional staff members.**Clients:** Seven total clients; one employee benefit department client with gross revenues less than \$200 million.**User support:** User groups and meetings, telephone assistance available nine hours per day, consulting services.**1988 gross revenues:** Not reported.**Principal officers:** Arnold Heinrich, president; Tim Stunz, vp.**SW Systems Inc.**

302 W. Carrillo St., Santa Barbara, Calif. 93101; 805-963-5959

**Year founded:** 1979.**Software products:**

- ClaimsWork: \$80,000; unbundled hardware and software; microcomputer, minicomputer or mainframe; year of first installation,

1980; 42 total installations, 18 in employee benefit departments; functions include automated claims processing, management reporting; can be used to administer claims under COBRA.

- BillingWork: \$10,000; unbundled hardware and software; microcomputer, minicomputer or mainframe; year of first installation, 1982; 12 total installations, three in employee benefit departments; functions include premium billing.

- CostWork: \$10,000; unbundled hardware and software; microcomputer, minicomputer or mainframe; year of first installation, 1985; 15 total installations, three in employee benefit departments; functions include administration of precertification, second opinion, utilization review.

**Staff:** 19 total staff members.**Clients:** 12 total clients, six employee benefit department clients.**User support:** User groups and

meetings, telephone assistance available 11 hours per day.

**1988 gross revenues:** \$2.1 million total; 65% from sale of software, 35% from services.**Principal officers:** William Whitmore, president; Gregory Giloth, senior vp; Sherry Hannigan, chief operating officer; Edwin R. Lissitz, vp-customer support.**Sanddollar Enterprises Inc.**

645 W. Carmel Drive, Suite 160, Carmel, Ind. 46032; 317-844-5244; 800-669-1550

**Year founded:** 1984.**Software products:**

- Sanddollar Health Management & Claims System: \$52,500; bundled hardware and software; personal computer; year of first installation, 1985; more than 10 total installations, in employee benefit departments; functions include processing of health benefit plans.

**Staff:** Six total staff members,

five professional staff members.

**Clients:** Five total clients, 100% with gross revenues less than \$200 million.**User support:** User groups and meetings, telephone assistance available eight hours per day.**1988 gross revenues:** Not reported.**Principal officers:** Mark Hersinger, president.**SPECTRUM Human Resource Systems Corp.**

1625 Broadway, Suite 2800, Denver, Colo. 80202; 303-534-8813

**Year founded:** 1984.**Software products:**

- The Spectrum HR/200: \$6,925; unbundled hardware and software; personal computer; year of first installation, 1984; more than 800 total installations; functions include determination of benefit eligibility, plan enrollment, administration of flexible benefit and spending accounts and claims under COBRA; can be used to communicate benefits to employees.

- The Spectrum HR/1200: \$1,995; unbundled hardware and software; personal computer; year of first installation, 1987; system is designed for companies with fewer than 300 employees; functions include determination of benefit eligibility, plan enrollment, COBRA tracking; can be used to communicate benefits to employees.

**Staff:** 30 total staff members.**Clients:** Not reported.**User support:** User groups and meetings, telephone assistance available nine hours per day, client training, data conversion, consulting.**1988 gross revenues:** Not reported.**Branch offices:** Morristown, N.J.; Pasadena and San Rafael, Calif. Tempe, Ariz.**Principal officers:** Jim Spoor, chief executive officer; Nancy Spoor, vp-marketing; J.C. Heinen, sales manager.**Stellar Software Inc.**

19406 E. Floyd Ave., Aurora, Colo. 80013; 303-680-9408

**Year founded:** 1986.**Software products:**

- FLEX-STAR: \$3,295; bundled or unbundled hardware and software; personal computer or minicomputer; first installation, 1986; 10 installations; functions include flexible benefit plan pre-enrollment, non-discrimination testing, payroll information, claims adjudication, check processing, report generation.

**Staff:** Four total staff members, two professional staff members.**Clients:** 15 total clients.**User support:** Telephone assistance, maintenance service for clients.**1988 gross revenues:** Approximately \$125,000 total; approximately \$75,000 from employee benefit information systems; 20% from sale of hardware, 60% from sale of software, 20% from services.**Principal officers:** Otto F. Feiler, president; Isabel Feiler, secretary.

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**TPF&C**

Centre Square West, 1500 Market St., Philadelphia, Pa. 19102; 215-569-6306

**Year founded:** 1934.**Parent company:** Towers, Perrin, Forster & Crosby Inc.**Software products:**

- SSCalc: Personal computer, \$1,000; unbundled hardware and

Continued on next page

*Continued from previous page*  
software; first installation, 1984; 200 installations, all in employee benefit departments. Mainframe: \$4,000; unbundled hardware and software; first installation, 1974; 90 installations, all in employee benefit departments. Functions include calculation of Social Security benefits; can be used to communicate benefits to employees.

• **PenCalc:** Personal computer, \$35,000; unbundled hardware and software; first installation, 1985; 65 installations, all in employee benefit departments. Mainframe: \$50,000; unbundled hardware and software; first installation, 1974; 50 installations, all in employee benefit departments. Functions include calculation of defined benefit pension plans; can be used to communicate benefits to employees.

• **PensionManager:** Unbundled hardware and software; personal computer; first installation, 1986; more than 30 installations, all in employee benefit departments; system maintains a database of defined benefit plan information for active and inactive employees; can be used to communicate benefits to employees.

• **FlexManager:** Unbundled hardware and software; personal computer; first installation, 1987; 30 installations, all in employee benefit departments; functions include administration of flexible benefit plans; can be used to communicate benefits to employees.

• **Interactive Communication/Administration:** Unbundled hardware and software; personal computer and phone system; 15 clients; system is used by employees for flexible benefit enrollment, retirement planning, benefit information and modeling; can generate electronic benefit statements.

• **AccountManager:** Unbundled hardware and software; mainframe; first installation, 1983; 165 installations, all in employee benefit departments; functions include recordkeeping, reporting and administration of defined contribution plans; can be used to communicate benefits to employees.

**Staff:** 4,500 total staff members and 3,085 professional staff members in entire company.

**Clients:** More than 8,000 clients.  
**User support:** Telephone assistance, on-site services for clients.

**1988 gross revenues:** \$600 million total, \$40 million from sales of employee benefit information systems.

**Branch offices:** 54 offices worldwide.

**Principal officers:** James E. Kielley, president/chief executive officer; Charles E. Peartree, executive vp.

#### **Tesseract Corp.**

150 Spear St., San Francisco, Calif. 94105; 415-543-9320

**Year founded:** 1971.

**Parent company:** The Prudential Insurance Co. of America.

#### **Software products:**

• **Tesseract Benefit/Flexible Benefit Plan Administration System:** \$100,000-\$200,000; unbundled hardware and software; mainframe; year of first installation, 1982; 74 total installations, all in employee benefit departments; functions include administration of flexible benefits, Section 89 and COBRA claims; can be used to communicate benefits to employees.

• **Tesseract Investment Plan Management System:** \$100,000-\$200,000; unbundled hardware and software; mainframe; year of first installation, 1987; 21 total installations, all in employee benefit departments; functions include ad-

ministration of defined contribution programs; can be used to communicate benefits to employees.

**Staff:** 280 total staff members, 140 professional staff members.

**Clients:** 24 total clients; 20 employee benefit department clients; 10% with gross revenues less than \$200 million, 10% with \$200 million-\$500 million, 30% with \$500 million-\$1 billion, 40% with more than \$3.5 billion.

**User support:** User groups and meetings; telephone assistance available 24 hours per day; consulting; client training; maintenance; software enhancements.

**1988 gross revenues:** Not reported; 70% from sale of software, 30% from services.

**Branch offices:** Inverness, Ill.;

Paramus, N.J.; Dallas; Boston.

**Principal officers:** William R. Leckonby, president; Gary Durbin, executive vp; William G. Wesemann, vp-sales; Mary Kay Marvin, vp-marketing; Lily Chang, vp-technology; Lyn Jensen, vp-finance.

#### **Touche Ross-Actuarial, Benefits & Compensation Practice**

111 E. Wacker Drive, Chicago, Ill. 60601-4342; 312-644-8900

**Year founded:** 1947.

#### **Software products:**

• **CompuFlex System:** Unbundled hardware and software; personal computer; year of first installation, 1985; 18 total installations, 10 in employee benefit departments; functions include

administration of flexible benefit programs; can be used to communicate benefits to employees.

**Staff:** 350 total staff members, 280 professional staff members.

**Clients:** Four total clients.

**User support:** User groups and meetings, telephone assistance available 10 hours per day, on-site assistance for clients.

**1988 gross revenues:** Not reported.

**Branch offices:** Boston; Dallas; Grand Rapids, Mich.; Hartford, Conn.; Los Angeles; Minneapolis and St. Paul, Minn.; New York; San Francisco.

**Principal officers:** Dave Dresner, national director-benefits practice; Keith Swenson, partner in charge-Chicago benefits practice; Debora Harvey, manager-benefit systems consulting.

#### **Travis Software Corp.**

1001 S. Dairy Ashford, Suite 206, Houston, Texas 77077; 713-496-3737

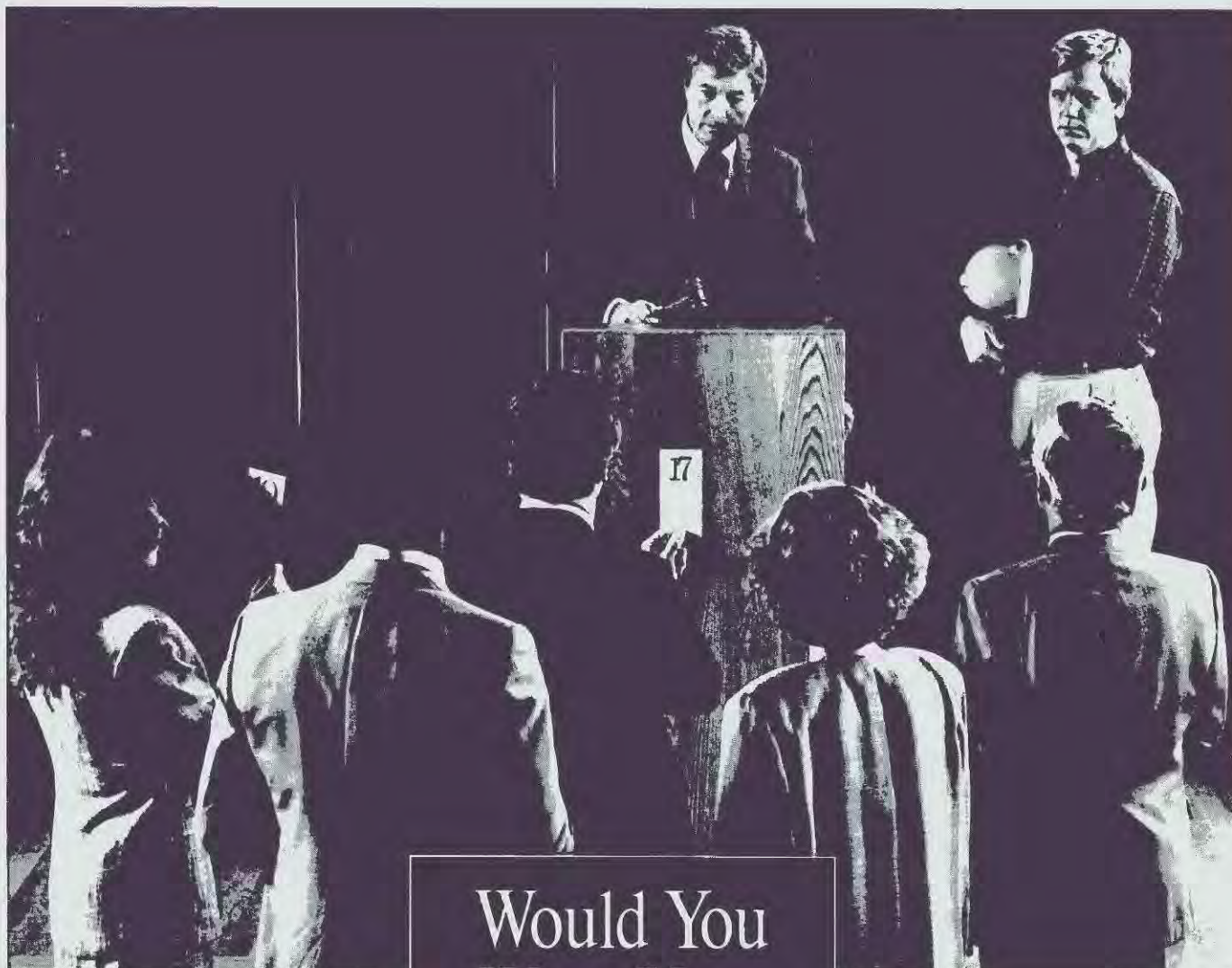
**Year founded:** 1986.

#### **Software products:**

• **Corporate COBRA Manager:** \$1,295; unbundled hardware and software; personal computer; year of first installation, 1986; 1,913 total installations, 1,688 in employee benefit departments; functions include administration of claims under COBRA, letter generation.

• **TravisFlex:** \$2,995; unbundled hardware and software; personal computer; year of first installation, 1987; 323 total installations, 308 in employee benefit departments; functions include administration

*Continued on next page*



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*Continued from previous page*  
of flexible benefit plans; can be used to communicate benefits to employees.

• **Section 89 Discrimination Testing:** \$2,890; unbundled hardware and software; personal computer; year of first installation, 1988; 1,210 total installations, 992 in employee benefit departments; performs Section 89 discrimination tests; can be used to communicate benefits to employees.

**Staff:** 20 total staff members, 17 professional staff members.

**Clients:** 963 total clients; 791 employee benefit department clients; 36% with gross revenues less than \$200 million, 17% with \$200 million-\$500 million, 34% with \$500 million-\$1 billion, 9% with \$1 billion-\$3.5 billion, 4% with more than \$3.5 billion.

**User support:** Telephone assistance available nine hours per day, software updates.

**1988 gross revenues:** \$2.8 million total; 71% from sale of software, 29% from services.

**Principal officers:** Alan Williams, president; Mary Brooks and John Worner, vps.

### Trilog Inc.

1700 Market St., Philadelphia, Pa. 19103; 215-564-3404

**Year founded:** 1966.

**Software products:**

• **Microshare Thrift/401(k):** \$8,100; unbundled hardware and software; minicomputer or personal computer; year of first installation, 1983; 60 total installations, 13 in employee benefit departments; functions include recordkeeping for defined contribution and employee stock ownership plans.

**Staff:** 100 total staff members.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available eight hours per day.

**1988 gross revenues:** Not reported.

**Principal officers:** Edward P. Jasudowich, president; Linda R. Saltzman, vp-sales/marketing.

**W**

### WLT Software of Florida Inc.

2087 U.S. 19 N., Suite D,  
Clearwater, Fla. 34623;  
813-797-7814

**Year founded:** 1980.

**Software products:**

• **MEDICLAIMS Health Claims Administration System:** Bundled

or unbundled hardware and software; minicomputer or personal computer; year of first installation, 1981; functions as a claims administration and billing system for medical, dental, vision, prescription drug, and long- and short-term disability; can be used to communicate benefits to employees and to administer claims under COBRA.

• **FLEXCLAIMS Flexible Benefits Administration System:** Bundled or unbundled hardware and software; minicomputer or personal computer; year of first installation, 1986; product is an administration, accounting and claims payment system for Section 125 plans; can be used to communicate benefits to employees.

• **COBRA PLUS Claims Administration System:** Bundled or unbundled hardware and software; minicomputer or personal computer; year of first installation, 1987; functions include administration, billing and accounting for claims under COBRA.

**Staff:** Not reported.

**Clients:** Not reported.

**User support:** User groups and meetings, telephone assistance available nine hours per day, newsletters, modem assistance, system enhancements.

**1988 gross revenues:** Not reported.

**Principal officers:** William L. Tiner Jr., president.

### WTR Data Services

708 Third Ave., New York, N.Y. 10017; 212-949-1344

**Year founded:** 1987.

**Software products:**

• **The Benefits Manager/Flexible Benefits Administration Module:** \$15,000; unbundled hardware and software; personal computer; year of first installation, 1986; 15 total installations; functions include administration of flexible benefit plans, billing, reporting; can be used to communicate benefits to employees.

• **The Benefit Manager/Flexible Spending Account Module:** \$3,500; unbundled hardware and software; personal computer; year of first installation, 1987; 45 total installations; functions include administration of spending accounts; can be used to communicate benefit programs to employees.

• **The Benefits Manager/Discrimination Testing Module:** Price varies; unbundled hardware and software; personal computer; year of first installation, 1988; 85 total installations; functions include Section 89 discrimination testing.

**Staff:** 25 total staff members, 12 professional staff members.

**Clients:** 107 total clients; 92 employee benefit department clients; 65% with gross revenues less than \$200 million, 20% with \$200 million-\$500 million, 10% with \$500 million-\$1 billion, 5% with \$1 billion-\$3.5 billion.

**User support:** User groups and meetings, telephone assistance available 10 hours per day, newsletters and manuals.

**1988 gross revenues:** Not reported.

**Branch offices:** Baltimore; Washington, D.C.; Richmond, Va.; Indianapolis; Atlanta; Philadelphia.

### The Wyatt Co.

Research & Information Center,  
Suite 400, 1850 M St. N.W.,  
Washington, D.C. 20036;  
202-887-4600

**Year founded:** 1947.

**Software products:**

• **COBRA Administration System (CAS):** \$5,000; unbundled hardware and software; personal computer; year of first installation,

*Continued on next page*

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**DENTAL BENEFIT PROVIDERS, INC.**

Continued from previous page  
1986; more than 500 installations, all in employee benefit departments; functions include administration of claims under COBRA.

• MediCost: \$50,000; unbundled hardware and software; personal computer or mainframe; year of first installation, 1986; functions include claims analysis for health care cost management.

• Benefit Connection: \$30,000; unbundled hardware and software; personal computer; year of first installation, 1985; four installations, all in employee benefit departments; functions include generation of electronic benefit plan enrollment and administration; system has voice response capability.

• Reimbursement Administration: \$15,000; unbundled hardware and software; personal computer; first installation, 1984; 130 installations, all in employee benefit departments; functions include administration of flexible spending accounts, including claims processing and disbursement of funds.

• Flex Enrollment: \$25,000; unbundled hardware and software; personal computer; year of first installation, 1985; 50 installations, all in employee benefit departments; product is an enrollment system for flexible benefit plans; can be used to communicate benefits to employees.

• Participant Administration Software System (PASS): unbundled hardware and software; personal computer; year of first installation, 1984; 25 installations, all in employee benefit departments; functions include administration of defined contribution and pension plans.

• PCPIA: Unbundled hardware and software; personal computer; year of first installation, 1985; six installations, all in employee benefit departments; functions include Social Security projections and payout calculations.

• Medical Benefit Modeling System: Unbundled hardware and software; personal computer or mainframe; year of first installation, 1988; seven installations; one in an employee benefit department; system values medical benefit plans and estimates the cost of making changes in existing plans.

• WISE (The Wyatt Investment Savings Estimator): \$4,000; unbundled hardware and software; personal computer; year of first installation, 1986; eight total installations, all in employee benefit departments; functions include tax-savings analysis, take-home pay analysis and savings projections for 401(k) savings plans; can be used to communicate benefits to employees.

• FLEX pert: \$20,000; unbundled hardware and software; personal computer; year of first installation, 1988; one installation in an employee benefits department; functions include flexible benefits selection and take-home pay modeling and analysis; generation of enrollment forms; can be used to communicate benefits to employees.

• Retirement Benefit Plan Programs: Unbundled hardware and software; personal computer; year of first installation, 1987; four installations, all in employee benefits departments; functions include retirement benefit modeling and communication of pension, Social Security and projected savings plan benefits to employees.

• Fastback: Unbundled hardware and software; personal computer; first installation, 1989; one installation in an employee benefit department; product prompts employee responses, tabulates results and prints reports of employee attitude surveys and performance management programs.

Staff: 2,800 total staff members.

**Clients:** More than 10,000 total clients.

**User support:** User groups and meetings, telephone assistance available nine hours per day.

**1988 gross revenues:** \$332 million total.

**Branch offices:** Atlanta; Wellesley Hills, Mass.; Chicago; Cleveland and Columbus, Ohio; Dallas and Stafford, Texas; Denver; Grand Rapids and Detroit, Mich.; Fort Lee and Upper Montclair, N.J.; Honolulu; Irvine, San Diego, San Francisco, Santa Ana and Sherman Oaks, Calif.; Memphis, Tenn.; Miami; Milwaukee; Minneapolis; New York; Philadelphia; Phoenix, Ariz.; Portland, Ore.; San Juan, Puerto Rico; Seattle; Stamford, Conn.

**Principal officers:** V. Clark Beaird, president/chief executive officer; Michael H. Davis, vp/treasurer; Leroy B. Parks, Paul H. Jackson and Robert L. Barnes, vps.

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# Human resource computer use rises

By JACQUELINE LaSOTA

The rising cost of employee benefits, combined with the volume and complexity of government regulations, are spurring an increased use of computers by human resource departments, a recent survey reports.

However, human resource department computerization—including employee benefit plan computerization—remains far more common among medium- and large-sized firms, according to a report by KPMG Peat Marwick, the international accounting and consulting firm.

Meanwhile, 62% of company executives responding to the survey reported that additional computerization of compensation, health

and retirement plan administration areas will occur during the next two years, the study says.

The study, "Computer Usage in Human Resources: A Competitive Advantage," surveyed 294 senior-level human resource executives in all industries.

"Increased governmental reporting and regulations, Section 89 welfare plan discrimination testing and long-range strategic planning are key areas which could benefit greatly from increased computerization within the human resources departments," said Charles F. Miller, Southwest regional partner and survey director.

Of the 294 respondents, 30% were small companies with fewer than 200 employees; 34% were medium-sized employers with be-

**100% of the 'large' companies surveyed said their human resources staff used a computer.**

tween 200 and 1,000 workers; and 36% were large employers with more than 1,000 employees.

While 89% of the respondents report some use of computers in their human resource departments, computerization is more common among larger companies.

One hundred percent of the "large" organizations surveyed said their human resources depart-

ments used a computer, while "medium-size" organizations reported a 96% usage rate and small organizations reported a 72% usage rate.

KPMG broke down the human resource functions into categories including health and welfare plans, defined contribution plans and pension plans. Each category was further divided into specific tasks regarding those functions.

The survey reported that small organizations are less likely to have total computerization than are medium and large organizations in performing the benefits-related tasks of administering health and welfare plans.

"As an organization increases in size, it tends to computerize more health and welfare administrative tasks," the survey reports.

Within the health and welfare plan category, only 3% of small organizations reported having totally computerized flexible spending account programs, because "it is easier for small firms to administer FSAs manually."

Sixteen percent of medium-sized organizations and 28% of large firms have totally computerized FSA programs.

For administration of health care continuation benefits under the Consolidated Omnibus Budget Reconciliation Act, 14% of small organizations are totally automated while 34% of medium-sized firms and 39% of large firms are totally automated.

Only 8% of small firms report total computerization for discrimination testing under Section 89 of the Internal Revenue Code, the survey notes (see story, page 3).

"Discrimination testing, which is extremely complex, has the lowest level of computerization since third-party administrators provide cost-effective services to small organizations," the survey reports.

Thirty percent of medium-sized employers are totally computerized for discrimination testing, as are 48% of large firms.

Computerization also is not the rule for administering defined benefit pension plans.

Twenty-one percent of small firms and 23% of medium-sized firms report total computerization of their pension plans, while large firms report 31% total computerization.

The availability of third parties to perform these functions also is responsible for the lack of human resources department computerization for pension plan tasks, according to the survey.

Small firms also are less likely to have totally computerized defined contribution plan administration than larger firms.

The survey reports that 19% of small firms report total computerization for defined contribution benefit administration, while 37% of the medium-sized firms and 55% of the large firms have total computerization for defined contribution plan administration.

According to the survey, most companies use mainframe computers to administer health and welfare benefit programs.

For example, for FSA administration, 49% of the respondents used mainframe computers, 25% used personal computers and 15% contracted with a third party for administration.

For flexible benefit plan administration, 53% used mainframe computers, 26% used PCs and 21% used a third party.

Mainframes also are more popular than PCs for both defined benefit and defined contribution plan administration.

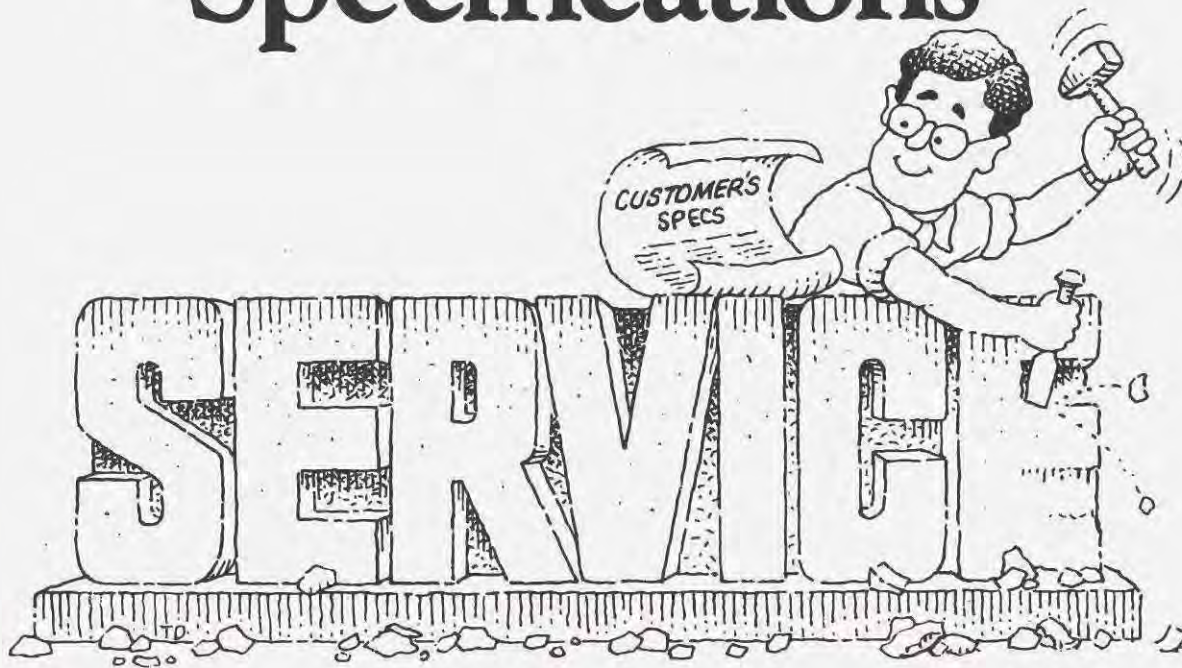
For instance, 51% of respondents used mainframe computers to administer their defined benefit plans, while only 19% used personal computers and 30% used a third party.

Likewise, 44% used a mainframe system to administer defined contribution plans, while 24% used personal computers and 32% contracted with a third party.

However, PCs were used more often for COBRA administration. Forty-seven percent of the companies used PCs to administer COBRA benefits, 32% used mainframes and 21% used a third party.

The survey did not track the types of computers used for Section 89 testing.

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Copies of the survey are available for \$15 each from KPMG Peat Marwick's Human Resources Consulting Group, 214-754-2000.

# Lloyd's passes underwriter restrictions

By CAROLYN ALDRED  
and STACY SHAPIRO

## London

### Leaving the 'Room'

Lloyd's of London underwriting agency Michael Payne & Others is the latest agency to move underwriters out of Lloyd's famous Underwriting Room to offices in other U.K. cities.

Payne underwriter Stephen Fitzgerald, who formerly worked as an underwriter for London-based insurer Eagle Star Insurance Co. Ltd., is underwriting risks with a team of three people in a new underwriting office in Manchester, England.

The Manchester-based operation specializes in U.K. commercial liability risks, according to Payne's Deputy Underwriter John Murphy.

The risks are written under the authority of a new and separate agency called Michael Payne Agencies Ltd.

The business then is ceded to Lloyd's syndicate 386/683, managed by Michael Payne & Others via Lloyd's of London reinsurance broker Alwen Hough Johnson Ltd.

In this way, the Manchester-based underwriter is able to accept risks from the regional offices of Lloyd's brokers and non-Lloyd's brokers.

Currently, all marine, non-marine and aviation business written by Lloyd's syndicates must be placed by authorized Lloyd's brokers. Lloyd's brokers usually are based near the Lloyd's building in the heart of London's financial district.

Although a recent policy document produced by a Lloyd's working party recommended that all commercial insurance business should continue to be placed by Lloyd's brokers for at least the next three years, many underwriters argue that this restriction means Lloyd's syndicates are missing out on potential business (BI, Feb. 27).

Some agencies already have opened up branches outside of London to attract more U.K. commercial risks through non-Lloyd's

brokers.

For example, Merrett Holdings P.L.C. opened a service company and underwriting office in Birmingham, England, in January 1988 (BI, Dec. 14, 1987).

### Underwriter exams

New Lloyd's of London underwriters will be required to pass several examinations beginning in January 1992.

Under a new rule passed May 10 by the Council of Lloyd's, "every active underwriter must have passed or be exempt from all examinations for the Lloyd's Market Certificate," effective Jan. 1, 1992, Lloyd's announced.

A syndicate's most senior underwriters as of Dec. 31, 1991, will automatically be exempt from this requirement.

Also exempt are persons becoming active underwriters on or after Jan. 1, 1991, who have accepted risks at Lloyd's for five or more years during the seven-year period ending Jan. 1, 1992, and are at least 30 years old.

"The intention is that this exemption should apply to deputy and class underwriters who become active on or after Jan. 1, 1992," said a Lloyd's statement.

The introduction of the exam was prompted by a January 1987 government inquiry into the Lloyd's market.

Headed by Sir Patrick Neill, the inquiry recommended that Lloyd's introduce a mandatory examination.

The examinations will be composed of three compulsory papers covering:

- English law with special reference to the law of an agency.
- The principles and practice of insurance.
- Lloyd's regulatory requirements.

The first examinations will be held in April 1990.

Thereafter, the examinations will be held every year for new underwriters.

### First-quarter results

Deterioration of U.S. business has contributed to a decline in first-quarter profits for at least two British insurers.

Commercial Union Assurance Co. P.L.C. announced May 10 that pretax profits for the three months ended March 31, 1989, fell 8.2% to 25.9 million pounds (\$43 million) from 28.2 million pounds (\$46.8 million) for the first quarter of 1988.

Premium revenues, however, increased 6.1% to 901.8 million pounds (\$1.5 billion) in the first quarter of 1989, from 850.3 million pounds (\$1.4 billion) during the corresponding quarter in 1988.

"Our largest territory, the United Kingdom, achieved another strong performance, and there was an excellent profit improvement from The Netherlands," said Chief Executive Tony Brend.

However, "in the United States, the operating loss was slightly higher, reflecting increased competition and a number of larger commercial claims," Mr. Brend added.

General Accident Fire & Life Assurance Corp. P.L.C. also announced a 5.3% drop in pretax profits for the first quarter to 55.5 million pounds (\$92.1 million) from 58.6 million pounds (\$97.3 million) the previous year.

However, premium revenues increased 20.7% to 783.9 million pounds (\$1.3 billion) from 649.5 million pounds (\$1.1 billion), during the same period.

GA's improved performance in the United Kingdom was offset by deterioration in North America and costs in connection with the banking operations of NZI Corp. Ltd., acquired by GA in July 1988, noted a statement from GA.

### Legal aid proposal

The Legal Aid Board recommends that the British government establish new guidelines for providing legal assistance to multiparty litigants who seek compensation for disaster- or drug-related injuries.

The recommendations are included in a consultative document sent to the Lord Chancellor's office—the government department responsible for the British legal system—this month by the Legal Aid Board, which administers government-sponsored financial aid for legal actions in the United Kingdom.

Currently, there is no special provision to grant legal aid for group action litigation. Litigants applying for legal aid are assessed by a means test based on the applicant's income and assets, so some

*Continued on next page*

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## London

Continued from previous page  
members of a group may be entitled to legal aid while others may not.

Those not entitled to legal aid may be forced to abandon litigation because of the high costs, the board noted.

"The cost of pursuing an action of this kind may run in millions of pounds, especially with the risk of having to pay defendants' costs if unsuccessful. This makes it impracticable for anyone not funded by the Legal Aid Fund, or with resources beyond the means of even the wealthy private individual, to litigate," the consultative document states.

Under the recommendations, an action that involves more than about 10 plaintiffs with claims arising out of the same event and involving common issues of fact and law will be coordinated through a single firm of lawyers, or a small group of firms. The coordinating lawyers would be entitled to claim legal aid for the entire group of plaintiffs under the Legal Aid Board's suggestions, the recommendation says.

Litigants included in the action would pay a contribution based on what they could afford the Legal Aid Board suggests.

Meanwhile, the litigants would continue to deal with the coordinating law firm through their own lawyers, the board adds

## Sedgwick personnel

Niven Duncan, vice chairman of international brokering group Sedgwick Group P.L.C. and chairman and chief executive of Sedgwick Ltd., will retire from the board on Dec. 31.

Mr. Duncan's position will not be replaced because Sedgwick Ltd. will "disappear" in the reorganization of the Sedgwick Group, according to a spokeswoman (BI, March 27).

Meanwhile, Sedgwick Deputy Company Secretary Jeremy Pinchin will replace Company Secretary George Hilton, who left the company earlier this month.

## Van Gogh exhibition

Dutch broker Amro Assurantie and London-based Sedgwick U.K. (London) Ltd. are placing up to 6 billion guilders (\$2.8 billion) of insurance coverage for an art exhibition in the Netherlands next year celebrating the centenary of Dutch painter Vincent Van Gogh.

The insurance package, believed to be the largest of its kind, will cover some 120 Van Gogh paintings and 250 drawings, which are being shipped and flown from private and public collections worldwide.

The risk will be placed largely in the Dutch and London markets and is being led in Lloyd's of London by Tim Jonas, an underwriter on syndicate 1133, managed by Merrett Underwriting Agency Management Ltd., said a Sedgwick spokeswoman.

Insurance will cover the transportation of the paintings and loss and damage during the four-month exhibition, which will begin March 30, 1990, and will include some of Van Gogh's most famous works, including "Sunflowers."

The paintings will be exhibited at Amsterdam's Rijksmuseum Vincent Van Gogh and the drawings will be displayed at the Kroller-Muller Museum in Otterlo, said a spokeswoman from Foundation Van Gogh 1990, the exhibition organizer.

## Willis Faber seminar

Lloyd's of London brokerage group Willis Faber P.L.C. treated its clients to a frank question-and-answer session during a recent seminar on captive management.

About 140 of Willis Faber's clients attended a one-day seminar recently in the company's headquarters on Trinity Square to hear seven speakers talk about various aspects of captive management.

The topics discussed included global risk management; needs of major buyers; captive locations; captive reinsurance; a buyer's perspective given by Robert Ealey, risk manager of Jaguar Cars; and an insurer's perspective by Tony Lancaster, senior vp of CIGNA Worldwide.

But one of the highlights of the day was a question-and-answer session in which policyholders asked Willis Faber executives a range of questions on all aspects of insurance brokering.

For example, one risk manager asked, "Why should brokers be paid on a fee basis rather than on a percentage of the premium?"

Michael Claydon, managing director of Willis Wrightson, answered that risk managers are looking to reimburse brokers the same way as they would reimburse banking services or accounting services. And, he predicted that within five to 10 years, all Willis Wrightson clients would be reimbursing the brokerage on a fee basis.

Willis Wrightson Executive Director Christine Douse, who chaired the seminar, added that fee remuneration "comes with unbundling services," which allows the client to pay for only those services

that are needed.

Another risk manager noted that accountants and actuaries are moving into the risk management consulting field and asked: "Can you provide competition to meet their challenge?"

"I would have thought they were following our lead," quipped Ms. Douse, adding that accountants are very active in providing risk financing information, but have a "long way to go" in providing loss control advice.

"Everyone's fishing in other people's water," said Mr. Claydon, who added that he thinks accountants charge more for their services than do insurance brokers.

Another risk manager commented that his company recently used an accounting firm to give it financial advice that was independent from the insurance market. "We wanted a detached view," he said. "The view was worth quite a lot."

"I guess we must stay on our toes," responded Ms. Douse. "We build in an audit function, but inevitably we expect our clients to seek outside advice" if it is deemed necessary.

Another participant asked whether 1992—the year in which all European Community trade directives are scheduled to be in place to allow cross-border trading—is a "threat or something to capitalize on" for insurance brokerages.

"There are so many mixed thoughts" on the opportunities that 1992 will bring, answered Willis Faber Chairman Roger Elliott. He added that he believes Europe eventually will become a unified entity like the United States instead of 12 separate countries split by legislation, culture and language.

"There is enormous opportunity for us as brokers," said Mr. Elliott. "I just think we will have to move around a bit quicker."

Another risk manager asked how long the insurance market will be soft and when liability rates will shoot up again.

Mr. Claydon replied that he sees no evidence of a hardening insurance market but, rather, finds the market is "becoming more competitive" as many foreign insurers try to break into the U.K. and European market.

It will always be difficult to find U.S. casualty coverage but casualty insurance for non-U.S. exposures is being offered by all insurers, he said.

"I think we would all agree that the market is fairly soft at the moment and very pleasant," said Mr. Elliott. "Now, if there are any problems—aside from American casualty which is fairly hairy—we can find solutions."

## Weavers disclaimer

H.S. Weavers (Underwriting) Agencies Ltd. last week "disclaimed" any involvement with the book, "Guide to the London Insurance Market" by Yvonne R. Paretzky.

The book, published in 1988 by The Bureau of National Affairs Inc., analyzes the three main U.S. liability insurance policies written in the London market (BI, Feb. 27). Ms. Paretzky is head of risk management communications specialist Paretzky Information Network Inc.

"While we have no objection to the general discussion of our role in the London insurance market, this publication was prepared without our authority," Weavers said in a statement.

The book "contains a number of interpretations of the provisions of our excess liability policy form which in our view are either inaccurate or do not accord with the intent and purposes of the form and our treatment of its provisions," Weavers said.

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# Surety market faces struggle despite profitable '88: Expert

By MARK A. HOFMANN

CHICAGO—Despite posting an underwriting profit for the first time in nine years, surety bond underwriters need to put their success into perspective, warns an industry executive.

Before we begin "patting ourselves on the back," we must face the challenges of refuting charges of discrimination against minority contractors and convincing lawmakers that there are limits to the kinds of obligations that can be insured, said Lloyd Provost, president of the Surety Assn. of America.

Mr. Provost offered his assessment of the state of the surety and fidelity bond industry at the 81st annual meeting of the Iselin, N.J.-based association in Chicago earlier this month.

Another speaker, N. David Thompson, president and chief executive officer of New York-based North American Reinsurance Corp., told the assembled surety company executives that North American Re remains committed to reinsuring surety business and said he was optimistic about the surety industry's continuing recovery from its recent financial problems.

Although it is too early to calculate an industrywide profitability figure, Mr. Provost said his estimates indicate a 2% profit on premium volume of \$1.7 billion. Contract bonds accounted for slightly more than \$1 billion of that overall premium.

The 1988 premium volume represented a 9% increase from the 1987 level for the surety industry as a whole.

Industrywide surety losses for 1988 are estimated at \$430 million, down from 1987 losses of \$800 million.

Mr. Provost pointed out that the 1988 combined ratio for surety business was 98%, a significant improvement from 1987's 125% combined ratio.

Contract bonds were "mainly responsible for this turnaround," Mr. Provost commented.

The loss ratio for contract bonds in 1988 was 36%, compared with 67% in 1987 and 103% in 1986, he continued.

The fidelity bond industry also posted a profit last year, for the third year in a row.

The fidelity bond industry's combined ratio was 70% in 1988, the same ratio as a year earlier, Mr. Provost said. However, a softening market caused the fidelity bond market's premium volume to fall about 2%, he noted.

But surety underwriters are not out of the woods yet, Mr. Provost said. The industry would need 12 years' worth of underwriting gains of 1988's magnitude to recover what the surety industry lost in 1987 alone, and it would need another 25 years to compensate for 1986.

The favorable results came from hard work, innovative thinking and "determination on the part of almost everyone in the surety industry to do what was necessary to turn around their experience," Mr. Provost said.

He noted that some of the changes the industry made were painful. While underwriting procedures were strengthened, some people lost their jobs and long-standing relationships with agents and contractors were in some cases broken, Mr. Provost. He praised industry leaders for refusing to lower their standards.

"They knew that if they failed, there might not be any more surety business. That's how close to the

edge we were," Mr. Provost pointed out.

But Mr. Provost made clear that the surety industry's woes have not ended. "We are just now starting to hear murmurs of softening markets and irresponsible underwriting in the contract bond field," he commented.

He noted that there are serious availability problems in some non-contract bond areas. For example, the markets for customs bonds guaranteeing duty payments by importers, bonds for surface mining companies guaranteeing land reclamation and bonds for companies that self-insure their workers compensation programs "run from tight to almost non-existent," Mr. Provost said.

He said surety insurers are going to have to do a better job of explaining to state and federal legislators that limits exist to the types of obligations that can be bonded. He said after his speech that he has heard of requests for bonds that would run for 2,000 years.

Mr. Provost also said that the surety industry has "taken a bad rap for too many years" for allegedly discriminating against minority contractors.

The problems faced by many minority contractors stem from the fact that their operations are small and do not have long track records, Mr. Provost said. To help small contractors understand the bonding process, the SAA and the Bethesda, Md.-based National Assn. of Surety Bond Producers have distributed more than 25,000 copies of an educational publication called "Your First Bond" and about 200 videotapes dealing with the same process, Mr. Provost said.

The association's educational efforts extend beyond contractors to legislators, Mr. Provost added. The SAA, with the assistance of the New York-based Insurance Information Institute, has produced a "surety legislative kit" for legislators, regulators, surety companies and surety bond producers, he said.

The kit contains basic educational material and background information on specific issues. For example, the SAA explains why it opposes establishing assigned risk plans or joint underwriting associations that would provide surety bonds to all contractors, regardless of qualification, he said.

North American Re's Mr. Thompson told the surety group that while "underwriting risk selection is always going to be the cornerstone of your business, less expense and more premium per unit of exposure, the basic and obvious remedies in most of our industry, would go a long way in effecting improvement" in surety results.

"From a reinsurance standpoint, surety looks a lot like a kind of catastrophe business," he said. Surety is similar because if economic trends such as inflation combine with a decline in construction activity, the whole surety industry is affected, said Mr. Thompson.

"Nobody in the surety business fully escapes the effects of fundamental economic forces. This is little different, from a reinsurance perspective, than a major fire or conflagration—a common external set of uncontrollable factors affects many separate risks at the same time. If the wind blows hard enough, all the houses on the beach are going to be hurt," Mr. Thompson said.

Reinsurers also are looking for greater participation in the surety

underwriting process, particularly when "unusually large multiple bond exposures" are involved, said Mr. Thompson.

But in seeking a larger role, Mr. Thompson said reinsurers "hope (we) will not be seen as trespassing on the primary company's underwriting prerogatives."

He said that he thinks the surety business is coming out of the trough and that last year's results indicate a turnaround in progress. "We are optimistic about the prospects" of 1989, he said.

The SAA currently has 637 domestic member companies and 10 foreign affiliates.

During the Chicago meeting, George F. Thompson, president and chief executive officer of New York-based Seaboard Surety Co., was re-elected chairman of the group.

John J. Dwyer, senior vp of Hartford, Conn.-based Aetna Life & Casualty group, was re-elected the SAA's vice chairman. ■



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# Court rules cleanup of waste site insurable

By STACY ADLER

PHILADELPHIA—For the first time, a U.S. District Court interpreting Missouri law has contradicted a famous 8th U.S. Circuit Court of Appeals decision by ruling that hazardous waste cleanup costs are legal damages and therefore insurable.

The district court ruling could help other policyholders involved in similar coverage disputes with their insurers, according to attorneys.

The May 9 ruling by the U.S. District Court for the Eastern District of Pennsylvania that hazardous waste cleanup costs are insurable damages under comprehensive general liability policies is in direct conflict with the full 8th Circuit Court's ruling in *Continental vs. Northeastern Pharmaceutical & Chemical Co.* (BI, March 7, 1988).

Both courts interpreted standard insurance policy language that says the insurer will "pay on behalf of the insured all sums which the insured shall become legally obligated to pay for damages."

However, Judge Clarence C. Newcomer Jr. of the U.S. District Court in Philadelphia ruled: "Based on Missouri case law, I conclude that the term 'damages' must be given a meaning that would ordinarily be understood by a layperson buying and paying for such a policy."

"Under Missouri law, the term 'damages' in the standard-form (comprehensive general liability) policy includes cleanup costs," he ruled.

Judge Newcomer said the majority of the U.S. appellate court misinterpreted Missouri law by ruling that cleanup costs are not insurable damages.

"Although the majority in *Continental* concluded that the term 'damages' is not ambiguous in the insurance context and has a plain meaning that refers to 'legal damages and does not include equitable monetary relief,' this conclusion was not based on Missouri case law or applicable rules of construction under Missouri law. In fact, in adopting a technical, insurance industry definition of the

term, the majority cited a 4th Circuit case applying Maryland substantive law," Judge Newcomer said.

Plaintiffs' attorneys believe that Judge Newcomer's decision is significant.

"Insurers have relied on the 8th Circuit's en banc decision in *NEPACCO*, which held that cleanup costs are not recoverable under Missouri law," said Doug Christian, an attorney with Reed, Smith, Shaw & McClay in Philadelphia.

Thus, the Philadelphia court's ruling contradicting the *NEPACCO* decision "will have a significant impact on insurance coverage actions," he said.

"This is a major decision for anyone who purchases insurance, because it recognizes that the language of insurance policies should be given its plain meaning, rather than a technical, legal meaning that will frustrate the expectations of the insured and allow the insurance company to avoid coverage," said Mr. Christian, who represented Jones Truck Lines of Springdale, Ark., the policyholder in the federal district court case.

Ellen Rosen Rogoff of Bolger, Picker, Weiner in Philadelphia, who represented defendant Transport Insurance Co. of Dallas in the case, would not comment on the decision. She said an appeal has not been filed.

Judge Newcomer's ruling stemmed from a coverage dispute between Jones Truck Lines and Transport Insurance over dioxin contamination at a Jones Truck Lines terminal in Missouri. Jones purchased \$5 million in liability coverage from Transport Insurance for the years 1970 to 1973.

Jones Truck Lines and Triad Carriers Inc. of Radnor, Pa., which is now legally responsible for the terminal, sued Transport seeking a court determination of whether the policies covered the \$320,000 spent to clean up dioxin on the land identified by the government as a hazardous waste site.

Jones had subrogated its rights under its policies to Triad Carriers, which allowed the case to be heard in federal court in Pennsylvania.

# Labor Department seeks comments on child care cover

By JERRY GEISEL

WASHINGTON—The Labor Department wants employer comments on problems in the commercial insurance market that may prevent companies from obtaining liability insurance for worksite child care services.

The department is seeking the information for a report mandated by the Bush administration in February (BI, Feb. 13).

The report, to be prepared by the Labor Department's recently organized Task Force on Child Care Liability Insurance, will be delivered to President Bush in October.

The task force is seeking information on a number of issues regarding child care liability insurance, according to a notice in the May 10 Federal Register, including:

- **Availability.** "How many insurance companies, writing which lines of insurance, provide either separate child care policies or are willing to add it to other policies? How many employers have been willing to self-insure or use a captive insurer for such a program and what is their liability experience?" the task force asked.

- **Affordability.** "How much does insurance cost, using measures such as per child per year? Are costs rising or falling? Are (industry) reserving practices appropriate?"

- **Adequacy.** "Do employers feel that the coverage available and affordable is adequate to protect them against future liability? What kinds of deductibles, exclusions, caps or other limitations are included in the insurance?"

- **Risk purchasing and risk retention groups.** "In what areas do such groups operate, if any? Are they becoming more common? Are the risk retention groups adequately reserved? What requirements exist for joining such groups?"

- **Reinsurance.** "How available is reinsurance and at what price? What requirements do reinsurers impose on insurers?"

- **Liability experience.** "Have the number of claims been rising? What are the differences by state? What specific tort law doctrines have resulted in liability? Have any states acted to modify tort doctrines to control liability?"

Comments should be sent to Debra Bowland, Director, Task Force on Child Care Liability Insurance, U.S. Department of Labor, Room S-3002, 200 Constitution Ave. N.W., Washington, D.C. 20007; 202-523-6611.

The deadline for comment is June 30.

## Proposal under fire

Proposed Internal Revenue Service rules that would force employers with flexible spending accounts to cover employee health care expenditures that companies never intended to pay are irrational, says Buck Consultants Inc.

Under most current FSA arrangements, employers fully reimburse employees participating in FSAs for eligible medical expenses only after the employee contributes enough money to the FSA to cover the expense.

By contrast, under the proposed IRS regulations slated to take effect on Jan. 1, 1990, companies generally would have to reimburse employees monthly after an em-

## Washington

ployee files an FSA claim, even if the employee's account does not yet contain sufficient funds to cover the reimbursement (BI, March 6; Jan. 30).

As a result, employees could schedule predictable and expensive treatment, like dental bridge-work, early in the year before they contributed large amounts to their FSAs.

Then, after receiving full reimbursement from their employer for uninsured expenses, they could quit, leaving employers stuck with big medical bills.

New York-based Buck Consultants, in a letter to the IRS, says this risk-shifting to employers has no rationale or foundation under the 1986 tax reform law or accompanying reports.

"Thus in our view, it is a rather arbitrary requirement that would not serve to enhance revenue and would discourage the growth, development and even the continuance of health flexible benefit plans," Buck said.

If flexible benefit plans are discouraged, all employees would be adversely affected, Buck said.

"These plans have enabled employers to continue to provide meaningful health benefits to their employees at a reasonable cost and, thus, should be continued," the letter added.

## ATRA chief leaving

Blair G. Childs, the first executive director of the Washington, D.C.-based American Tort Reform Assn., is resigning from ATRA to join an insurance company.

Mr. Childs, who joined ATRA after the trade group was started in 1986, helped build ATRA from a fledgling organization with a few dozen members to an influential trade group that now has more than 450 members.

Mr. Childs will leave next month to become director of public affairs at Aetna Life & Casualty Co. in Hartford, Conn.

"I was looking for new challenges and certainly the insurance industry faces many," Mr. Childs said.

Mr. Childs will be succeeded by Martin F. Connor, a long-time Washington, D.C., attorney for General Electric Co., and a well-known spokesman for tort reform.

## PBGC appointment

Wayne Robert Poll, a veteran Pension Benefit Guaranty Corp. official, has been selected to become the agency's first inspector general.

The appointment is in response to legislation passed last year requiring 33 federal agencies, including the PBGC, to establish offices of inspector general.

As inspector general, Mr. Poll is responsible for monitoring the PBGC's efficiency as well as detecting and preventing fraud and abuse.

Mr. Poll will submit semiannual reports to the PBGC and to Congress on any serious problems at the PBGC.

Mr. Poll joined the PBGC in 1979 after working for five years for the U.S. General Accounting Office in Washington, D.C. Most recently, Mr. Poll served as the PBGC's Director of Internal Audit. ■

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**MAY 22-24. NAIH's 1989 Executive Underwriting Clinic** in Rosemont, Ill., sponsored by the National Assn. of Independent Insurers; \$185. NAIH, 2600 River Road, Des Plaines, Ill. 60018-3286; 312-297-7600.

**MAY 23-24. Killer Diseases—Technical & Insurance Aspects** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 380 pounds (\$333.84). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**MAY 23-25. Can We Afford the Future?—Benefits in the 21st Century** conference in Washington, D.C., sponsored by the Assn. of Private Pension & Welfare Plans; \$525 for APPWP members; \$595 for non-members. APPWP, 1331 Pennsylvania Ave. N.W., Suite 719, Washington, D.C. 20004; 202-737-6666.

**MAY 24. Employer Compliance with Section 89** conference in Springfield, Ill., sponsored by The Illinois State Chamber of Commerce Center for Business Management; \$120 for ISCC members; \$180 for non-members. Also **May 26** in Chicago. ISCC Center For Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

**MAY 24. Financial Institutions—Special Risks and Insurance** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 210 pounds (\$350.28). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London,

England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**MAY 24. The Ohio Manufacturers Assn.'s and the Coalition for Cost Effective Health Services' Seventh Annual Health Care Management Conference** in Columbus, Ohio; \$105 for OMA or CCEHS members; \$140 for non-members. Ohio Manufacturers Assn. 33 N. High St., Columbus, Ohio 43215-3005; 614-224-1722.

**MAY 24-25. On-Site Groundwater and Soil Remediation** seminar in Los Angeles, sponsored by Groundwater Technology Inc.; \$425 for corporations; \$325 for government. Discounts for three or more registrants from the same organization. Brian Jaffarian, Groundwater Technology Inc. 220 Norwood Park S., Norwood, Mass. 02052 617-769-7600.

**MAY 24-26. Captive Insurance** conference in Grand Cayman, Cayman Islands, co-sponsored by the Cayman Insurance Managers' Assn. and the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; \$685. Conference Director, Tillinghast/TPF&C, Financial Center, 695 E. Main St., Suite 600, Stamford, Conn. 06901-2138; 809-949-8228.

**MAY 25. Employee Benefits in the Courts** breakfast seminar in Lisle, Ill., sponsored by the West Suburban Chicago chapter of WEB; \$10 for WEB members; \$20 for non-members. L. Zoeller, 200 W. Adams, Suite 2015, Chicago, Ill. 60606; 312-558-4585.

**MAY 25. Second Annual Claims Seminar** in Atlanta, co-sponsored by Draw Eckl & Farnham and Forcon International-Georgia Ltd.; no charge. Forcon International-Georgia Ltd., P.O. Box 49721, Atlanta, Ga. 30359; 404-321-4969.

**MAY 25-26. Brief Reinsurance** course in New York City, sponsored by The College of Insurance; \$195 for College sponsors; \$245 for non-sponsors. College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

**MAY 30-JUNE 2. Reinsurance Accounting & Finance for Ceders & Assurers** seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,445. Robert W. Strain Seminars Inc., Box 1000, Wingdale, N.Y. 12594; 914-832-8334 or 212-677-5976.

**MAY 31. Insuring Long Term Care** seminar in Chicago, co-sponsored by the Society of Actuaries and the American Academy of Actuaries; \$355 for society members; \$390 for non-members. Society of Actuaries, P.O. Box 71293, Chicago, Ill. 60694; 312-706-3545

**JUNE 1-2. Risk and Insurance Management in Banking** seminar in Washington, D.C., sponsored by the American Banking Assn.; \$495 for ABA members; \$620 for non-members. Tom Aubrey American Banking Assn., 1120 Connecticut Ave. N.W., Washington, D.C. 20036; 202-663-5293.

**JUNE 1-2. Legal Aspects of Occupational Safety and Health** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$385. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202 Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 1-2. Current Issues in Insurance Letters of Credit** conference in New York City sponsored by Executive Enterprises Inc.; \$990 Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880

**JUNE 5-6. The Environmental Insurance Law Institute** in New York City, sponsored by Executive Enterprises Inc.; \$490. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 5-9. Practical Risk Management** course in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 775 pounds (\$1,292.70). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 5-9. Management and Administrative Skills for the Occupational Safety and Health Professional** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$735. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 7-8. Product Development Boot Camp** seminar in Oak Brook, Ill., co-sponsored by the Society of Actuaries and Individual Life Insurance and Annuity Product Development Section; \$460 for Society of Actuaries members; \$495 for non-members. Society of Actuaries Seminar Department, P.O. Box 71293, Chicago, Ill. 60694; 312-706-3545.

**JUNE 7-9. Fundamentals of Insurance** course in San Francisco, sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. Fran Jordan, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-296-9292.

**JUNE 8. Reinsurance Law Update** conference

in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 220 pounds (\$366.96). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 8-9. Financial Analysis for Risk Management** course in Washington, D.C., sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-964-3381.

**JUNE 8-9. Health Care Risk and Insurance Management: Constructing the Comprehensive Program** seminar in Chicago, sponsored by the American Society of Health-care Risk Management; \$345 for ASHRM members; \$465 for non-members. Trudy Goldman, ASHRM, 840 N. Lake Shore Drive, Chicago, Ill. 60600; 312-289-6425.

**JUNE 8-9. Linking Data and Long Term Care Services** conference in Washington, D.C., sponsored by the National Assn. of Health Data Organizations; \$225 for NAHDO regular and associate members; \$300 for NAHDO individual members and non-members. Julie Greene, NAHDO, 316 Pennsylvania Ave. S.E., Suite 202, Washington, D.C. 20003.

**JUNE 8-9. ERISA Basics: A Primer on**

**ERISA Issues** conference in San Francisco, co-sponsored by the American Bar Assn. sections on Business Law, Labor and Employment Law, Real Property, Probate and Trust Law, Taxation, and Tort and Insurance Practice, and the ABA Division for Professional Education; \$400 for ABA members; \$375 for members of sponsoring ABA sections; \$425 for others. Division for Professional Education, American Bar Assn., 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

**JUNE 11-13. Annual American Insurance Assn. General Counsel's Symposium** in Washington, D.C., sponsored by AIA; \$150 for members; \$225 for non-members. Ronald S. Gass, AIA, 1130 Connecticut Ave., Washington, D.C. 20036; 202-828-7100.

**JUNE 11-14. Setting the Stage—HMOs and the American Health System in the Next Decade** institute in Atlanta, sponsored by the Group Health Assn. of America Inc.; \$555 for GHAA members; \$655 for non-members; \$230 for students/retirees. Registrar, Group Health Assn. of America Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036.

**JUNE 12. The Basics of Benefits Administration** seminar in Peoria, Ill., sponsored by Key Productivity Center; \$145. Also **June 13** in Chi-

*Continued on next page*

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Continued from previous page

June 14 in Neenah, Wis.; June 15 in Milwaukee; and June 16 in Minneapolis. Key Productivity Center, P.O. Box 27-480, Kansas City, Mo. 64180; 800-821-3919; 913-345-2140.

**JUNE 12-13. Transportation of Hazardous Materials/Waste** course in Sacramento, Calif., sponsored by the University of Southern California's Institute of Safety and Systems Management; \$100. Also **July 10** in Los Angeles. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 12-13. Claims Reserving in Non-Life Insurance** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 410 pounds (\$683.88). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 12-13. Fundamentals of Statutory Insurance Accounting** conference in New York City, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 12-14. Techniques of Risk Management** course in Orlando, Fla., sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. RIMS, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017; 212-286-9292.

**JUNE 13. Flexible Benefits: Are They Right for Your Company?** conference/trade show in Boston, sponsored by the New England Benefits Council; \$110 for NEBC members; \$150 for non-members. NEBC, 675 Massachusetts Ave., Cambridge, Mass. 02139; 617-547-6484.

**JUNE 13-14. Reinsurance Systems** course in Boston, sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. Also **Oct. 24-25** in Chicago. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

**JUNE 13-14. Divergent Paths: The Insurance Industry and Its Reinsurers—Are They at a Crossroad or Have They Passed It?** symposium in Parsippany, N.J., sponsored by the Society of Chartered Property & Casualty Underwriters' Reinsurance Section; \$300 for section members; \$310 for Society of CPCU members; \$350 for non-members; \$15 charge after June 23. Mari Jennings, Professional Services Coordinator, Society of CPCU, 720 Providence Road, CB#9, Malvern, Pa. 19355-0709; 215-251-2741.

**JUNE 13-15. Hazard Communication for the Industrial Hygienist** seminar in Boston, co-sponsored by the National Center for Hazard

Communication, the University of Maryland's Center for Professional Development and the American Industrial Hygiene Assn.; \$595. Also **June 27-29** in Los Angeles. Registration Clerk, University of Maryland Center for Professional Development, University Boulevard at Adelphi Road, College Park, Md. 20742.

**JUNE 13-15. Seventh Annual Hazardous Materials Management** conference and exhibition in Atlantic City, N.J., sponsored by Hazmat World; \$80 for June 13; \$135 for June 14 and 15; \$325 for all three days; \$395 for all three days plus copy of 1989 proceedings Tower Conference Management Co., 800 Roosevelt Road, Building E, Suite 408, Glen Ellyn, Ill. 60137-5835; 312-469-3373.

**JUNE 14. The 5500 Series Forms: Recent Actuarial Changes** workshop in Commerce, Calif., sponsored by The National Institute of Pension Administrators; \$85 for regular and associate NIPA members; \$110 for non-members. NIPA, 145 W. First St., Suite A, Tustin, Calif. 92680; 714-731-3524.

**JUNE 14-16. Understanding Property/Casualty Statutory Financial Statements** seminar in New York City, sponsored by Executive Enterprises Inc.; \$990. Also **July 17-19** in San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 15. Assn. of Professional Insurance Women's 1989 Insurance Woman of the Year Awards** in New York City; \$50. APIW, Cath-

erine Ancone, 212-785-2500.

**JUNE 15-16. The 1989 Insurance & Reinsurance Research Bureau's Lloyd's Conference: Developing Lloyd's Business** in London; 410 pounds (\$683.88). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 15-16. First Annual Excess and Reinsurance Symposium** in Montreal, sponsored by the Defense Research Institute; \$370 for DRI members; \$395 for non-members. DRI, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-977-0575.

**JUNE 15-16. Second Annual Symposium for Third-Party Administrators and Consultants** in San Francisco, sponsored by the Employers Council on Flexible Compensation; \$585 for members of the ECFC, Society of Professional Benefit Administrators or the Self-Insurance Institute of America; \$635 for non-members. Employers Council on Flexible Compensation Seminar, 6140 S. Marion St., Tulsa, Okla. 74136; 918-628-3939.

**JUNE 15-17. Brief Reinsurance** course in New York City, sponsored by The College of Insurance; \$195 for college sponsors; \$445 for non-sponsors. The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 21-962-4111.

**JUNE 18-21. Annual National Assn. of Insurance Women** convention in Honolulu; \$195 for NAIW members; \$215 for non-members. Nancy

Runge, NAIW, 1847 E. 15th St., Tulsa, Okla. 74159; 918-744-5195.

**JUNE 19-20. The Property/Casualty Reinsurance Accounting** course in New York City, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 19-20. Insurance Company SEC Reporting and Compliance** course in Boston, sponsored by KPMG Peat Marwick; \$825. Executive Education Registrar, KPMG Peat Marwick, 3 Chestnut Ridge Road, Montvale, N.J. 07645; 800-762-3932.

**JUNE 19-21. Fundamentals of Risk Financing** course in Washington, D.C., sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 19-23. Fundamentals of Employee Benefits Management** course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$1,000 for the five-day Fundamentals Course, \$600 for the three-day Intermediate Course. Also **July 17-21, Sept. 18-22 and Oct. 2-6**. Registration Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53009-0069; 414-786-6700.

**JUNE 19-23. Employee Benefits** seminar in Lincolnshire, Ill., sponsored by Hewitt Associates; \$1,475. Diane E. Coleman, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

**JUNE 20. Insurance for International Trade** conference in New York City, sponsored by the International Insurance Council; \$150. IIC, 202-331-7221.

**JUNE 21. Merging Primary Cover With the Umbrella/Excess Cover—How to Prevent the E&O Claim** seminar in Atlanta, sponsored by Professional Liability Risk Managers Inc.; \$15. PLRM, 2814 New Spring Road, Suite 304, Atlanta, Ga. 30339; 404-436-5241.

**JUNE 21-22. The Global Restructuring of the Insurance Industry** conference in New York City, sponsored by KPMG Peat Marwick; \$895 for first attendee; \$795 for each additional attendee from the same organization. Chris Chandonet, KPMG Peat Marwick, 3 Chestnut Ridge Road, Montvale, N.J. 07645; 201-307-7289.

**JUNE 22. Illinois Insurance Exchange Brokers Assn. Seminar** in Fort Lauderdale, Fla.; no charge. Also **July 20** in Pittsburgh. Terry Ryan, Illinois Insurance Exchange, 175 W. Jackson Blvd., Chicago, Ill. 60604; 312-939-2400.

**JUNE 22-23. Developments in Offshore Insurance** conference in the Isle of Man, co-sponsored by Manx Insurance Assn., and the Risk and Insurance Research Group Ltd.; 350 pounds (\$583.80). RIRG Ltd., 4 Henrietta St., Covent Garden, London WC2E 8PS; 01-8360614.

**JUNE 23. Expert Systems in Underwriting** symposium in Houston, sponsored by The Society of Chartered Property & Casualty Underwriters; \$85 for Society of CPCU members; \$115 for non-members. Bonnie Kinsley, The Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

**JUNE 23-24. The ABCs of Pension Administration** course in Marina del Rey, Calif., sponsored by the National Institute of Pension Administrators; \$170 for regular and associate members; \$195 for non-members. National Institute of Pension Administrators, 145 W. First St., Suite A, Tustin, Calif. 92680-3209; 714-731-3524.

**JUNE 25-27. Insurance Regulatory Examiners Society Workshop** in Kansas City, Mo.; \$35. Insurance Regulatory Examiners Society, 6811 W. 63rd St., Suite 208, Overland Park, Kan. 66202; 913-831-0080.

**JUNE 25-28. Annual Society of Insurance Trainers and Educators** conference in Lake Lanier, Ga., sponsored by SITE; \$395 for SITE members; \$450 for non-members; \$150 for guests. Hank Drewes, Box 513, Cary, Ill. 60013; 312-516-1921.

**JUNE 26-28. Reinsurance Accounting & Auditing** course in Kansas City, Mo., sponsored by The College of Insurance; \$795 for College sponsors; \$895 for non-sponsors. Also **Sept. 25-27** in Chicago and **Nov. 1-3** in San Francisco. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

**JUNE 26-28. Inspecting Buildings for Asbestos-Containing Materials** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$490. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 26-28. 1989 Trustees and Administrators Institute** in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; \$525 for IFEBP members; \$600 for non-members. Registration Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

• **"Financial Institution Directors & Officers Liability Loss Prevention"** is a 36-page handbook addressing the unique loss exposures of the financial services industry, including lender liability, insurance claims handling, corporate takeovers and employment-related claims. Written by Dan A. Bailey, a noted D&O expert with the Columbus, Ohio, law firm Arter & Hadden, the booklet offers loss prevention tips and ways to maximize legal protection. Chubb Corp. commissioned the handbook and offers limited free copies through local Chubb branch offices or by written request to Jean Kenney, Department of Financial Institutions, Chubb Corp., 15 Mountain View Road, Warren, N.J. 07060-1615.

• Reprints of a speech presented during the 1989 Risk & Insurance Management Society conference, **"An Attorney's Suggestions on How to Manage Attorneys' Fees,"** now are available. Chicago attorney Jeffrey Singer spoke of how to resolve problems between clients and attorneys regarding fees, methods of selecting competent defense counsel, and how to control defense costs for nuisance and catastrophic injury litigation. The paper also includes a sample format for attorney invoicing, a sample "litigation budget" and advice on how to prevent runaway legal bills. One to five copies are \$10 each, six to 49 copies are \$5 each and more than 50 copies are \$4 each. Copies may be requested on company letterhead or with a business card, prepaid, to Jeffrey Singer, Segal, McCambridge, Singer & Mahoney Ltd., 111 W. Washington St., Suite 855, Chicago, Ill. 60602; 782-3800. After June 15, address will be: 2 First National Plaza, 20 S. Clark St., Suite 700, Chicago, Ill. 60602.

• **"Guide to Benefit Plan Administration"** is a 416-page guide to the management of employee benefit trust funds. It includes sections on the role of the professional administrative manager, the manager/trustee relationship, communication, administrative functions and the potential liability of administrative managers. Benefit plan administration changes mandated by recent federal laws also are discussed in the book written by benefits experts and published by the International Foundation of Employee Benefit Plans. The book is \$25 for foundation members and \$40 for non-members. Prepaid orders for publication ISBN 0-89154-349-X may be sent to the Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• The Crane Institute of America Inc. offers its quarterly publication, **"The Indicator,"** free to construction crane operators and supervisors. The company performs on-site safety inspections and crane operator safety certification. Subscriptions are available from Cathy Chamberlin, Crane Institute of America Inc., 1053 N. Orlando Ave., Suite 4, Maitland, Fla. 32751; 407-647-1800.

• Benefit managers who need to keep up with private and public benefit trends worldwide may find **"Corporate Benefit Plans: International and Domestic Perspectives"** helpful. The 201-page book published by the International Foundation of Employee Benefit Plans addresses current benefit practices in specific countries and outlines social, economic and demographic factors influencing the international benefits climate. Topics affecting U.S. benefit managers include the AIDS crisis, re-

tiree health care plans and elder care plans. The book, publication ISBN 0-89154-365-1, is \$25.50 for foundation members and \$30 for non-members. Prepaid orders may be sent to the Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• A poster explaining how to use the **material safety data sheets** required by the Occupational Safety and Health Administration is now available. Designed for display in the workplace, the poster reminds workers and managers of safety requirements involved in the handling and storage of chemicals. Cost is \$14.95 each for one to five posters; \$13.95 each for six to 49 posters; and \$11.95 each for more than 50 copies. Requests should be made to Laura Lopetz, Hazard Communication Specialists, P.O. Box 320971, Cocoa Beach, Fla. 32932-0971; 407-783-6641.

• Comprehensive Loss Management Inc. has a catalog of its **safety and health training videos** available for sale to employers. New titles in the 1989 catalog from the communications company include Back Injury Prevention, Hazard Communication and Workers Compensation Case Management. Free copies of the catalog are available from Janine Lippert, Marketing Administrator, Comprehensive Loss Management Inc., 7405 Washington Ave. S., Minneapolis, Minn. 55435; 800-533-2767.

• A division of the American Insurance Services Group Inc. has published a **guide for employers evaluating and qualifying potential drivers.** "Driver Qualification" was compiled by the Engineering & Safety Services division to help reduce commercial auto account losses. The booklet includes sample forms for inquiries to former employers, medical exams and records of road tests. The information provided meets the statutory requirements of the Federal Motor Carrier Safety Regulations. The 27-page booklet is \$1 per copy for E&SS subscribers and \$2 for non-subscribers and may be ordered by requesting publication CV-9, Driver Qualification, Publications Department, AISG, 85 John St., New York, N.Y. 10038; 212-669-0419.

• **"How Do I Pay For My Long-Term Health Care?"** is published by Berkeley Planning Associates, a research and consulting organization with an emphasis on health care, disability and aging issues. The 110-page paperback helps benefit counselors and insurance professionals as well as consumers examine the options for retirees or workers nearing retirement. The book includes analyses of Medicaid, long-term indemnity insurance policies for extended nursing home and home care as well as reverse mortgages and other health care financing mechanisms. Single copies are \$12.95 and may be obtained by contacting Stuart Hanson, Berkeley Planning Associates, 440 Grand Ave., Suite 500, Oakland, Calif. 94610; 415-465-7884.

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# Comp rate hikes generate demand for insurer reforms

By MEG FLETCHER

Double-digit increases in workers compensation insurance rates nationwide are rallying employers, legislators and others to demand changes in the way the coverage is written.

While some work comp reform proposals are meant to eliminate so-called abuses in the workers compensation system—like the explosion in workers comp-related litigation—and improve administrative functions, several are aimed directly at workers compensation insurers.

For example, some states are considering changing the formula that insurers use to set workers compensation rates, while others are calling for more competition among work comp insurers.

"It's not only a fight about changing the benefit structure, but reallocating the way premium is allocated to employers," observed John Lewis, a workers compensation expert from Coconut Grove, Fla., who has been hired to analyze several troubled state work comp systems.

For example, small employers are seeking more credit for good loss experience, he said.

"There are major, unresolved problems in the workers compensation system countrywide," said Kevin Ryan, president of the National Council on Compensation Insurance in New York.

But, for many employers, the most serious of the many problems affecting the workers compensation system is cost of coverage.

Employers that purchase workers compensation insurance are facing premium increases year after year that exceed the increase in employers' payroll, on which workers compensation insurance rates are based (see story, page 75).

The "employer cost issue" has sparked most of the recent efforts for statutory changes in the states, Mr. Lewis said.

"We are seeing rate increases consistently," said Herbert Knoblauch, vp of risk management for Anco Industries Inc., a Baton Rouge, La.-based contracting firm that currently operates in about 20 states.

Yet while employers complain about the high cost of workers compensation insurance, insurers complain that rates are not high enough to cover their costs.

In fact, some companies, including Anco's Louisiana operations, now can only purchase coverage in the residual market since few insurers will write coverage in the voluntary market, because they say rates in the voluntary market are inadequate in Louisiana and other states (see story, page 74).

Although employers that self-insure their workers compensation risks are not subject to the seemingly endless premium increases by and the pitfalls of the residual market, self-insurers—like insured employers—still face the problem of escalating workers compensation medical and indemnity costs. And, it is those costs that insurers say are fueling the rate increases.

"There is no question that medical costs are skyrocketing," said Charles Krysiak, president of the International Assn. of Industrial Accident Boards & Commissions, which represents state work comp administrators.

In fact, medical costs can comprise about 40% to 50% of workers compensation benefit costs, said

Mr. Krysiak, who is chairman of Maryland's Workers' Compensation Commission.

Medical costs are continuing to rise by about 7 percentage points in excess of the annual increase in wages, according to the NCCI. Thus, based on the 4.3% increase in salaries and wages in 1988 according to the U.S. Bureau of Labor Statistics, work comp medical costs alone rose by more than 11% last year.

At the same time, workers compensation indemnity costs also are soaring, noted Richard Fein, NCCI executive vp.

An analysis of trend factors shows that indemnity costs in states for which the NCCI calculates rates are increasing by about 6 percentage points above the annual increase in wages, even though few states are increasing work comp benefit levels, Mr. Fein said.

For example, work comp indemnity benefits for the 3,900 employees of the city of Tampa, Fla., have risen steadily during each month of the city's current fiscal year, said Michael McNabb, the city's risk manager.

Tampa's total work comp indemnity payout for the first six months of fiscal 1989 was \$392,000, up 56.2% from \$251,000 during the same period the previous year, he said.

Contributing to this increase are loopholes in a Florida wage-loss workers compensation law that allow recovered workers who do not return to work for the city to conduct half-hearted job searches while still collecting work comp indemnity benefits, Mr. McNabb said.

In addition, indemnity costs are pushed upward by factors such as increased claims frequency and the never-ending expansion of the workers compensation system, especially through increased acceptance of stress and cardiovascular claims, said Steven Millikan, vp and director of workers compensation for the Alliance of American Insurers in Schaumburg, Ill.

State workers compensation officials are interpreting claims "really liberally," noted Lucille Gallagher, vp of risk management for the Monfort Inc. in Greeley, Colo. "It's work comp unless an employer can disprove that," she said.

However, Ms. Gallagher added that as a risk manager, her goal is to see that employees with legitimate work-related injuries promptly receive benefits.

Besides the problem of rising medical and indemnity costs, the oversight mechanism provided by state work comp administrators is also coming under scrutiny as work comp observers in some states seek ways to reduce litigation and streamline the system.

Many critics think that the billion-plus dollars spent annually in the United States for lawyers' services and physicians' evaluation and witness fees include unnecessary "friction" costs for both employers and employees (BI, Jan. 16).

They complain that the structure of some states' work comp systems foster adversarialness at the expense of prompt and fair settlement. The result is prolonged delays in the hearing of cases and overutilization of lump-sum settlements.

Continued on next page

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All of these problems are flooding the offices of state regulators and legislators, who must weigh the cost of the system against how well it works.

Too often, state legislators and administrators design systems that offer "Cadillac" benefits and services but then do not want to pay more than "Chevy" prices to provide them, one observer said.

"Employers scream on one hand to the legislature that it has to do something about cost," Mr. Millikan said. Then the legislature faces the dilemma of how to improve the system without increasing the cost, he added.

State legislators are particularly sensitive to work comp costs, because "states are in competition with each other to create the most advantageous business climate," he pointed out.

Legislators' sensitivity to workers compensation issues has been heightened by the general politicization of the climate for insurance-related issues.

The antitrust lawsuits filed against insurance industry defendants by state attorneys general and California's Proposition 103 do not directly affect workers compensation insurers, but they have helped create an anti-insurer atmosphere that spills over into work comp discussions, observers say.

In light of the Insurance Services Office Inc.'s decision to no longer provide non-workers compensation insurers with full developed rates, the NCCI may feel similar pressures (BI, April 10).

The National Assn. of Insurance Commissioners soon plans to study workers compensation ratemaking, which will include a review of the NCCI's operations.

"It's got to be a tough time for the NCCI and the industry," Mr. Lewis said.

The NCCI currently files fully developed rates, which include profit and expense components, in more than two dozen states. Those rates are subject to prior approval by the state insurance regulator.

And other groups perform the NCCI's function in several other states.

However, 12 states—most of which passed "open competition" or "competitive rating" laws in the early 1980s—restrict in some way the ability of the NCCI to file rates, said Michael Camilleri, the NCCI's senior vp and general counsel. Those states are: Arkansas, Georgia, Illinois, Kentucky, Louisiana

Maryland, Michigan, Minnesota, New Mexico, Oregon, Rhode Island and Vermont.

Maine had an open rating system for workers compensation until it eliminated it last year and returned to a prior approval system with rates filed by the NCCI.

Besides these states, six states with monopolistic state workers compensation funds do not allow commercial insurers to write workers compensation insurance: Nevada, North Dakota, Ohio, Washington, West Virginia and Wyoming.

Now, some critics of workers compensation insurers want to restrict commercial insurers' ability to write work comp insurance in more states or, at least, change the way the coverage is written.

Industry critics favoring such proposals seek to improve the system by increasing competition among writers of workers compensation or modifying what they perceive as alleged price-fixing among insurers.

But insurers see it as a "kill the messenger approach," one insurer spokesman said.

"Many states try to tinker with the rating system but not the hard, political problems of the system itself," Mr. Millikan said.

The proposals now pending in state capitals include legislation that would:

- Change ratemaking-related procedures.

Indiana is expected to approve a bill, S.B. 542, that would convert its system to competitive rating from prior approval, according to Larry Hochstetler, the NCCI's director of government, consumer and industry affairs for the region.

That move is "ironic" because Indiana employers pay among the lowest rates for workers compensation insurance in the nation, an observer noted.

In addition, Connecticut legislators are considering a bill, H.B. 99, that would restrict the NCCI to filing only pure premium—or loss cost only—information for the voluntary workers compensation market instead of fully developed rates, which include insurer profit and expense components.

However, the legislation would allow the NCCI to continue filing complete rates for the state's residual market.

Meanwhile, New Mexico nearly enacted a measure earlier this spring that would have limited all rating organizations—including the NCCI—to providing only un-trended loss costs, rather than

fully developed rates for property/casualty insurance. The measure, H.B. 287, was approved by the state Legislature but vetoed by Gov. Garrey Caruthers, said Everett Brookhart, NCCI senior vp.

- Establishing a competitive state fund that would compete with commercial insurers to sell insurance to policyholders.

Supporters of competitive state funds contend that they increase the number of players in the market, thereby enhancing competition.

However, Peter Burton, the director of government, consumer and industry affairs for the NCCI's northern region, said: "It's not a solution but just a different delivery system which will experience the same cost pressure that insurance carriers have."

Thirteen states currently have competitive state funds: Arizona, California, Colorado, Idaho, Maryland, Michigan, Minnesota, Montana, New York, Oklahoma, Oregon, Pennsylvania and Utah.

In addition, Hawaii has created a competitive state fund but has not yet appropriated money to get it started, said Maureen Ramert, the NCCI's director of national affairs.

Several other states also recently have discussed establishing some type of fund, according to the NCCI.

Currently, Rhode Island is considering establishing a competitive state fund in an effort to increase the number of sellers in the market. States in which state funds were considered last year include Georgia, Maine, Minnesota, Mississippi and New Mexico.

- Changing the exposure base for determining an employer's work comp premium.

Nearly all states now use an employer's total payroll as the basis for determining an employer's workers compensation premium. Premiums are calculated by multiplying payroll by the rate per \$100 for a particular class of employee.

However, seven states have recently discussed—but have not yet approved—legislation that would either base workers compensation premiums on the number of man-hours worked or would cap the amount of payroll on which work comp premiums are calculated, said the Alliance's Mr. Millikan. Those states are Arizona, California, Delaware, Iowa, Missouri, Oklahoma and Oregon.

Employers, especially those in the construction industry, that pay

their workers higher than average wages often favor these changes because they say basing premiums on payroll penalizes them for paying higher wages.

However, the Alliance opposes the switch to man-hours from payroll as a premium base because it is hard to administer and difficult to verify the number of hours worked, Mr. Millikan said.

"In Washington, the only state to

use the hours-worked system, employers must keep track of hours worked by each of their employees and independent verification is difficult," the NCCI points out.

"In the case of wage caps, as salaries rise, the caps eventually deteriorate into headcounts of staff members and the basis of premium become arbitrary," the NCCI says.

Capping the amount of payroll

Continued on next page



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# NCCI calls for work comp congress

The president of the National Council on Compensation Insurance is asking all participants in the workers compensation system to gauge how well the system works.

NCCI President Kevin Ryan is calling for a "a fresh assessment of where we are today and where we want to be tomorrow."

To complete this evaluation, the New York-based NCCI is holding a Workers Compensation Congress on Sept. 8 in Philadelphia.

With a nod to Benjamin Franklin—who urged disparate members of the Continental Congress to "hang together"—Mr. Ryan said insurers, employers regulators, labor unions and legislators are all "in danger of hanging separately" without a new consensus about ends and means of workers compensation.

"No one party to the system has monopoly of wisdom, and even if one did, no single group has the strength to impose its vision on all the rest. So, we must re-invent the consensus," he said.

The program for the congress includes formation of a broad-based "blue ribbon" panel that will include representatives of insurers, policyholders, self-insurers, legislators, regulators, labor officials and academics.

The panel, which will be announced later this spring, will assign topics to eight committees, which will meet over the summer to outline specific problems and proposals, especially those that will increase the efficiency of the workers comp system and reduce costs.

In addition, the meeting will feature an overall review of problems with the workers comp system from several perspectives, including state and federal regulators and legislators, employers, organized labor and

insurers.

Following comments from the audience, the NCCI will modify any papers or reports and publish the final result.

"We expect to build on the research we have done in recent years, presenting recommendations that offer practical solutions to the system's problems," Mr. Ryan said. "It is our hope that they will reflect a revitalized approach—a new consensus—one that will receive the serious hearing of legislators and regulator authorities who have been searching for a way to calm the troubled waters of the workers compensation system."

The gathering is strategically timed to precede two important meetings of state officials who oversee different parts of state workers compensation systems.

Top state insurance regulators, who oversee workers comp rate requests in most states, will gather Sept. 10-13 at the National Assn. of Insurance Commissioners' fall zone meeting in Wilmington, Del.

In addition, state workers comp administrators are meeting Sept. 17-20 in Baltimore for the annual conference of the International Assn. of Industrial Accident Boards and Commissions.

One risk manager said she supports the NCCI's attempt to gather workers comp experts to study the system.

"I think it is a good idea," said Lucille Gallagher, vp of risk management for Monfort Inc. in Greeley, Colo. "I certainly think it is a place to start," she said.

For more information about the congress, contact Edith Lichota, Congress Coordinator, NCCI, 1 Penn Plaza, New York, N.Y. 10119; 212-560-1000. ■

# NCCI seeks to cut residual market losses

By MEG FLETCHER

The organization representing the nation's workers compensation insurers wants to discourage employers from purchasing coverage through the residual market.

The New York-based National Council of Compensation Insurance has stepped up its drive to make the residual market less attractive, after the amount of premium written through residual markets in various states rose to a record 19.3% of all direct written work comp premiums (see chart).

In fact, the residual market, also known as assigned risk pools, is now the largest single source of work comp insurance nationwide.

The NCCI operates residual market pooling mechanisms in 41 states and the District of Colum-

bia. It also operates a reinsurance pool that reinsures residual market coverage in 31 states and provides additional coverage in about a dozen other states, including nine with state funds.

To reduce the size of the residual market, the NCCI wants states to:

- Increase rates in the voluntary market and the residual market.
- Impose surcharges on employers in the residual market.
- Eliminate mandatory premium discounts for larger policyholders in the residual market.
- Bar entry to the residual market to any employer that refused coverage in the voluntary market.

Historically, the residual market is the work comp insurance market of last resort.

Even though states require employers to have workers compensation coverage, some employers are unable to find coverage in the voluntary market due to a lack of loss experience or a poor loss history. Those employers mostly include small companies in hazardous classifications such as trucking, restaurants and carpentry for private residences.

In the residual market, employers are assigned to a participating insurer, which would be required by the state to provide coverage at a specified rate, even if it is sure to produce a loss.

"Over the last five years, the residual market has swollen to the point where it is poisoning the voluntary market," said Erwin Fromm, the NCCI's board chairman.

In the past four years, the number of risks in residual markets has grown 137%, while written premium volume has increased a "startling" 549%, he said.

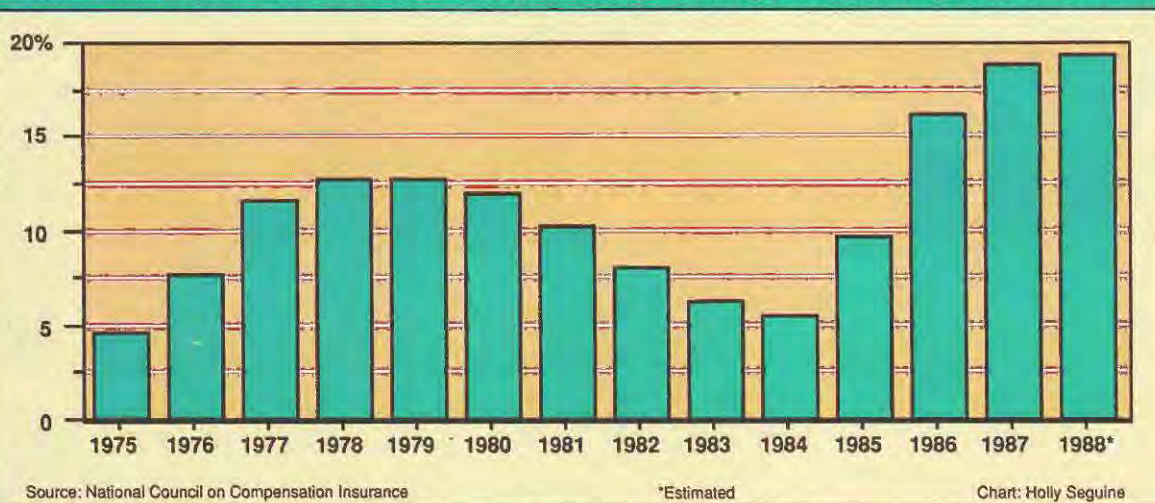
In 1988, more than 500,000 risks, including employers that are "both good and bad, large and small," produced more than \$3 billion in premium in residual market mechanisms administered by the NCCI, Mr. Fromm said.

And, the growth in the residual market is not limited to a handful of states. Residual market premiums comprised 20% or more of the total work comp premiums written in 18 states during 1988, according to the NCCI.

The states in which the residual market wrote the highest percentage of total premiums in 1988 included: Maine, 69.6%; Rhode Island, 51%; Louisiana, 41%; New Mexico, 30.6%; Vermont, 28.7%; Mississippi, 28.6%; Arkansas, 28%; New Hampshire, 27.7%; South Dakota, 24.8%; Tennessee, 24.7%; Missouri, 23.7%; Kansas, 22.7%; Kentucky, 22.1%; Texas, 22%; Indiana, 20.9%; South Carolina, 20.6%; Florida, 20.2%; and Alabama, 20%.

In addition to the growth in sheer numbers, there are more large policyholders in residual markets than ever before, Mr.

## Residual market's share of workers compensation premiums



Fromm said. More than 40% of the residual market is made up of policyholders that pay annual workers compensation premiums exceeding \$50,000, and nearly 70% of the policyholders in the residual market pay annual premiums in excess of \$10,000, he said.

The growth of the residual market has meant increasing losses for insurers, which subsidize residual market programs through allocations that are proportional to their share of the voluntary market premiums in a state.

The residual market suffered an operating loss exceeding \$4.4 billion during the past four years, according to the NCCI.

The \$1.6 billion loss generated by the residual market in 1988 alone equaled 12.3% of voluntarily written work comp premiums, up from 4% in 1984.

"Clearly, this puts the workers compensation insurance industry at a significant disadvantage in competing with alternative mechanisms," which do not have to pay residual market assessments, Mr. Fromm said.

"A large and highly unprofitable residual market actually undermines the voluntary market," he added. Because of the residual market assessment mechanism, an insurer may be wary of writing too much voluntary market business in a state with a large residual market, he explained.

Indeed, huge losses in the residual market were partly responsible for a mass exodus of insurers from the Maine workers compensation market in 1987 (BI, Nov. 30, 1987).

There are a few reasons for residual market growth, Mr. Fromm said.

"One reason the residual markets swelled to their present size was the precipitous end of cash-flow underwriting" in the mid-1980s, Mr. Fromm said. "Once insurers returned to their customary standards of underwriting, with the idea that the premiums should yield a profit, the marginal risks

were dropped into the residual market," he explained.

Also contributing were persistent, inadequate rates in some states—like Louisiana—that have made insurers less willing to write coverage on a voluntary basis.

As a result, even good risks in Louisiana were forced into the residual market, wiping out any "stigma" that once was attached to buying coverage there, said Herbert Knoblauch, vp of risk management for Anco Industries Inc. in Baton Rouge.

"I would much prefer to choose my own carrier," Mr. Knoblauch said, pointing out that it is difficult to persuade a residual market insurer to tailor claims data into a useful format.

Meanwhile, other risk managers have been attracted to the residual market in some states because they can actually get a better deal on their workers compensation coverage from an assigned risk pool than from commercial insurers operating in the voluntary market.

For example, by buying coverage in the residual market, policyholders may be able to avoid the retrospective rating plans voluntary market insurers may want to impose in states with inadequate voluntary market rates to protect themselves from the possibility of unexpectedly high losses during the policy term, one market observer said.

They have been able to do this because, "in most states, there is no penalty for being in the residual market," Mr. Fromm said.

Insurers want that to change.

Now, the NCCI is asking state legislators and regulators—with some success—to adopt approaches that allow insurers to collect more premium from risks that end up in residual markets.

"I think it is appropriate to have companies with poor loss ratios pay more. It's an incentive to improve safety," said Maine Insurance Superintendent Joseph Edwards.

For example, 12 states and the District of Columbia now allow the NCCI to impose surcharges or higher rates on employers seeking coverage in the residual market. Those states are: Arizona, Alaska, Georgia, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, North Carolina and Texas. Also, regulators in eight additional states are considering similar measures: Alabama, Arkansas, Mississippi, Missouri, New Mexico, Rhode Island, South Dakota and Vermont.

Nine states have eliminated premium discounts—sometimes given to large employers—if an employer buys coverage in the residual market. They are: Alaska, Florida, Indiana, Iowa, Maine, Mississippi, South Dakota, Tennessee and Texas. In addition, regulators in Georgia, Missouri, Rhode Island and Vermont are considering similar measures.

"By removing premium discounts, larger insureds are deprived of a benefit of the competitive market, while at the same time they are pressed to contain their losses," Mr. Fromm said.

In addition, the NCCI is asking some states to institute a new rating plan for larger policyholders in the residual market that requires employers to pay a final premium based on their experience during the policy period.

The plan was approved in Florida earlier this year and will be filed elsewhere, Mr. Fromm said.

The NCCI also wants to amend residual market application forms to bar entry to any employer that refused an offer of voluntary coverage under one of NCCI's standard rating plans.

However, the "most important" solution to residual market problems is raising rates in the voluntary market, Mr. Fromm said. That would encourage insurers to write more business in the voluntary market, hence reducing the number of employers entering the residual market. ■

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## Work comp rates rising

Continued from previous page  
also would reduce insurers' premium base and trigger further rate hikes, he added.

In addition to these proposals to change a state's rate-making structure, employers, insurers, state administrators and labor representatives are seizing on other different solutions and lobbying state legislators to adopt them (see story, page 77).

Among these proposals is one to strengthen Texas' administrative system and to reduce litigation by requiring that appeals be based on the record developed during the work comp administrative proceedings, thereby limiting an unsatisfied claimant's right to a completely new trial.

Meanwhile, Florida is considering limiting attorneys' fees in workers compensation cases.

In Illinois, a wide range of observers are discussing measures to improve data collection so the state can begin to understand where benefit payouts are going. Both Texas and Florida are considering measures to contain medical costs as well as to promote safety and accident prevention among employers. Rhode Island is considering a measure that requires that work comp benefits be offset against benefits from other programs. And, Oregon is considering adopting a uniform definition of independent contractor to promote equitable treatment by some state agencies. ■

# NCCI seeks rate hikes averaging 15%

By MEG FLETCHER

Workers compensation insurers are asking state regulators across the United States for rate increases averaging 15% this year.

Insurers need the increases—which range from less than 5% in some states to more than 30% in others—to keep pace with inflation in both indemnity and medical benefits, said Richard Fein, executive vp of the New York-based National Council on Compensation Insurance (see story, page 72).

Although workers compensation insurance accounted for less than 13% of U.S. insurers' total property/casualty premiums, it produced 45% of the industry's net underwriting losses, the NCCI says. Workers comp operating losses topped \$1 billion last year.

However, the NCCI expects workers compensation insurers' combined ratio to plateau this year, suggesting the prospect of smaller rate hikes in years to come.

This decade has been "an increasingly contentious environment" for workers comp because critics have demanded more scrutiny as compensation costs and prices rose, according to the NCCI's 1989 Issues Report.

The NCCI prepares and administers rates, rating plans and systems for work comp insurance in 32 states and provides similar assistance in about one-half of the remaining states.

Severe rate inadequacy persists in several states because "regulators in the past have taken the tack of granting part of a rate increase, which continues to defer the problem," Mr. Fein said.

For example, the handful of states that already have approved rates this year have reduced the increases requested by the NCCI. For instance, South Dakota approved a 12.8% increase, while the NCCI sought an increase in excess of 20% (see story, page 76).

Mr. Fein conceded that "the regulator can only go so far when he sees large numbers."

Consequently, there is an inverse relationship between the size of the rate request and the percentage that is ultimately granted, he explained. For example, the NCCI may receive about half of a rate increase request that exceeds 50%, but will probably receive more than half of a requested 15% rate increase.

"Some would have the view that we ask for larger numbers than we need," he said. But NCCI data, which regulators scrutinize, shows "these are large numbers because we need it," Mr. Fein said. "This is not a negotiating process."

However, the needed increases "will be harder than ever to obtain," he said.

The NCCI's proposed 15% average rate increase for this year comes on the heels of four consecutive years in which workers compensation insurance rates have risen by more than 10%. The NCCI was granted an average 11.4% rate increase by state regulators in 1988; 10.1% in both 1987 and 1986; and 16.4% in 1985.

Insurers hoped that the workers compensation combined ratio for the line would improve in 1988 but instead faced the "disheartening" fact that the combined ratio climbed half a percentage point to an estimated 118.1% last year, up from 117.6% in 1987, in the states where the NCCI operates, said NCCI President Kevin Ryan.

However, when results from the five states with the worst work comp combined ratios last year—Louisiana, 160%; Florida, 150%; Rhode Island, 150%; Maine, 145%; and Texas, 125%—are excluded, the overall work comp combined

ratio improves by four percentage points, Mr. Ryan said.

During 1988, earned workers compensation premiums increased by 12% to approximately \$25.9 billion from \$23.1 billion the previous year, according to the NCCI.

A worrisome contributor to workers comp insurers' financial results is a new escalation in indemnity costs, said the NCCI's Mr. Fein. An analysis of trend factors shows that indemnity costs in NCCI states are increasing at an average rate that is 6 percentage points above the annual increase in wages, although hardly any states are increasing benefit levels, he said.

Such an increase is "a sign of a system problem," he said.

That development could stem from causes like an increasing

push for temporary injuries to be classified as permanent, adding to their costs, Mr. Fein said. In addition, some states have extended the maximum length of time over which benefits must be paid or have raised caps on permanent partial benefits.

The problem is particularly acute in Texas and Florida, where the indemnity cost trend factor is approaching twice the country-wide average for states served by NCCI.

Meanwhile, medical costs, which comprise at least 40% of total work comp benefit costs, are continuing to escalate at a rate about 7 percentage points greater than annual wage increases.

Also contributing to the discouraging financial picture for work comp insurers is "an unex-

pected use of deviations and dividends in the face of large underwriting losses," according to the NCCI 1989 Issues Report.

Workers compensation insurers in states in which rates are mandated by state regulators are allowed to calculate rate deviations or pay dividends to reward employers with good loss records.

"The insurers are doing damage to themselves" through such competition, Mr. Ryan said in an interview. However, if they do not "reward" good risks with an average 10% discount through deviations and dividends, they will lose good risks to other insurers, he said.

The workers compensation combined ratio is expected to improve slowly over time due to continued rate level improvements, Mr. Fein predicted. The NCCI estimates a

one percentage-point improvement in the work comp combined ratio to 117.3% during 1989, and it predicts the ratio will drop further to 115.4% in 1990.

"There are some signs that the workers compensation underwriting situation has begun to improve," said Erwin Fromm, the NCCI's chairman of the board, in a recent statement.

"We have seen the worst states are not as bad as they were, and double-digit rate increases are needed in fewer states," he said.

For example, "things in Maine are looking much better than they have in the past 10 years," said Peter Burton, a regional director of government, consumer and industry affairs for the NCCI.

Insurers' underwriting losses in

*Continued on next page*

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## Work comp rates

Continued from previous page  
Maine decreased to \$160 million last year from an eight-year high of \$175.1 million in 1987, according to NCCI statistics. In addition, the workers compensation combined ratio in Maine dropped to 145% in 1988 from 177% in 1987.

Legislative changes approved in Maine in 1987—which are currently under attack by some state legislators—cut workers comp costs by 41.9% last year, primarily by capping the length of time for which a worker could receive benefits and reducing scheduled increases in benefits, explained Insurance Superintendent Joseph Edwards (BI, Nov. 2, 1987; Nov. 30, 1987). In addition, Mr. Edwards approved two rate increases during a 12-month period.

Rates for employers in the voluntary market and the residual market "safety pool," which is designed for those employers with good loss histories, experienced average increases of 25% a year ago and a 22.5% increase in March.

Meanwhile, employers in the "accident prevention account," which is that segment of Maine's residual market for those with the poorest safety records, were subject to average rate increases of 30% and 26.3%, respectively.

"I think we will begin to see efforts to identify and write more voluntary market business," Mr. Burton said. About a dozen large insurers now are writing workers comp insurance in Maine, though Liberty Mutual Insurance Co., which had been the largest writer of compensation insurance in the state, still has not returned.

Commenting on the improvement in workers compensation insurers' results, Mr. Ryan said: "In most states, rate filings have dropped to single-digit levels. Indeed, in a few isolated instances, we have actually filed for small decreases in premium levels" in the past year.

For example, regulators last year approved decreases in four jurisdic-

dictions, according to NCCI statistics. The voluntary market's fully developed rates, which include expense and profit factors, were decreased 5.8% in the District of Columbia, 5.7% in Alaska and 2.9% in Idaho. And, a similar rate for Michigan's assigned risk plan dropped 2.6% last year.

In addition, the voluntary mar-

ket's pure premium rates, which include only loss costs and not profit and expense factors, were reduced 5.5% in Michigan and 7.6% in Maryland, effective July 1, 1988, and 6.2% in Maryland effective Jan. 1 of this year.

However, the NCCI is not proposing any rate cuts for 1989 in the states for which it files rates.

## NCCI rate proposals

The New York-based National Council on Compensation Insurance has proposed rate increases ranging from less than 5% to more than 30% in 37 individual states in the coming year.

According to preliminary data, the NCCI is seeking increases of:

- Less than 5% in Alaska, Arizona, Georgia, Hawaii, Idaho, Iowa, Maryland and North Carolina.

- Between 5% and 20% in Arkansas, Colorado, Illinois, Indiana, Kansas, Kentucky, Missouri, Montana, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Wisconsin and the District of Columbia.

- More than 20% in Alabama, Connecticut, Maine, Mississippi, Nebraska, New Hampshire, South Dakota, Vermont and Virginia.

- More than 30% in Florida, Louisiana, New Mexico, Rhode Island and Texas.

However, several states already have reduced the NCCI's rate requests.

For instance, while Maine approved a 22.5% rate hike, South Dakota approved only a 12.8% increase.

Other states that have approved rate hikes include Tennessee, 5.1%; the District of Columbia, 3.8%; and Wisconsin, 1.2%. In addition, New Mexico authorized a 1.5% decrease in pure premium rates, which include only loss costs without any expense or profit components.

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# NCCI to use data to assess comp reforms

By MEG FLETCHER

Workers compensation insurers are hoping to use data to help solve problems in state work comp systems around the country.

The National Council on Compensation Insurance, which represents work comp insurers in most states, is using its data to take a leadership role in benefit reform debates, rather than merely using the data to justify rate requests.

The New York-based organization plans to thoroughly review the benefit delivery systems in selected states "in an effort to develop solutions to their problems," said Richard Fein, NCCI executive vp.

This will provide "a window of opportunity" for these individual states to re-examine their systems, he said. The goal is to control costs by reducing unnecessary expenses, not lowering benefits, he said.

"Among the factors slated for review will be the non-statutory influences on benefit costs," he said. This will entail comparing the amount and types of benefits paid in a state with the benefit provisions in the state's workers compensation law and benefit patterns in other states, Mr. Fein said.

Most of the states chosen by the NCCI for the project are states in which workers compensation insurance rates have risen sharply.

In two of the target states—Connecticut and New Mexico—legislators have sought to change the workers compensation ratemaking structure.

Connecticut legislators are considering a bill, H.B. 99, that would allow the NCCI to file only pure premium, or loss cost only, information for the voluntary workers compensation market instead of fully developed rates, which include insurer profit and expense components. However, the bill would allow the NCCI to continue filing complete rates for the state's residual market.

On the other hand, New Mexico attempted to enact a law earlier this spring that would have limited all rating organizations to providing only untrended loss costs, rather than fully developed rates. The measure, H.B. 287, was vetoed by the governor, said Everett Brookhart, an NCCI senior vp.

Here are the issues in the other seven states targeted by the NCCI:

## Texas

The average cost of a Texas workers compensation claim has nearly doubled to \$13,300 from \$6,800 in the past four years, according to NCCI data.

Increases in claim costs make the Texas work comp system compare poorly with neighboring states, said Lucille Gallagher, risk manager for Monfort Industries Inc. in Greeley, Colo., which operates meat processing plants in both Texas and Colorado.

Monfort's combined indemnity and medical benefits for an average lost-time case last year totaled \$8,934 in Texas, compared with \$2,608 in Colorado, she said.

"We have seen a great escalation in premium rates during the past five years" and especially the past two years, Ms. Gallagher said, noting that Monfort's work comp premiums in Texas rose 38% last year and 19% in 1987.

Higher claim costs in Texas have been caused in part by the increased involvement of lawyers in the system, she said.

About half of all Texas workers compensation cases involve attorneys, as compared to 7.8% in 16 other states" studied by the NCCI.

The state's trial de novo system—under which an injured worker can appeal an award to a state court jury—means state work

**In Texas, 'the fear of going to trial—and getting a jury that doesn't relate to the (no-fault) system of workers compensation—increases the value of a claim drastically,' says Lucille Gallagher, risk manager for Monfort Industries Inc.**

comp officials' adjudication of an injured worker's claim is influenced by the knowledge that an unsatisfied claimant has a right to a completely new trial. As a result, employers tend to settle claims for larger amounts than they would otherwise, observers say.

"The fear of going to trial—and getting a jury that doesn't relate to the (no-fault) system of workers compensation—increases the value of a claim drastically," Ms. Gallagher said.

In addition, some medical claims cost more than necessary in Texas because state laws make it tough to apply case management techniques, she said.

For example, because a court order is required to obtain an independent medical evaluation of an employee's injuries, a claim often goes "down the tubes" before the needed evaluation can be obtained, she said, adding that both employee and employer would benefit if the injured employee is first directed to a top-quality specialist.

In addition to reforming these problems with the Texas system, Ms. Gallagher noted that private Texas employers want the option to self-insure workers compensation risks, which currently is not allowed in Texas.

While employers complain about high workers compensation insurance rates, insurers complain that losses still are too high. Texas work comp insurers posted a 125% combined ratio last year, which was an improvement over 137.6% in 1987 and 151.7% in 1985.

Legislation, H.B. 1, which has been approved by the Texas House and is supported by Senate leaders, would solve many of the problems, insurers and employers say.

Major provisions of the proposed bill would eliminate the de novo

system. Instead, appeals would be heard by a state court judge, who would only be able to rule on whether the Texas Worker's Compensation Board correctly applied state law.

In addition, all workers compensation insurers would be required to maintain accident prevention facilities and furnish policyholders with training programs, surveys, analyses of accident causes and comprehensive accident prevention services.

The bill also allows employers to self-insure their workers compensation risks.

## Rhode Island

Rhode Island employers are facing substantial workers compensation rate increases if insurers succeed in obtaining even part of their rate requests, which are now before state regulators.

The NCCI is asking for a 94.2% average overall rate increase, including a 139.6% rate hike for the residual market where more than half of all of the state's work comp premium is written, said Peter Burton, the NCCI's director of government, consumer and industry affairs in the Northeast region.

The NCCI is seeking an 81.6% average rate hike for small insurers in the voluntary market, he said. Large insurers file their own rates under the prior approval mechanism of the state's unique competitive rating law, he explained.

The rate inadequacy in Rhode Island is underscored by the fact that the state attorney general's office, which traditionally reviews rate increase requests in Rhode Island, recommended approval of an average 64% rate increase, he said.

Insurers were granted average rate increases of 19% in 1988 and 22.5% in 1985, Mr. Burton said. However, the system continues to

be "extremely out of balance," he said, noting that Rhode Island work comp insurers reported a 150% combined ratio last year.

As a result of the problems in the market, more than two dozen workers comp bills are awaiting action in the Legislature this session. The proposals, among other things, would create a competitive state work comp fund and an appellate commission within the Workers Compensation Commission to expedite appeals.

In addition, one proposal would transfer ratemaking authority for workers compensation insurance from the Department of Business Regulation to the Department of Workers Compensation. Another would extend state antitrust law provisions to the insurance business.

Despite the need for rate increases, several proposals are pending that would increase work comp benefits, while other bills would attempt to reduce benefits by requiring work comp benefits to be offset against other employer-paid benefits injured workers receive.

## Louisiana

Rates for the Louisiana assigned risk plan, which wrote 41% of the state's work comp premium last year, rose 37.3%, effective Feb. 1.

That increase, coupled with a competitive rating law and other work comp reforms, should stabilize the Louisiana workers compensation market, said an NCCI spokesman.

Workers compensation insurers in Louisiana reported a combined ratio of 160% in 1988 and 164.5%

in 1987. However, "Louisiana's benefit costs are substantially higher and growing faster than in most other states," the NCCI spokesman said. "Recent data from the U.S. Department of Labor indicate that Louisiana's level of lost work days due to injuries is 31% higher than the U.S. average."

In addition, "data from the American Hospital Assn. reveals that Louisiana's general hospital costs are higher and increasing faster than the national average," the spokesman said.

However, despite the problems, there are no major work comp reforms pending in the state.

## Illinois

Closed door negotiations are continuing between representatives of employers, organized labor and the governor to prepare proposals for reforming the Illinois work comp system.

Among the material being discussed is a study prepared for Gov. James Thompson by John Lewis, a nationally recognized work comp expert from Coconut Grove, Fla. In addition, reports by the state Chamber of Commerce and a consumer coalition are under review.

Mr. Lewis found that Illinois employers' work comp costs are about on par with the national average, but higher than those in neighboring states. However, the study found construction firms in Illinois face costs significantly higher than most other states, according to a statement from Gov. Thompson's office.

The study also found significant

*Continued on next page*

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## State comp problems

*Continued from previous page*  
deficiencies in the administration of the work comp system in Illinois.

For instance, the state Industrial Commission is limited, both by statute and resources, in providing mechanisms for resolving disputes and overseeing self-insured employers.

In addition, little data is collected and even less is analyzed, according to the statement.

"This is one of the most significant flaws in Illinois' present system: We don't know with precision how much workers compensation costs, who pays, how effective it is in providing benefits and rehabilitating injured workers, or how changes would affect workers and costs," Gov. Thompson said.

"It is a system that has been settlement-driven," with little data to guide it and little oversight by state work comp officials, Mr. Lewis said in an interview.

There is a high degree of attorney involvement in the system and decisions are "highly subjective," he said.

The focus of any change is likely to be on improving data collection and other administrative changes, he said.

### Oregon

Oregon employers face persistently high workers compensation costs that put them at a disadvantage with competitors in neighboring states, said Rep. Robert Shiprack, D-Beaver Creek.

Last year, legislators "made a lot of changes" to the state's workers compensation system, "but we haven't been able to determine the impact yet," said Larry Young, manager of the compliance section of the state's Department of Insurance and Finance.

Those changes included "dramatically" reducing the time before a case is heard and establishing standards for rating disability, Rep. Shiprack said.

In addition, the state tightened eligibility requirements for vocational rehabilitation and set accountability standards for rehabil-

itation providers.

During the current session, legislators are concerned only with fine-tuning the system, observers say.

One pending proposal, H.B. 2348, which already has been approved by the House, would liberalize the "designated adjuster" rule.

Under current Oregon law, both insurers and self-insurers must handle all work comp functions—including underwriting and claims handling—from one address.

The bill would allow insurers to operate from up to eight locations in the state, while it would allow self-insurers to operate from up to three locations.

This would essentially allow self-insurers to use multiple third-party administrators or other service providers.

In addition, the measure would give employers more workers compensation options by increasing the Oregon market's attractiveness to private insurers, Rep. Shiprack said.

Currently, the state fund writes about 45% of the work comp premium in the state. Liberty Northwest Insurance Co., a unit of Liberty Mutual Insurance Co., writes the lion's share of the remainder, he added.

State legislators are hammering out a uniform definition of independent contractor for use by officials in the workers comp, employment and revenue authorities.

Under the definition in H.B. 2320, employers in the state will find it more difficult to underreport full-time employees to work comp insurers by dubbing them independent contractors.

Oregon legislators are also considering measures to control medical costs, including a pilot program allowing injured employees who are health maintenance organization subscribers to be treated through the health maintenance organization.

However, employees with other types of health care coverage arrangements will not lose their free choice of physician, according to Rep. Shiprack.

### Florida

Nearly a decade after Florida passed its wage-loss workers compensation law, which

compensates workers for actual wages lost, "the state's initial gains toward achieving an efficient and healthy workers compensation system have been reversed," according to the NCCI.

The Florida work comp system now is plagued by rising medical costs, high benefit payouts and dramatically increasing attorney involvement, said an NCCI spokesman. Insurers' combined ratio in the state hit 150% last year.

Reform legislation introduced last month represents months of "intensive" work by the 26-member Governor's Task Force on Workers Compensation, which represented all players in the system, according to a spokesman for the Alliance of American Insurers.

If adopted, the wide-sweeping, compromise proposals, among other things, will give employers or their insurers access to medical reports and medical providers in work comp cases.

The measures also will create procedures for medical review of cases where overutilization or inappropriate care is suspected and beef up the authority of state officials to investigate questionable claims.

In addition, a new safety data base will identify employers with poor safety records and require them to institute employee safety training programs.

Other proposed measures will limit attorneys' fees in workers compensation cases, improve data collection, and tighten controls on rehabilitation services through establishment of a maximum fee schedule and development of a code of ethics.

One proposal will revise requirements for determination of permanent physical impairment and tighten controls so workers who have reached maximum medical improvement are required to make good-faith job searches.

"It is possible that workers compensation legislation may not be successful this year," because the 60-day legislative session may be dominated by budget considerations, the Alliance spokesman said.

"However, either this year or next, it's a sure bet that some far-reaching legislation will be enacted because all the groundwork

has been done and the need established," the spokesman added.

### Colorado

Researchers and legislators spent last year analyzing the state's work comp system, but that did not result in any significant reform proposals during the current legislative session.

Among minor changes the governor signed into law earlier this year was a bill that authorizes self-insurance pools for public entities to include protection for work comp risks along with other types of risks.

Besides the states targeted for review by the NCCI, sweeping workers compensation reform legislation also is pending in California.

The legislation is supported by employers, insurers and labor groups, though attorneys for work comp claimants are vowing to defeat the legislation.

A.B. 2032, now pending in the Assembly, would increase benefits to workers by an estimated \$2 billion over three years, create a new state agency to manage the workers compensation system, and reduce the expense provisions insurers use when calculating workers comp insurance rates (BI, May 1).

The legislation would attempt to control employers' and insurers' costs by:

- Reducing the number of litigated cases by increasing benefit levels.
- Reducing the portion of premiums paid to workers comp insurers for overhead costs.
- Limiting stress claims to only those accidents demonstrated to have caused observed physical symptoms.
- Providing incentives to employers and employees to use the most effective methods of vocational rehabilitation.
- Designating approved physicians as "impartial medical evaluators" to decide the existence and degree of a worker's disability.

The California Workers' Compensation Institute said the changes are expected to result "in only modest increases in employers' premiums," with increases estimated at 1.3% in 1990, 3.3% in 1991 and 1.9% in 1992.

## D&O decision

*Continued from page 1*

written by Harbor Insurance Co. of Los Angeles, a Continental Corp. unit.

Excess coverage for the Kaiser Steel directors was written by National Union Fire Insurance Co. of Pittsburgh Pa., a unit of American International Group Inc., and Federal Insurance Co., a unit of Chubb Corp. The limits of these excess policies are being disputed.

Harbor argued that it has long been the understanding of policyholders and insurers that defense costs deplete D&O policy limits.

It is because of this industrywide understanding of how D&O insurance should operate that most policyholders and insurers expected the appellate court to overturn the decision by the trial court.

Had the trial court decision been upheld, insurers said they would have had to raise D&O rates in California, subject to the limitations of Proposition 103.

The appellate court decision "is wholly consistent with the sense and understanding of the insurance in-

dustry," said D&O attorney John Morrison of Althamer & Gray in Chicago.

"Any other result would have been an aberration or a distortion," he said.

Harbor attorney Bruce D. Celebrezze agreed. "Harbor expected the court of appeals would reverse

the trial court, and I suspect that the insurance industry felt the same," he said.

"It is understood by all in the D&O field—both insurers and policyholders—that these policies should be read this way," said Mr. Celebrezze, of Sedgwick Detert, Moran & Arnold in San Francisco.

Kaiser attorney William Shernoff said his clients may appeal to the California Supreme Court.

"Harbor has admitted this is a novel issue and of widespread importance to the insurance industry," said Mr. Shernoff, noting that this is just the type of case the state high court would be interested in.

"Clearly the language is ambiguous if two courts had differing results," said Mr. Shernoff, who is with Shernoff, Scott & Bidart in Claremont, Calif.

**'Clearly the language is ambiguous if two courts had differing results,' says William Shernoff.**

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# Catastrophe losses decline: Swiss Re

ZURICH, Switzerland—Fewer catastrophes worldwide led to a 20% reduction in insured damages in 1988 compared with 1987, says Swiss Reinsurance Co.

Despite the decline in insured damage, however, the number of people killed in catastrophes more than doubled last year from 1987, according to Swiss Re's annual survey of catastrophes.

Swiss Re logged 90 major catastrophes in 1988, down from 101 catastrophes in 1987.

However, the number of fatalities rose about 2½ times in 1988 to 50,398, almost all victims of natural rather than man-made catastrophes.

"From the point of view of extent of damage, 1988 was a fairly average year. After \$7 billion in the previous year, insured damage of about \$5.7 billion, or almost 20% less, was registered in 1988," the report said.

Although natural catastrophes accounted for the greatest percentage—35.1%—of the overall disasters last year, they were closely followed by waterborne traffic, with 32.6% of the total; major fires, 20.1%; aviation losses, 12.0%; and mine disasters, 0.2%.

Swiss Re classifies as a catastrophe those losses that cause 20 or more deaths and/or insured losses of at least \$6.6 million in the marine sector and \$13.2 million in the aviation sector.

Two major 1988 catastrophes stand out in terms of damage and loss of life, according to Swiss Re.

The first is the July 6 explosion of the Piper Alpha drilling platform, which killed 167 people and is projected to cost insurers between \$1.2 billion and \$1.5 billion, making it the biggest single man-made loss (BI, July 11, 1988).

The other major event is the December 1988 earthquake in Soviet Armenia that killed some 25,000 people. This was the fifth-most serious natural catastrophe since Swiss Re began collecting these statistics in 1970. Total, uninsured damage amounted to \$14 billion.

According to Swiss Re, the 10 worst catastrophes in 1988 in terms of insured damages were:

- The Piper Alpha explosion.
- Hurricane Gilbert, which struck the Caribbean in September and caused approximately \$790 million in insured damages (BI, Sept. 26, 1988; Sept. 19, 1988).
- The April 24 blowout and fire of the Enchova oil platform near Brazil, which caused about \$330 million in insured damages.
- Storms that hit portions of Texas and Oklahoma June 2-3, resulting in \$130 million in insured damages.
- Storms that hit several states May 5-10, also causing \$130 million in insured damages.
- The Aug. 28 air show disaster in Ramstein, West Germany, in which three Italian jets collided over a crowd of spectators, causing \$112 million in insured damages (BI, Sept. 5, 1988).
- The explosion of a rocket fuel factory in Henderson, Nev., May 4, which caused \$100 million in insured damages (BI, June 27, 1988).
- Storms and flooding in Oklahoma March 28-29, which produced \$100 million in insured damages.
- A Sept. 26 fire in a food products factory in Corby, England, resulting in \$95 million in insured damages.
- Storms that hit portions of Arkansas, Mississippi, North Carolina and Texas Nov. 25-28, producing \$95 million in insured damages.

Worldwide, Swiss Re recorded 90 natural catastrophes last year—down from 101 in 1987—of which 42 were floods, 45 storms and 3 earthquakes.

## Worldwide

North American storms account for 58% of the 1988 worldwide total, up from 24% in 1987.

In North America, the number of natural catastrophes decreased slightly last year, while insured losses rose. The 14 storms registered in the first half of 1988 alone resulted in more than \$800 million in insured losses, and six more storms in the November/December period added another \$300 million to that total, Swiss Re notes.

Hurricanes Gilbert and Joan, which struck Central America, were singled out in the Swiss Re report. Gilbert caused more than \$40 million in insured losses in Texas and as much as \$750 million in Jamaica.

Insured losses for Hurricane Joan have not been completely tallied, but the hurricane caused an estimated \$800 million in damage in Nicaragua, Swiss Re estimates.

Swiss Re logged 46 major fires worldwide last year, up from 43 in 1987 and 32 in 1986. Fires last year caused \$1.2 billion in insured damages, down about 20% from the previous year.

Thirty-three major aviation losses were recorded in 1988, up 33% from 26 losses in 1987.

"This is the highest figure since 1972 and is well above the long-term trend," Swiss Re reports.

Last year, aviation losses cost \$686 million in insured damages, down 13% from the previous year, the report said.

Waterborne traffic losses—including freighters, tankers, passenger ships and drilling platforms—produced the worst losses for the insurance industry last year, according to Swiss Re.

There were 41 waterborne traffic losses in 1988, unchanged from 1987. Of these, five were oil drilling platform losses.

Besides the Piper Alpha loss, damage from the other platform losses totaled almost \$500 million.

—By John Parry and Paul D. Winston

## Asbestos settlement

PERTH, Australia—Australian sugar exporter CSR Ltd. and its workers compensation insurer, the Western Australian State Government Insurance Commission, will contribute to a settlement to avoid a legal wrangle over compensation to asbestos victims.

While initially the two parties will contribute a total of \$50 million Australian (\$39.6 million)—\$15 million Australian (\$11.9 million) from the SGIC and \$35 million Australian (\$27.7 million) from the CSR—future losses could boost the total cost to both parties to \$560 million Australian (\$443.5 million), sources say.

Under terms of the settlement, SGIC and CSR have each agreed to put \$15 million Australian into a fund to provide settlements to miners who worked at the Wittenoom blue asbestos mine after Jan. 1, 1959—the date that SGIC's cov-

erage began.

CSR will contribute an additional \$20 million Australian to a separate fund to pay for pre-1959 asbestos-related claims from the mine.

As part of the agreement, CSR and SGIC will split the costs for future claims on a 50-50 basis, according to Rob Griffiths, SGIC's group manager for corporate insurance.

While neither the CSR nor the SGIC will estimate the total losses resulting from the asbestos-related diseases, the government-funded National Health and Medical Research Council estimates that as many as 2,800 new asbestos cases could be filed, boosting total claims to \$560 million Australian, based on an average payout of \$200,000 Australian (\$158,400) per victim.

The mine was operated by a now-defunct CSR subsidiary, Midalco Pty. Ltd., from 1943 to 1966. SGIC insured CSR for workers compensation from 1959 to 1966, while the company was virtually uninsured for workers compensation risks from 1943 to 1959.

The settlement between SGIC and CSR follows a decision last September by Victoria's Supreme Court upholding a punitive damage award against CSR. It was the first time an Australian Supreme Court upheld a punitive claim.

In that case, a lower court had awarded \$250,000 Australian (\$198,000) in punitive damages and \$426,000 Australian (\$337,392) in compensatory damages to Klaus Rabenalt, a former asbestos miner dying of cancer.

At the time, CSR said it faced 288 additional claims that could total \$50 million Australian (\$39.6 million) (BI, Oct. 17, 1988).

—By Kate McIlwaine

## Insurers go private

LISBON, Portugal—The Portuguese government plans to partially privatize three state-owned insurance companies, which together write almost 30% of the nation's property/casualty insurance.

The government proposes to sell 49% of each of the shares of state-owned insurers Alianca Seguradora EP, which writes about 8% of the country's insurance market; Fidelidade Grupo Segurador EP, the third-largest insurer with 11% of the market; and Tranquilidade-Seguros EP, which writes around 10.5% of the market.

The proposed sale is part of a major government program to privatize huge chunks of industry and finance that were nationalized in 1974 when the Portuguese dictatorship was overthrown.

Currently, state-owned companies control 65.9% of the Portuguese market, private sector Portuguese companies hold 5.7% and the remainder is held by Portuguese subsidiaries of foreign companies.

—By Maria Kielmas

## Interest on damages

BRISBANE, Australia—Compound interest should be paid on damages for economic loss, Australia's High Court has ruled.

The decision could mean substantially higher payouts for economic losses resulting from negligence or breach of contract that could have been anticipated by the responsible party, observers say.

"Courts will be entertaining cases of consequential losses—cases that will produce higher awards than the ordinary grant of statutory interest," said John Unkles, executive director of Australia's National Insurance Brokers Assn.

The decision arose from a case in which South Australian firm Radio Electrix sued accounting firm KHM Hungerfords for mistakes it made in calculating income tax for financial years 1975 and 1981. While Radio Electrix had recovered overpaid tax from 1978, it was barred by statute from recovering more than \$47,000 Australian (\$37,224) paid from 1975 to 1977.

The South Australian Supreme Court awarded Radio Electrix damages of \$145,000 Australian (\$114,840), including non-compounded interest. However, the Full Court of the Supreme Court of South Australia overturned that decision, awarding damages of \$335,000 Australian (\$265,320), including compound interest.

Later, the court reduced the amount to \$270,000 Australian (\$213,940) to allow for the fact that some of the \$47,000 Australian (\$37,224) may have been used for "non-business purposes."

—By Kate McIlwaine

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# Women, minorities needed in management: Panel

By KATHRYN J. McINTYRE

DENVER—The small numbers of women and minorities in top risk management posts and insurance company management can be increased by three efforts, according to several women and minorities already in the business.

Employers can create an atmosphere for advancement, including improved training and promotion programs; women and minorities in the business can help others advance; and female and minority employees can push harder to get ahead, said panelists discussing the progress of women and minorities in risk management and insurance during Rocky Mountain Insurance Day IX, held May 11 in Denver.

Generally agreeing that women and minorities are underrepresented in risk management and insurance company management ranks, the panelists discussed what they see as the obstacles for women and minorities and how those obstacles can be overcome.

Women and minorities "are grossly underrepresented" in the insurance business, according to Lester Shadwick, principal of Pyramid Financial & Insurance Services Inc. in Aurora, Colo., and a black who has worked in the insurance business for 15 years.

"Women and minorities are not

represented in management levels," said Linda Gibson, district sales manager of Allstate Insurance Co. in Denver and a black 16-year veteran in the insurance business.

While female risk managers have increased in number in the last 10 years and some are holding top risk management positions, "there are not many minorities" in risk management, observed Gwen Thayer, manager of corporate insurance for Forest Oil Corp. in Denver, a white female risk manager with 10 years of experience.

"In top and middle-level management, you do not see women," said Ruth O'Kain, a supervising underwriter of commercial lines at Continental Insurance Co. in Aurora, Colo., and a black with an 11-year insurance career.

Women are employed in the insurance business, but too many women and Hispanics with some college education are still employed in the clerical ranks, said Gloria Jimenez, commercial territorial marketing representative for Crum & Forster Commercial Insurance in Denver. Ms. Jimenez entered the insurance business four years ago.

The panelists placed part of the blame for the few women and minorities in the business with employers, citing a sometimes discriminatory attitude toward

**While doors are unlocked to women and minorities, 'few doors are open,' says Gloria Jimenez.**

women and minorities and a lack of adequate training and advancement programs.

"It's not that we aren't qualified. We have not been accepted to hold those positions," said Ms. O'Kain, speaking of women.

"That also applies as far as minorities are concerned," she observed, adding, "Maybe minorities don't know about the opportunities."

Ms. Thayer cited as an obstacle for women the different attitude of top management toward women compared with men. "If a man pounds the table, that's strong and forceful. If a woman does the same thing, that's unacceptable behavior," she said.

Ms. Gibson suggested that women "need behavior modification to compete in the corporate world" and advised women to "observe how successful people handle conflict, stress, and try to integrate those."

And, she suggested that employers have a responsibility to help satisfy this learning need. "Companies get numbers and then do nothing to strengthen the individuals," she said.

Les Grant, a sales manager with CNA Financial Corp. in Denver and a black 20-year veteran of the business, commented that a key issue is what mechanisms employers use to identify candidates with the talent to move up.

"We've opened the bottom," observed Mr. Shadwick, referring to minorities and women in entry-level and clerical positions. Upper management needs to take the initiative "to make changes to allow us into top management," he said.

Ms. Jimenez pointed out that while doors are unlocked to admit women and minorities, "few doors are open."

"Many companies have great training programs if you take the initiative to find the companies that offer them," Ms. Jimenez continued. "If you end up in a company that doesn't offer or promote these programs, the doors will not be open."

Ms. Gibson suggested that employers also will benefit from training programs to "get the most value" out of their employees.

While generally agreeing that

employers have a responsibility to offer training programs and make advancement more accessible, none of the panelists endorsed a quota system for increasing the number of women and minorities in insurance and risk management professions.

"Remember the token female and the token black?" asked Ms. Thayer. "That does more damage than good. We have to help the individual and not look at them as female and minorities."

"Every person should be hired on qualifications and not just to fill a position," said Ms. O'Kain, noting, however, that her employment in the 1970s was "a product of affirmative action."

"And, once hired, give that person an opportunity to move up," Ms. O'Kain said, adding that women and minorities should be "encouraged to progress."

The panelists agreed that women and minorities already in the insurance and risk management business have a responsibility to help others progress in similar careers.

"We have a responsibility to be positive role models," said Mr. Grant. Women and minorities should "share your successes and failures with people looking at you as a role model," he said.

"We have a responsibility inside and outside our industry to help others," agreed Mr. Shadwick. "We have to go beyond our work and be sure we are bringing our future leaders up with a good sense of fairness and competition."

"It is my job to try to motivate people," said Ms. O'Kain.

Ms. Thayer said: "We want to help people, but I also want people who work for me to succeed. It makes my job easier."

Women and minorities entering the insurance and risk management business also must work hard to get ahead, the panelists said.

While suggesting that the "doors are open to minorities and women," Ms. O'Kain stressed, "To open the door, I have to push hard, work harder."

To open the doors, "you have to prepare yourself. You have to set goals and pursue them," Ms. O'Kain advised the audience, which was predominantly made up of women.

And, she suggested that women have to be prepared to "sacrifice as far as children and husband," which she considers "a real drawback."

Ms. Gibson suggested: "You have to sell yourself. You can't wait to be discovered. You have to look like a manager, act like a manager. Develop those skills through out-

side professional programs. Join professional organizations. Develop yourself. Get credentials and designations."

Ms. Thayer noted that in risk management, women "are not all at the top yet," with more women employed in middle-level positions, such as assistant risk manager. "Give us five to 10 years" to change that, she said, pointing to the "really great strides" made by women in the last 10 years.

The panelists also shared their own strategies for success.

Mr. Shadwick advised: "Develop a pretty thick skin. Never give up, and never let the system beat you down."

Ms. Jimenez agreed that a "thick skin" is important, as is the need to "keep your eye on the goal."

Ms. Thayer suggested, "Go the extra mile."

Ms. O'Kain cited the importance of "the right qualifications," hard work and alerting management to personal ambitions.

Ms. Gibson added to these suggestions: "You have to be happy and excited about your job. You have to be unique, committed and happy about what you are doing."

Mr. Grant cited "a lot of hard work and endless hours away from the family."

Women, Ms. Gibson also added, will have to fight the perception that they are not interested in promotions because they have families. "Sometimes you will have to prove yourself all over again—that you are just as dedicated," she said of women returning to work after having a child.

Ms. Thayer commented that some women do want a job that will allow them to leave the office at 5 p.m. because of family responsibilities, and that is not a problem. "A company should not penalize a person who does a very good job but does not want more responsibility," she said.

Mr. Grant commented that with proper "trade-offs" in marriage between a husband and a wife, the woman should not have to "impede career aspirations."

The insurance business will benefit by promoting more minorities in its sales ranks, commented Mr. Shadwick. "Sometimes a black agent can better communicate to a black prospect," he said.

Furthermore, some white insurance agents are "reluctant to deal with blacks," he said.

A woman agent in the audience also commented that female agents can better service female clients, who are liable to get the "short shift by men who treat women as though they can't understand insurance." ■



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# Merrett reports loss on open '85 account

By STACY SHAPIRO

LONDON—Lloyd's of London's largest syndicate lost nearly \$29 million on its 1985 underwriting account and is leaving that account open for the second year in a row.

Syndicate 418/417, underwritten by Lloyd's Council member Stephen Merrett, posted the loss even though syndicate's manager said it did not expect a loss when it left the account open last year because of problems with runoff reinsurance policies (BI, May 23, 1988).

However, the 1986 underwriting year generally "is a much better year than has been seen by the market for awhile," said Ken Randall, managing director of the syndicate's managing agency, Merrett Underwriting Agency Management Ltd. "But, it is not the vintage year some people were forecasting."

Despite the loss on syndicate 418/417's 1985 account, the agency does not "intended to make a cash call at this stage" against members, Mr. Randall told Lloyd's members' agencies in a letter earlier this month.

MUAM decided last year to keep syndicate 418/417's 1985 account open pending discussion with cedants over the runoff policies. No cash call was made because the syndicate expected that its reserves of more than \$100 million would be adequate to cover estimated losses.

Because the discussions—now termed "disputes"—over runoff contracts written by the syndicate are continuing, the MUAM board has decided it would be imprudent to close syndicate 418/417's 1985 accounts this year, according to Mr. Randall.

"The Board has reluctantly come to the conclusion that it would not be appropriate to close the 1985 account at this stage," said Mr. Randall in the May 3 letter.

The MUAM board also "regrets" that syndicate 418/417's open year "is showing deterioration on the position a year ago making a cumulative deficit of approximately 11% (for every 10,000 pounds written), after all syndicate and personal expenses," Mr. Randall said in the letter.

Because the syndicate, which has more than 4,000 members, had a total capacity in 1985 of 139.9 million pounds, the deficit described by Mr. Randall would amount to 15.4 million pounds (\$25.6 million at current exchange rates).

MUAM will defray some of the losses for 1985 members who also are were syndicate members during the profitable 1986 underwriting year, which is just closing under Lloyd's three-year accounting system. MUAM will offset their 1985 losses with the profit commission that it receives for 1986 for managing the syndicate, the letter added.

MUAM will close the syndicate's 1985 accounts "as soon as we can. We are disappointed we couldn't do it this year," Mr. Randall said in an interview.

"The main area of uncertainty continues to be that of potential deterioration of the alleged liabilities on the disputed excess-of-loss contracts," Mr. Randall said, referring to the runoff policies. "Over the last year, there has been evidence of further deterioration. We are faced, as a precaution, with the anomaly of making higher provisions for potential losses on disputed contracts whilst at the same time taking steps to challenge their validity."

Meanwhile, the syndicate's smaller sister non-marine syndicate 421 is making a cash call this year of slightly less than 1.4 million pounds (\$2.3 million at current exchange rates) for its 1983 underwriting year, which also is being left open.

Last year, MUAM made a cash call of 1 million pounds (\$1.81 million at year-end 1988 exchange rates), or 30% of the syndicate's 3.4 million pound capacity, on syndicate 421's

1983 members.

MUAM may ask syndicate 421 members next year to pay the balance of the total loss of 3.4 million pounds (\$5.6 million at current exchange rates), which represents the syndicate's total capacity in 1983, Mr. Randall noted in his letter to member agencies.

"While it's painful to name, it is a small syndicate," Mr. Randall said.

The MUAM board thinks that requesting syndicate 421 members to fund the total loss is "inappropriate at this stage," though "names must be made aware that (the balance) will be called next year if there is an adverse outcome to the current disputes" over runoff reinsurance contracts written by that syndicate, Mr. Randall said in the letter.

Both syndicates 418/417 and 421 are suffering from a "deterioration"

in negotiations between MUAM and ceding insurers over 11 contracts written by the two syndicates, according to Mr. Randall.

The disputes include Mr. Merrett's two lawsuits in London's High Court against two British insurance companies that seek approval of cancellation of two runoff policies he wrote for the insurers and the return of claims he has paid under them (BI, May 8).

Mr. Merrett's syndicate, which would return the original premiums the companies paid if the policies are canceled, could be liable for as much as \$10 million in claims under the policies.

Of the 11 contracts, four were written by syndicate 418 and seven were written by incidental non-marine syndicate 417, which is considered part of 418 because it has the

same members. Syndicate 421 jointly underwrote the seven contracts with syndicate 417.

Keeping open both syndicates' accounts is contributing to the delay in the plan by MUAM's parent company, Merrett Holdings P.L.C., to offer its stock on the London Stock Exchange, Mr. Randall confirmed in an interview.

The offering, which has been considered for the last few years, "is not on the agenda right now," he said.

"The conditions aren't right" in part because of the runoff reinsurance disputes, Mr. Randall said. The disputes "are not positive to our reputation, but they must be pursued in the interests of our names."

Mr. Randall is more optimistic, though, about the MUAM syndicates' 1986 results, which closed Dec. 31,

1988, and are just being reported.

For example, he told members in the letter that syndicate 418/417 will pay 4,474 pounds (\$7,427) aftertax, or 8.9%, profit to each member for every 50,000 pounds of capacity written in 1986.

Syndicate 421 will pay 937 pounds (\$1,555) aftertax, or 9.37%, for every 10,000 pounds of capacity for 1986.

For Merrett syndicate 522, after-tax profits are 1,396 pounds (\$2,317) aftertax, or 6.98%, for every 20,000 pounds in capacity.

Also, former Lloyd's non-marine syndicate 799—which has been divided into three syndicates following Merrett director Robin A.G. Jackson's retirement from underwriting—is paying 6,104 pounds (\$10,132) aftertax or 12.2%, for every 50,000 pounds in capacity, according to Mr. Randall.

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## LTV decision

Continued from page 1

that it was based partly on the fact that LTV's operating income during the first five months of 1987 had surpassed earlier projections, the appeals court said.

"But five months is too short a period of time to determine an income trend. A longer period of time should have been used to determine whether the improved financial conditions would have a long-lasting effect on LTV," the appeals court said.

In addition, while LTV may have been able to fund its pension plans over a short period of time because of an improvement in its financial condition, "the administrative record included no information addressed to the long-term ability of LTV to fund the plans," the appeals court said.

"Here, if the restored plans were viable only for a short period of time, they might in the near future once again have to be re-terminated, thereby defeating the purposes and objectives of ERISA and the tax laws," the appeals court added.

The appeals court also said the PBGC failed to "appraise" LTV of the material on which it based its decision to restore the plans or to give LTV an adequate opportunity to offer contrary evidence.

"Failure to do any of these things renders the decision arbitrary and capricious," the appeals court concluded.

LTV attorneys last week praised the appellate court ruling. "We have said all along that a company and union have the right and duty to bargain and that plan restoration could not be based on a bargain made in good faith," said Frank Cummings, a partner with LeBoeuf, Lamb, Leiby & MacRae, the Washington, D.C., counsel for LTV.

PBGC Executive Director Kathleen P. Utgoff said she was surprised and disappointed with the ruling. She added that the agency has not decided whether to ask the U.S. Supreme Court to review the decision.

"We are reviewing a number of options," Ms. Utgoff said.

While the decision potentially adds more than \$2 billion to the PBGC's existing \$1.5 billion deficit from other terminated underfunded plans, the PBGC has no plans to ask Congress to raise termination insurance premiums, Ms. Utgoff said.

The previous premium increase, which went into effect in January 1988, assumed that the PBGC would be hit with a "catastrophic" claim once every five years, she explained.

"The size of the premium was calculated to assume there would be a large claim like LTV," Ms. Utgoff said.

That 1988 increase established a new variable-rate premium structure under which an employer's annual premiums now range from \$16 to \$50 per plan participant, depending on how well the employer's pension plan is funded.

Previously, the annual flat-rate premium was \$8.50 per plan participant, an amount that was so low—in the wake of skyrocketing claims—that the PBGC was faced with the prospect of selling off assets to pay for benefits it guaranteed to participants of terminated underfunded plans.

While Ms. Utgoff says the new higher variable-rate premium will allow the PBGC to absorb one jumbo claim every five years without seeking a premium increase, pension experts are divided on whether the agency soon could be hit with an explosion of new jumbo-size claims as other companies jettison their pension liabilities onto the PBGC.

Indeed, some pension experts had warned in 1987 that an LTV court victory would flash a signal to other companies to terminate large underfunded plans, shift the liabilities to the PBGC and then establish cheaper plans that provide benefits not guaranteed by the PBGC.

Such a strategy could remove from a company the yoke of

**"We have said all along that a company and union have the right and duty to bargain and that plan restoration could not be based on a bargain made in good faith," says LTV attorney Frank Cummings.**

hundreds of millions of dollars in unfunded pension promises. At the same time, workers and retirees would not lose anything since the combined benefits they would receive from the PBGC and their new plans would be about equal to what they were entitled to under the terminated plans, pension experts surmised.

"If LTV were allowed to proceed, it makes terminations virtually irresistible," Ms. Utgoff said at the time the PBGC attempted to restore to LTV the terminated pension plans.

Some still share that concern.

"The decision increases the likelihood that some corporations could take actions to abuse the PBGC insurance program and in the process abuse the sponsors of defined benefits plans who pay the premiums to support the insurance program," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

"It may be a little more difficult to terminate a plan, but it still can be done. This can happen again," said a pension attorney.

"The decision is disturbing. It gives vent to employers who are creative" in trying to shed their pension liabilities, said a federal pension official.

But others, citing provisions in 1987 pension reform legislation enacted after the termination of LTV pension plans, say a scenario of many financially troubled companies terminating underfunded pension plans, shifting the liabilities to the PBGC and starting new pension plans is not likely to develop.

"The hurdles to be cleared in order for a termination to be allowed are a lot higher. It would be much harder to duplicate an LTV-type situation," said Frederick Rumack, director of tax and legal services at Buck Consultants Inc. in New York.

"There are a lot more brakes on terminations," agreed Baruch Fellner, former associate general counsel at the PBGC and now a senior associate in the Washington, D.C., office of the law firm of Gibson, Dunn & Crutcher.

Experts note that the 1987 pension reform law—known as the Pension Protection Act—removed Chapter 11 bankruptcy filing as one way in which a company could unload its pension liabilities onto the PBGC.

Under the PPA, a "distress" termination essentially is allowed only if a company can prove to a bankruptcy or other appropriate court that it would face liquidation without terminating the plan.

"The PPA said the standard for a Chapter 11 termination is one that requires that a company face imminent liquidation before termination," said Gary Ford, former general counsel at the PBGC and now a principal with the Washington, D.C., law firm of Groom & Nordberg.

"A bankruptcy judge has to decide that termination is necessary to survival," concurred Richard Davids, a consultant with Hewitt Associates in Lincolnshire, Ill.

In addition, the PPA closed many loopholes in pension law that led to severe underfunding of pension plans and ultimately massive terminations, benefit experts pointed out.

For example, employers used to have up to 30 years to amortize pension benefit increases. That, in itself, could lead

to huge underfunding.

By contrast, the PPA requires employers to amortize new pension liabilities in as little as three years, depending on how severely underfunded a pension plan is. The faster amortization schedule does not affect fully or overfunded pension plans.

In addition, the PPA makes it more difficult for an employer to get a waiver from the Internal Revenue Service from making required pension contributions. These waivers can substantially add to the size of underfunding and ultimately the PBGC's liability if a company later terminates a plan.

For example, LTV received a waiver in 1985 that allowed it to forgo required pension plan contributions of about \$175 million, according to the PBGC.

Under the PPA, an employer now must prove that its financial difficulty is of a temporary rather than long-standing nature before it can receive a waiver. In addition, an employer has to prove that making a required pension contribution would impose a financial hardship on all members of a corporate family, legally known as a "controlled group."

For example, if an employer had a healthy aerospace unit and a financially ailing steel unit, it would be unlikely to receive a funding waiver for the steel unit's pension plan.

At the same time, the amortization period for funding waivers was reduced to five years from 15 years.

The PPA also requires employers to make minimum pension contributions in quarterly installments. Previously, contributions could be made as late as 8½ months after the close of the prior year.

The PPA makes an employer and its affiliates jointly and severally liable for funding shortfalls in each unit's pension plan. If required contributions are not made, the PBGC can go to court to place a lien on corporate assets.

The combined effect of tougher funding rules and waiver restrictions will decrease over time the likelihood that enormously underfunded pension plans will be terminated, said Mr. Davids of Hewitt Associates.

"Over time, there will be better funding of pension plans," predicted Mr. Rumack of Buck Consultants.

Others say that it may be too soon to say whether other big terminations may be in the offing.

"I view the (appellate court) decision as a second round in an ongoing fight. I would not draw any conclusions yet," said Mr. Ford, the former PBGC general counsel. He noted that other courts may rule differently and that the Supreme Court has not yet reviewed the issue.

In addition, Mr. Ford pointed out that the appeals court decision was not a complete defeat for the PBGC. For example, the court upheld the right of the PBGC to return a terminated plan to an employer, even though it ruled that the establishment of a follow-on plan is not in itself automatic grounds for returning a terminated plan, he said.

While the appellate court disagreed with the PBGC's contention that the new LTV plans are "merely continuations of the old plans," the court said, among other things, that benefits under the new plans are not guaranteed by the PBGC and that they have more restrictive age and service requirements than the terminated plans.

An LTV spokesman last week reiterated that the company is "very willing to negotiate a settlement" of its dispute with the PBGC.

"It is time to make a deal. The show is over," added Mr. Cummings, LTV's Washington attorney.

Previously, LTV offered to pay the PBGC about \$1 billion, most of it in stock and debt offerings. In return, the PBGC would take over the underfunded plans.

But, the PBGC rejected the offer, saying it wants LTV to fund its pension plans. ■

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# Bank asks Fed to reject insurers' position

By JUDY GREENWALD

WASHINGTON—Fleet/Norstar Financial Group Inc. is asking a federal agency to reject arguments by insurance trade groups contesting the bank's efforts to take an active role in the ownership and control of a financial guarantee insurer.

In a statement filed May 12 with the Federal Reserve Board, which eventually must decide the issue, the Providence, R.I.-based bank holding company charges the trade groups are seeking "to deter increased competition in a traditional banking activity."

In March, the American Insurance Assn. and several other insurance trade groups filed statements with the Fed opposing Fleet/Norstar's efforts to gain a more active

**'Fleet/Norstar seeks only to continue to provide the kind of credit enhancement product that it has provided in other, substantially identical forms through its subsidiary banks for many years,' says the company's statement.**

role in the affairs of San Francisco-based Capital Guaranty Corp., the parent of financial guarantee insurer Capital Guaranty Insurance Co.

The trade groups also asked for a full hearing by the Fed's Board of Governors on the issue (*BI*, May 1).

Fleet/Norstar is seeking permission from the Fed to convert its primarily non-voting investment in Capital Guaranty to a fully voting

investment, which would give it about 35% of the firm's outstanding voting stock.

The Fed oversees enforcement of the Bank Holding Company Act, the 1956 law that limits bank holding companies' non-banking activities to those that are "closely related" to banking.

It also oversees implementation of the Garn-St Germain Depository Institutions Act of 1982,

which explicitly prohibits federally chartered bank holding companies from selling insurance except for seven narrowly defined instances that do not include financial guarantee insurance.

In its statement, Fleet/Norstar criticizes the arguments advanced by the insurance trade group and says a full hearing is unnecessary.

The insurance trade groups "deliberately obfuscate the real issues at hand through mischaracterization of the application, extraordinary selectivity in the citation of authorities and irrelevant descriptions of transactions not at all proposed in the application," the statement says.

Fleet/Norstar contends its application presents the board with two narrow issues to determine:

- Whether financial guarantee

contracts constitute "insurance" transactions forbidden under the Bank Holding Company Act.

- Whether these contracts are closely related to banking and will result in net public benefits.

The trade groups reach the "preposterous conclusion" that insurance companies' entry into a form of credit extension, which is a "core" banking activity, means that bank holding companies are now precluded from the same activities, Fleet/Norstar says.

In its statement, Fleet/Norstar argues that:

- There is no risk that approval of its application will lead to "non-credit-related insurance activities" by the bank holding company.

"Fleet/Norstar seeks only to continue to provide the kind of credit enhancement product that it has provided in other, substantially identical forms through its subsidiary banks for many years," says the statement.

- The fact that financial guarantee contracts are treated as insurance for "various state law purposes" is "wholly irrelevant" insofar as interpretation of the BHCA is concerned.

- Financial guarantee contracts are a "credit product" and "starkly different from the 'insurance' proscribed by Congress to bank holding companies in the Garn-St Germain Act."

- Congress did not intend to include financial guarantee contracts as prohibited insurance in the Garn-St Germain Act.

"Machine-like overextension of the Garn-St Germain Act to the credit product at issue here would not further congressional intent and would serve no public policy," says the statement.

- Approving its application will provide competitive benefits and not result in adverse effects like conflicts of interest or unsound banking practices.

"The self-evident weakness" in the insurance industry trade groups' arguments that approving the application would be non-competitive and raise novel public benefit questions "speaks volumes as to the degree to which industry protestants must grasp at straws in order to oppose the application," says Fleet/Norstar.

AIA Counsel Michael Lovendusky, in response to Fleet/Norstar's statement, said: "He thinks they doth protest too much."

The bank holding company is trying to establish that financial guarantee insurance is no different from other products banks already offer, he said. Yet, if that were truly the case, they would not be laboring "so mightily" to enter the financial guarantee business, said Mr. Lovendusky.

## Blood bank wins verdict from jury

SAN FRANCISCO—An AIDS victim has not yet appealed a jury verdict that Irwin Memorial Blood Bank is not liable for infecting the woman with the AIDS virus through a blood transfusion.

After a three-week trial that ended late last month, the jury said the blood bank was not negligent in its screening of blood donors in 1985, when blood banks first screened donors for acquired immune deficiency syndrome.

In a similar case last December, a jury ordered Irwin to pay \$750,000 to the family of a child who contracted AIDS from blood transfusions (*BI*, Dec. 12, 1988). The judge reduced this award to \$475,000.

Irwin Memorial Blood Bank is appealing that award.

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## Walbrook results

Continued from page 2  
writes 45%.

Early this year Walbrook employed the London office of the actuarial firm Tillinghast to review its loss reserves and those of its subsidiary companies (BI, May 8).

Although Tillinghast has not yet completed its work, the actuary currently considers the loss and unearned premium reserves of Walbrook and LUI Insurance Syndicate Inc., a subsidiary of Walbrook, "to be in a range which they consider to be reasonable," both LUI and Walbrook's reports state.

Weavers Managing Director Peter Wilson said in an interview last week that Walbrook and the Department of Trade and Industry, which licenses insurance companies in the United Kingdom, had discussed employing actuaries during meetings last year.

"The DTI were aware of what we were doing," said Mr. Wilson, referring to Walbrook's appointment of Tillinghast.

However, "Tillinghast was appointed by us and was Walbrook's client, not the DTI's," he said, referring to a London newspaper report that claimed Tillinghast was employed at the "behest" of the DTI.

"Over the last few years the involvement of actuaries in our type of business has increased. The DTI has its own actuaries and welcomes the use of actuaries by property/casualty insurance companies," he said.

Loss reserves for other LUI insurance companies based in the United Kingdom also were increased due to the professional liability book of business, LUI Chairman Ronnie Driver noted in LUI's annual report.

"For the year ended December 31, 1988, our United Kingdom insurance companies' reserves have been strengthened due to the need to make provisions related primarily to United States professional indemnity business providing coverage for lawyers and accountants," Mr. Driver

## LUI directors

Continued from page 2

London-based LUI owns H.S. Weavers (Underwriting Agencies) Ltd., the largest U.S. liability insurance market in London, as well as Weavers' lead underwriter, Walbrook.

Russell Re, formed in 1977, writes property/casualty reinsurance, specializing in property catastrophe reinsurance.

A "substantial part" of the reinsurance business written by Russell Re has been reinsured through quota share reinsurance arrangements with H.S. Weavers, confirmed Mr. Wilson, who also is managing director of Weavers.

Mr. Wilson, Mr. Driver and Mr. Weavers "participated in the formation of Russell Reinsurance Services Inc. and subscribed \$10,000 for 500 of the 975 shares initially issued" in 1977, the LUI annual directors' report states.

The shares were held by a U.S. attorney who acted as nominee, it adds.

"When the agency started trading in 1977, we weren't sure what was going to come of it," Mr. Wilson said in an interview last week. However, "we felt in 1988 it was time it came into the group," he said.

LUI directors said in their report to shareholders: "In December 1988, (Messrs. Wilson, Driver and Weavers) informed the directors of (LUI) that, although they subscribed for shares in Russell Re in order to facilitate the establishment of Russell Re, they did not regard themselves as having any beneficial interest in the shares of Russell Re."

The report to shareholders continues: "Following receipt of this information, the directors carried out investigations into these arrangements, on which they have taken legal advice.

"They have been advised that whether Russell Re should have been treated as a subsidiary since 1977 is not free from doubt, but if Russell Re did not fall to be treated as a subsidiary prior to December 1988, then in that event the interest of Mr. Driver, Mr. Wilson and Mr. Weavers should have been notified to the company, as required by the relevant Companies Act."

The 500 shares in Russell Re now have been transferred to LUI "for no consideration," the directors report says.

At year-end 1988, the value of the shares was 525,000 pounds (\$950,250) after deducting a loss for the year of 111,000 pounds (\$200,910), according to LUI's report.

The remaining shares of Russell Re are held by a number of individuals, including some Russell Re staff members and some outside shareholders.

In addition, a \$300,000 shareholding dividend paid by Russell Re and held in a client account by the nominee attorney since 1986 also was transferred to LUI in December, after deducting taxation and adding accumulating

wrote.

"This business was ceded to our United Kingdom insurance companies by way of treaty reinsurance during the 1981-1984 underwriting years of account," he noted.

Besides Walbrook, LUI's U.K.-based insurers include El Paso Insurance Co. Ltd., Kingscroft Insurance Co. Ltd. (formerly Kraft Insurance Co. Ltd.), Lime Street Insurance Co. Ltd. (formerly Louisville Insurance Co. Ltd.) and Mutual Reinsurance Co. Ltd., all former members of the Weavers underwriting stamp and all now running off their business. All but El Paso were purchased last year.

Only the loss reserves of Walbrook are reported separately.

Loss reserves for all insurers owned by LUI, which also include The First Reinsurance Co. of Hartford, LUI Insurance Syndicate Inc., LUI Insurance Syndicate Number Two Inc. and Desert Insurance Co. Ltd. of Bermuda, total 485.9 million pounds (\$879.5 million), according to LUI's report.

The outstanding claims reserves, including IBNR provisions, for the most part are discounted at 7.5%, which is lower than the rates of interest earned on deposits "with maturities matching the anticipated settlement period," the report notes.

However, "certain of the run-off companies discount their provision at the rate of interest earned on the relevant deposits," it adds.

Meanwhile, the mean term of the liabilities discounted has been reduced to 4.9 years from 6.4 years in 1987, the report also notes.

Although the 1981-84 underwriting years "have shown adverse results I am very pleased with the development to date of the 1985 and subsequent years of account," wrote Mr. Driver in his chairman's statement.

"Although a prudent view has been taken at this stage we expect significant profits to arise from these years. This experience reflects substantially improved underwriting conditions which have prevailed since 1986,"

Mr. Driver noted.

"In the latter part of 1985 our insurance group was instrumental in introducing many significant changes with regard to the underwriting of United States liability business, including improved policy wordings to enable claims development to be assessed at an earlier date," he noted.

This was achieved "through the introduction of policies using 'claims made' language as opposed to the 'occurrence' language. These underwriting changes also encompassed increased premium rates and reduction in exposure to risks susceptible to high loss frequency," he added.

And, while "our United Kingdom insurance companies have always had a high proportion of North American business," the percentage of U.S. risks will reduce as more business is underwritten from other territories, he predicted.

Walbrook's gross premiums from North America last year increased 11.8% to 157 million pounds (\$284 million) from 140.4 million pounds (\$264 million), while gross premiums from the rest of the world fell to 34.5 million pounds (\$62.4 million) from 41.9 million pounds (\$79 million).

Meanwhile, Walbrook's gross premiums from liability business stayed fairly stable at 172 million pounds (\$311 million) compared with 169.5 million pounds (\$318.7 million), while gross premiums from property risks increased to 19.3 million pounds (\$35 million) from 12.9 million pounds (\$24.3 million).

Walbrook and its subsidiaries report 1988 year-end capital and surplus of 66.4 million pounds (\$120.1 million), an increase from 63.1 million pounds (\$118.6 million) for 1987. The subsidiaries are El Paso, Desert, LUI Insurance Syndicate Inc., the syndicate's management company and a property investment company.

Meanwhile, LUI reports capital and surplus for 1988 of 63.5 million pounds (\$114.9 million), up from 58.2 million pounds (\$109.4 million) in 1987. ■

interest, the report noted.

From 1978 to 1987 Russell Re "wrote insurance business on behalf of U.S. insurance companies in which neither the company nor any of its subsidiaries had shareholdings," the LUI report states.

However, "there were transactions in the normal course of business between these U.S. insurance companies and the company's underwriting subsidiary, Walbrook, including acceptance of a quota share reinsurance agreement relating to the business written on behalf of the insurance companies by Russell Re," it notes.

Russell Re underwrote on behalf of Transit Casualty Co. from January 1978 to December 1984.

Missouri-based Transit was ordered liquidated in December 1985.

Russell Re also underwrote on behalf of Employers Mutual Casualty Co. of Des Moines, Iowa, from July 1982 to December 1987. Employers Mutual is rated "A" by A.M. Best Co.

Since Jan. 1, 1988, Russell has written reinsurance for The First Reinsurance Co. of Hartford, an LUI subsidiary.

Russell Re "writes a worldwide account on virtually all classes and types of treaty reinsurance business," specializing in property/casualty, said Russell's reinsurance underwriter Jim Allen.

Weavers "would have been the main reinsurer" for the risks written by Russell since 1977, said Mr. Allen.

Mr. Wilson also confirmed that H.S. Weavers provided a "substantial" amount of reinsurance for the programs written by Russell.

According to Walbrook's annual returns to the Department of Trade and Industry, gross premiums paid by Employers Mutual for property/casualty treaty reinsurance during 1987 totaled 3.7 million pounds (\$7 million).

The DTI return does not state how much of the premiums stemmed from business written by Russell.

In 1986, Employers Mutual was Walbrook's largest treaty reinsurance cedant, paying premiums of 3.4 million pounds (\$5 million).

Meanwhile, between 1983 to 1985 inclusive, Transit was Walbrook's largest property/casualty treaty reinsurance cedant, paying a total of 7.7 million pounds (\$10.6 million at appropriate exchange rates) in premiums to Walbrook during the three-year period, according to DTI returns.

The returns do not include information on property/casualty reinsurance accepted by Walbrook before 1983.

The business ceded to Weavers from Russell has "always been profitable as far as we're concerned," said Mr. Wilson, referring to LUI.

Mr. Wilson would not detail how much business was written under the quota share reinsurance agreement between Russell Re and Walbrook. ■

## Update

### IRS eyes broader pension rules

WASHINGTON—The Internal Revenue Service last week proposed that non-discrimination rules that formerly applied to private pension plans be extended to governmental and church pension programs.

Under those rules, public or church plans would have to prove that they do not discriminate in favor of highly compensated employees. Alternatively, the pension plans would have to satisfy a test under which a plan is considered non-discriminatory if it covers or benefits a certain percentage of eligible employees.

Private pension plans face a different set of non-discrimination rules laid down by the Tax Reform Act of 1986.

### Kemper finalizes unit sale

LONG GROVE, Ill.—Kemper Corp. has completed the sale of its American Motorists Insurance Co. subsidiary—its national property/casualty insurance subsidiary—to Lumbermens Mutual Casualty Co. in exchange for 9.6 million shares of Kemper Corp. common stock.

The move—aimed at insulating Kemper Corp.'s shareholders from commercial property/casualty market swings—also reduces Lumbermens' shareholdings in Kemper Corp. to 38.6% from 49%. The two companies retain a common board of directors and chairman and chief executive officer, but "the sale sets the stage for eventual separate managements and boards of directors," a Kemper spokesman said.

Kemper Corp. still writes property/casualty business through two regional insurers, but the sale reduces its commercial property/casualty writings to 13% of net written premiums from 40%. Other operations are life insurance, reinsurance and investment services.

Kemper Corp.'s stock value rose to \$36.25 a share late last week from \$23.88 when the proposed sale was announced Jan. 23 (BI, Jan. 30). John H. Fitzpatrick, vp of corporate finance, noted that while most stock values have risen over that period, much of the increase is attributable to the divestiture.

### Suit alleges harm from cleanup

DENVER—Property owners near the Rocky Mountain Arsenal claim in a lawsuit that Shell Oil Co. failed to warn nearby residents they would be exposed to hazardous substances during cleanup of the site and that many have suffered short- and long-term health effects.

The suit, which seeks class-action status, was filed in U.S. District Court in Denver.

Shell, which will seek dismissal of the case, believes it has coverage under comprehensive general liability insurance, said Allen Lackey, general counsel for Houston-based Shell. He also said that "Shell paid for medical tests, and they showed no long-term health effects."

But, Barry Ostrager, an attorney with Simpson, Thatcher & Bartlett in New York, who represents Shell's primary insurer, The Travelers Insurance Co., pointed out that a California jury ruled late last year that Shell's insurers would not have to pay the estimated \$1 billion the oil company will spend to clean up the site (BI, Dec. 26, 1988). "It has been determined that Shell doesn't have coverage for anything arising out of pollution at the Rocky Mountain Arsenal," he said.

### Briefly noted

A New Jersey state appellate court last week overturned a trial court decision and ordered that the massive hazardous waste coverage litigation between **Westinghouse Electric Corp.** and its insurers be consolidated and heard in one court. Westinghouse is suing more than 140 of its property and liability insurers, seeking defense and indemnification for the costs to clean 81 hazardous waste sites nationwide and to respond to more than 3,000 personal injury claims alleging exposure to toxic substances (BI, Sept. 28, 1987; June 15, 1987; March 28, 1988; April 4, 1988). . . . Even though Exxon Corp. has paid \$115 million to clean up the **Exxon Valdez oil spill**, the company has not filed any formal claims with its Bermuda protection & indemnity club, International Tanker Indemnity Assn., sources in Bermuda and London say. Exxon has \$400 million in pollution liability coverage through the P&I club, subject to a \$15,000 deductible (BI, April 3). . . . The U.S. government has asked the 1st U.S. Circuit Court of Appeals in Boston to rehear its March 27 ruling that the Navy must contribute to an **asbestos bodily injury settlement** for a family member exposed to asbestos brought home by a shipyard worker (BI, April 10). . . . Creditors and shareholders have approved **UNR Industries Inc.'s proposed reorganization plan**, which calls for channeling asbestos bodily injury claims into a central claims-handling facility funded by company stock (BI, April 3). A bankruptcy court hearing on the plan is scheduled for May 31. . . . A bill in the California Legislature that would form a non-profit **insurance consumer advocacy corporation** is headed for a floor vote this week after being approved by a Senate insurance committee. A state Supreme Court ruling struck down a provision in Proposition 103 calling for the creation of such a facility (BI, May 8). . . . A Boston U.S. District Court jury last week found that intrauterine contraceptive devices manufactured by **G.D. Searle & Co. and Ortho Pharmaceutical Corp.** did not cause the infertility of a Billerica, Mass., woman. . . . **Maurice R. Greenberg**, president and chief executive officer of American International Group Inc., has assumed the additional title of chairman of the insurance holding company. . . . A federal jury in Seattle cleared **Jim Beam Brands Co.** of charges that it was negligent for failing to label its alcoholic beverages with warnings that the unborn children of women who drink the beverages while pregnant may suffer birth defects (BI, March 28, 1988). . . . The New York Court of Appeals sent back to the Appellate Division of the Supreme Court for consideration three insurer suits seeking the return of at least \$87 million that the Legislature appropriated from the **New York guaranty fund** in 1982 (BI, Jan. 23; May 9, 1988). . . . Southern Pacific Transportation Co. is substantially self-insured for property and liability losses resulting from a 69-car **freight train derailment** in a residential area near San Bernardino, Calif., May 12. Two train crewmen and two children were killed in the wreck. The San Francisco-based railroad estimates the loss of its freight cars, six locomotives and track amounted to \$3.8 million.

## Liberty Mutual fine

Continued from page 1

The New Castle office handles upstate New York accounts while the Lynbrook office handles New York City and Long Island accounts, he said.

Insurance Department examiners looked at 100 multiperil policies written for small businesses by each of the two offices and found that the Liberty Mutual companies had "arbitrarily" cut their filed base rates by 25% to 50% by applying rate modifiers not filed with the department, the spokesman said.

The examiners found that 98% of the policies inspected in the New Castle office had rating violations, while 50% of those examined in the Lynbrook office had rating violations.

The record fine follows the New York department's announcement in February that it would crack down on insurers and insurance company managers found to be violating rating laws (BI, March 6).

Liberty Mutual officials were not personally fined for the violations, though the Insurance Department had earlier announced that it may hold insurer directors, officers and managers personally responsible for causing or failing to prevent violations.

The Liberty Mutual examination began before the New York department's crackdown on insurance company officials was announced in February, the spokesman said.

The market conduct exam of Liberty Mutual was prompted by tips the Insurance Department received

on its flex-rating hot line, known as the Rating Abuse Telephone Exchange System, he added.

In addition to paying the fine, the Liberty Mutual companies will re-rate all commercial multiperil policies in force in New York as of September 1989, and will re-bill or refund to each policyholder any difference greater than \$15, the Insurance Department announced.

The department spokesman said he is unsure how many policies Liberty Mutual will have to re-rate.

A Liberty Mutual spokesman, reading from a prepared statement, said that the insurer's "failure to conform all of its activities with every aspect of the areas examined by the department did not result from any conscious company policy to evade such requirements."

Noting that the violations occurred following the implementation of flex rating—a "radical departure" from prior procedures—the spokesman said that Liberty Mutual "has improved its procedures in an effort to conform its underwriting activities to the laws and regulations of New York."

In February, the New York department fined 10 companies or groups of companies a total of \$446,700 for similar flex-rating violations.

The second highest fine ever levied by the department was \$348,900, against the Insurance Co. of the State of Pennsylvania, a unit of American International Group Inc.

However, that fine involved rating violations related to insurance for taxis and not violations of flex-rating regulations. ■

**A Liberty Mutual spokesman said that the insurance company 'has improved its procedures in an effort to conform its underwriting activities to the laws and regulations of New York.'**

## Hall's new CEO

Continued from page 2

• Hire new technical and sales people.

• Implement an incentive plan.

• Begin an acquisition campaign.

Pursuant to Mr. Steinberg's plans, litigation matters were turned over to corporate and outside attorneys.

The biggest threat among several lawsuits pending against Hall involves a suit brought in March 1987 by New York Insurance Superintendent James Corcoran over the collapse of Hall insurer subsidiary Union Indemnity Insurance Co. of New York.

However, that suit was close to settlement last week (see Update column, page 1).

Uncertainties related to this suit, combined with corporate changes and other pending lawsuits, has caused Hall's stock value to plummet to \$3.50 late last week from \$16.38 in March 1987.

And, in line with other plans outlined by Mr. Steinberg, Hall in late 1987 terminated more than 500 employees internationally. It also launched its incentive plan.

In 1988, the broker began aggressively hiring top producers and technical people from within the brokerage community (BI, Feb.

27). And, in the first quarter of 1989, Hall began its acquisition campaign.

Mr. Steinberg also had vowed to improve Hall's balance sheet by year-end 1987.

But, the broker's balance sheet has continued to deteriorate. In fact, Hall posted a first quarter net loss in 1989 and net losses in both 1987 and 1988 under Mr. Steinberg's leadership, following three consecutive years of net losses (BI, May 15).

However, Mr. Bell is upbeat about Hall's future. "One thing that intrigued me about this position was the challenge," he stressed.

Mr. Bell also cited a similarity of views and a "good chemistry" between himself and Mr. Steinberg.

"We'll be walking parallel," said Mr. Bell, who described his relationship with Mr. Steinberg as "an active partnership."

"Peter (Pruitt) is another part of that partnership. He has a wealth of knowledge and talent, and I'm going to rely on that and utilize it," Mr. Bell stressed.

Mr. Bell said his first task at Hall will be to familiarize himself with the organization and Hall employees. "I think it is both presumptuous and a mistake for someone to come in and, without making an appraisal, say, 'I am going to do this.' My intent is to go out throughout our system and meet our people as soon as I can.

"Once I do that, I can come to some larger conclusions and, almost simultaneously, make plans," Mr. Bell explained.

Mr. Bell stressed that his primary focus will be on the needs of Hall's clients.

"If I can instill a sense of urgency in our people that, as far as our clients are concerned, they are people—not companies—I will be very happy. I hope to have a staff that believes in that like a religion," he said.

"We are going to concentrate on client service—on doing what the client wants rather than what we want. We want new business, but there's no point in trying to grow if your foundation leaks out from under you," Mr. Bell added.

Security analysts generally gave Mr. Bell high marks but disagreed over what Mr. Bell's appointment means for Hall.

"Don Bell is very well regarded in the industry. He is a good selection. I think he will work well with Peter, and Saul will continue to be actively involved," observed Ira H. Malis, a securities analyst with Alex. Brown & Sons Inc. of Baltimore.

"I think at this point it sends a positive message out about the company," Mr. Malis said.

While there are "still a lot of unanswered questions regarding Hall's non-operational problems, its revenues have held up rather well, given the turmoil," Mr. Malis said.

Hall "would be an interesting company to look at, if it weren't for those problems," he noted.

However, analyst Thomas G. Rosencrans, senior vp and director of research for Interstate/Johnson Lane in Atlanta, is not as upbeat about the move.

"I think that no matter what Mr. Steinberg might admit publicly, this represents a capitulation on his part, stemming from his recognition that running an insurance brokerage is more difficult than he once thought," he said.

"I hear good things about Don Bell, but the problems of this company are well known and cannot be easily overcome," Mr. Rosencrans added. ■



Mr. Bell

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# Broker stocks may reflect poor '89 earnings picture

By LEONARD M. WILSON  
Special to Business Insurance

SPRING HAS FINALLY arrived with the soft breezes of May, but it still is autumn for insurance brokerage.

First-quarter financial reports were a sober and unneeded reminder that the publicly owned insurance brokers are still tightly in the grip of the soft market. Not one of the brokers was able to record an increase in pre-tax profits for the quarter.

The economics of insurance brokerage are relatively simple. Reduce the growth in the stream of revenues to low single digits, and profit margins will be squeezed. Expenses, even with the hatches batted down, have an internal momentum that cannot be wholly stemmed. Each of the reporting brokers

posted a percentage gain in revenues less than the increase in costs. Revenues expanded 3% to 4% on average in the first quarter against a 7% average rise for expenses.

Domestic insurance brokerage commissions, by our calculation, increased 3% to 4%, including contingent commissions. The gain might have been slightly greater without contingents, which in almost every instance were moderately lower as compared with last year.

Premium rates on renewals were clearly very soft in the quarter. Brokerage contacts typically estimated the decline in pricing at 10% to 15% with commissions perhaps not falling quite as much as rates. Our own calculations suggest that price reductions across a full book of business were probably at the upper end of that range. Since prices began to soften in the fourth quarter of 1986 or the first quarter of 1987, the industry is now ex-

periencing its third round of price reductions.

Straightforward arithmetic indicates that premium rates on an absolute basis could be flirting with the lows registered at the trough of the cycle in 1984. No rational person could have foreseen a retracement of this magnitude, given the underwriting distress at the last trough, but the numbers make this conclusion almost inescapable.

Fortunately for the public brokers, new business continues at a brisk pace. New business, though, faces the hurdle of falling prices along with renewals. As a consequence, new business measured in dollars rather than units actually understates the strength. Prolific new business production has become a kind of habit for the public brokers.

Lost business has stabilized, and we estimate that attrition in an existing book of business was around 6% of the prior year's renewals. In a price-sensitive market, price—not professionalism—gains ground. Presumably, brokers are doing a highly effective job of keeping the client happy about price while maintaining or improving the content of professional service. Possibly, clients are staying put with an eye to the next capacity crunch and the value of reciprocal loyalty.

Brokerage commissions for reinsurance brokerage were flat to down modestly. As one contact put it, the current demand for reinsurance does not provide much impetus for the reinsurance intermediary. All signs point to continued high retentions on the part of primary insurers. Reinsurance pricing is easing, we think, but has not suffered the sharp reductions characteristic of the direct market.

Self-insurance demand is always difficult to gauge. Arthur J. Gallagher & Co. is the sole public broker to break out fees from risk management activities. Double-digit gains in the first quarter were certainly creditable. But results slowed somewhat from last year's pace.

The soft market may be a deterrent to the self-insurance alternative, but this view must still be regarded as conjectural on the limited evidence of a single quarter.

Performance in benefit consulting contrasts strikingly to the weak progress in insurance

brokerage commissions. Marsh & McLennan Cos. Inc., the leader in this sector, registered a 23% increase in revenues from consulting. We used to think of consulting as having an inherently slower growth rate than insurance brokerage, and this may still be valid. But over the past few years, benefit consulting, broadly defined, has seemingly become a dynamic business, spurred by the ever greater complexity and costs of employee benefits.

It is an ill wind that blows no good, and so it is with interest rates. Investment income, generally, expanded substantially despite little growth in investable funds. The quarter was a clear beneficiary of elevated interest rates. No one talks about it much, but the virulence of price cutting in commercial lines could be partly related to the lofty real interest rates that currently prevail.

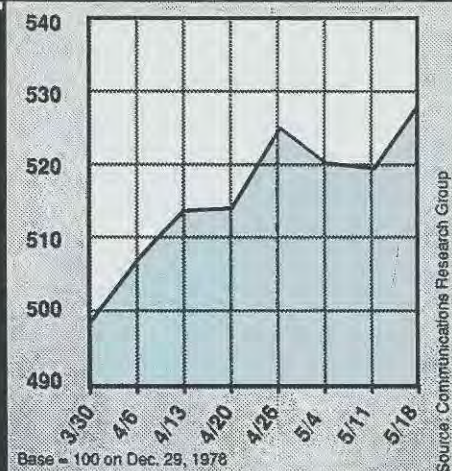
In the realm of expenses, it is difficult to fault the public brokers. For around five consecutive quarters, cost restraint has received more than lip service. Head counts are stable, and expense growth seems in line with the need to sustain essential programs while recognizing the imperatives of protecting profits. Nonetheless, as we noted earlier, costs did outstrip the rise in revenues.

Earnings per share, the bottom line for investors, edged lower. Share buybacks helped by reducing the number of shares outstanding. Tax rates for 1989 were not materially lower than the year earlier accrual levels.

Expectations are critical to common stock prices. Investors seemingly were not surprised by the lackluster comparisons and brokerage stocks hardly budged on the earnings reports. Given the lack of any noticeable reaction to first-quarter earnings, we theorize that stock prices may have already discounted the possibility of tepid 1989 results.

Concerns are now centered on the duration of the soft market and the timing of a turn in premium rates. The optimists of a year ago are scarce, while the once persuasive arguments for a short cycle and judicious competitive pricing are tarnished. Soft markets, we are convinced, are a slug, not a sprint, and therefore watch and wait seems to be the attitude of most investors at this juncture.

## BI Insurance Index



Insurance industry stocks reversed their downward trend last week, as the *Business Insurance Index* rose 8.3 points to 528.6 on May 18, from 520.3 on May 11. Advancing issues were led by Lawrence Insurance Group, up 18.5%; Safeguard Health Enterprises, up 13.5%; and Berkshire Hathaway Inc., up 8.2%. Decliners followed Nobel Insurance Ltd., down 13.5%; Sierra Health Services, down 7.8%; and Statesman Group Inc., down 7.1%. The most active issue during the week was Sears, Roebuck & Co. (Allstate), 4.5 million shares traded. The *BI Index* gained 1.6% for the period; the Dow Jones 30 Industrials, 3.7%; the Standard & Poor's 500, 3.6%; and the New York Stock Exchange Composite, 3.2%.

## British Issues

May 18 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Commi Union	378	13.1	25.3	6.7	384-375
Genl Accident	967	9.0	58.7	6.1	969-958
Gdn Royal Exch	216	11.1	13.3	6.2	216-214
Royal	413	12.9	30.0	7.3	428-413
Sun Alliance	1173	9.2	54.7	4.7	1184-1173

Brokers	Price	P/E	Div.	Yield	1 Week High-Low
Bradstock	222	12.5	9.0	4.1	222-222
CE Heath	480	15.2	34.5	7.2	480-470
Hogg Robinson	145	12.8	8.7	6.0	147-144
Lloyd Thompson	221	17.0	8.0	3.6	221-221
PWS Holdings	44	11.9	4.6	10.6	57-44
Sedgwick Grp	262	21.7	16.0	6.1	262-257
Steel Brll Jones	229	19.6	13.3	5.8	229-229
Willis Faber	240	17.8	15.3	6.4	240-235

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

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## BI Industry Stock Report

MAY 18, 1989

5/12/89 THRU 5/18/89

### BROKERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	25.00	1.0	6.4	26.50	22.63	298	1.00	4.0	16.9	3.71	6.74
Berkshire & Black Corp	35.00	4.1	12.4	35.00	30.75	126	1.24	3.5	13.7	12.40	2.82
Gallagher Arthur J. & Co.	19.63	2.6	17.2	19.88	16.13	38	0.52	2.6	13.9	5.33	3.68
Hall Frank B. & Co.	3.38	-3.4	17.4	4.63	2.50	45	0.00	0.0	-1.9	0.00	N/A
Hilb, Rogat & Hamilton	14.25	-0.9	-6.8	15.75	13.75	218	0.20	1.4	12.8	4.60	3.10
Marsh & McLennan Cos. Inc.	61.13	1.7	8.7	64.50	55.13	371	2.50	4.1	15.1	6.48	9.43
Poe & Assoc. Inc.	8.75	0.0	6.1	8.75	8.25	5	0.40	4.6	9.5	0.27	32.41
BROKERS	AVERAGE	0.7	8.8					2.9	11.4		

### CONGLOMERATES & HOLDING COMPANIES

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Berkley W R Corp	30.63	0.4	3.8	34.00	29.25	512	0.40	1.3	6.4	20.24	1.51
Berkshire Hathaway Inc. DEL	6275.00	8.2	33.5	6475.00	3567.00	83	0.00	0.0	22.2	2492.68	2.52
ITT (Hartford) Group	57.00	0.4	13.7	59.50	49.75	2353	1.48	2.6	9.7	56.33	1.01
Sears Roebuck & Co. (Allstate)	46.88	5.6	14.7	46.88	40.13	4481	2.00	4.3	17.6	36.09	1.30
CONGLOMERATES	AVERAGE	3.7	16.4					2.1	13.9		

### INSURERS/REINSURERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Aetna Life & Cas Co.	53.00	1.9	12.2	54.88	46.75	613	2.76	5.2	8.2	58.11	0.91
American General Corp.	35.88	4.4	20.1	36.13	29.50	751	1.50	4.2	10.8	28.04	1.28
Amer Heritage Life Inv	26.00	0.0	1.0	27.88	25.00	6	1.20	4.6	10.3	22.47	1.16
Amer Indly Fin'l Corp.	11.50	2.2	9.5	12.25	9.50	9	0.56	4.9	7.4	17.06	0.67
American Int'l Group	82.75	5.2	22.1	84.25	66.25	1437	0.48	0.6	11.6	33.55	2.47
Aon Corp	53.63	4.7	20.1	34.25	27.00	450	1.40	4.2	11.7	16.67	2.02
Argonaut Group	34.25	-1.8	24.0	56.00	43.50	69	0.00	0.0	7.5	36.83	1.47
AVEMCO Corp	23.13	1.7	-10.6	26.13	22.63	82	0.40	1.7	12.2	9.20	2.51
Baldwin & Lyons Inc.	17.13	0.8	15.1	17.25	14.50	8	0.20	1.2	8.7	17.57	0.97
Beivedere Corp	5.13	-4.6	14.0	6.50	4.50	1	0.04	0.8	7.8	8.43	0.61
Chandler Insurance	11.88	-1.0	28.4	12.75	8.75	68	0.00	0.0	5.5	6.65	1.79
Chubb Corp	67.88	2.3	17.0	69.00	57.63	540	2.32	3.4	7.9	53.50	1.27
CIGNA Corp	53.50	1.9	13.5	56.13	45.88	661	2.96	5.5	9.4	53.08	1.01
CNA Fin'l Corp	70.63	8.0	16.7	70.25	57.63	329	0.00	0.0	11.0	46.40	1.52
Continental Corp	34.25	4.2	5.8	36.00	31.50	720	2.60	7.6	23.3	42.10	0.81
Durham Corp	32.50	-2.3	-1.5	33.75	30.00	4	0.92	2.8	18.8	26.32	1.23
Fireman's Fund Corp.	32.00	-3.0	9.4	34.88	29.00	375	0.60	1.9	7.9	32.74	0.98
Forum Re (Bermuda)	1.13	0.0	-30.7	1.75	1.13	0	0.00	0.0	-8.7	2.53	0.45
Fremont Gen Corp	16.00	0.8	19.6	18.25	12.13	201	0.60	3.8	9.6	16.06	1.00
Frontier Insurance Group	15.38	2.5	23.0	16.75	12.25	33	0.00	0.0	7.3	7.53	2.04
General Re Corp.	64.88	2.8	16.9	68.25	54.38	1421	1.36	2.1	12.2	29.04	2.23
Home Group Inc.	13.25	-1.0	20.5	14.50	11.00	289	0.20	1.5	5.3	18.66	0.71
Hanover Ins Co	26.25	1.9	-1.9	30.25	25.75	36	0.44	1.7	5.4	31.47	0.83
Hartleysville Group Inc	22.50	2.8	25.0	22.50	17.75	10	0.48	2.1	7.8	18.94	1.19
Hartford Steam Boiler	40.75	1.2	10.9	42.50	34.75	192	1.40	3.4	11.3	13.04	3.13
Kans City Life Ins	35.75	0.7	3.6	35.75	32.75	25	0.00	0.0	12.8	39.22	0.91
Kemper Corp	36.25	4.3	51.0	36.75	22.75	1044	0.84	2.3	9.2	28.91	1.25

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Lawrence Ins. Group	8.00	18.5	1.5	8.50	6.63	20	0.24	3.0	17.0	3.19	2.51
Liberty Corp S.C.	34.00	1.5	-5.6	38.00	32.50	547	0.80	2.4	19.3	21.17	1.61
Lincoln Nat'l Corp.	48.63	2.1	10.5	50.63	42.75	300	2.48	5.1	12.1	39.12	1.24
NAC Re Corp.	38.25	5.1	20.5	38.75	31.00	146	0.00	0.0	13.7	22.81	1.68
Navigators Group	24.00	5.5	20.0	24.00	20.50	9	0.00	0.0	10.3	15.22	1.58
Nobel Ins Ltd.	2.38	-13.5	-49.9	5.00	1.50	119	0.42	7.6	-9.2	7.76	0.31
Northwestern Nat'l Life	35.00	8.1	12.4	34.25	26.88	403	1.20	3.4	12.6	37.50	0.93
Ohio Cas Corp.	43.25	3.0	21.0	45.25	35.50	335	2.08	4.8	6.3	33.30	1.30
Old Rep Int'l Corp.	24.13	2.1	0.5	28.88	23.38	504	0.74	3.1	13.5	26.50	0.91
Orion Cap Corp.	21.75	3.6	41.4	22.25	15.38	78	0.84	3.9	7.1	12.93	1.68
Phoenix Re Corp	9.38	4.2	-1.3	11.00	8.75	107	0.00	0.0	5.2	12.49	0.75
Protective Life Corp.	14.13	0.9	6.6	14.50	12.88	118	0.70	5.0	70.7	14.54	0.97
Re Capital Corp.	10.75	0.0	17.7	11.13	9.13	8	0.00	0.0	10.8	12.60	0.85
RLI Corp.	7.75	3.3	1.6	9.25	7.13	17	0.36	4.6	7.6	10.71	0.72
Provident Life & Acc Ins Co.	21.88	-1.7	13.7	24.75	19.13	534	0.68	3.1	9.3	21.96	1.00
St. Paul Cos. Inc.	49.50	3.1	13.8	51.00	43.00	753	2.20	4.4	6.7	32.00	1.55
SAFECO Corp.	28.63	6.0	21.2	29.13	23.13	1296	1.20	4.2	7.1	24.88	1.15
SCOR US Corp.	9.00	2.9	-1.4	9.50	7.50	17	0.20	2.2	6.8	10.35	0.87
Seibels Bruce Group Inc.	11.25	0.0	-1.1	13.00	10.25	117	0.80	7.1	9.4	13.42	0.84
Selective Ins Group Inc.	24.00	0.0	4.3	25.50	21.75	92	1.40	5.8	5.2	22.33	1.07
Statesman Group Inc	2.50	-7.1	-20.1	4.00	2.38	94	0.05	2.0	62.5	3.48	0.72
Tokio Marine & Fire Ins	73.00	-4.9	-20.1	95.50	73.25	9	0.22	0.3	44.2	0.00	N/A
Torchmark Corp.	38.75	4.7	27.0	39.63	30.00	795	1.20	3.1	11.9	12.24	3.17
Transamerica Corp.	34.50	3.0	1.8	36.00	32.75	363	1.88	5.4	7.7	30.70	1.12
Travelers Corp.	39.75	0.6	14.4	40.88	34.50	484	2.40	6.0	31.1	44.85	0.89
Trenwick Group Inc.	16.00	0.0	10.3	17.75	13.75	102	0.24	1.5	9.0	16.91	0.95
United Fire & Cas Co.	30.00	1.2	-1.6	30.75	29.00	516	1.08	3.6	5.5	22.56	1.33
United States Fid & Gty	32.50	5.2	14.0	32.88	28.50	772	2.80	8.6	2.1	22.57	1.44
UNUM Corp.	32										



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