**Benefits: Confronting the future . . . Page 3**

MAY 28, 1984

# business insurance®

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## update

### Former AFIA chief Butler takes posts at Frank B. Hall

NEW YORK—Paul F. Butler is the new chairman of Frank B. Hall Overseas Inc. and president of Frank B. Hall Re, replacing William R. Dolan, who left the company last year.

Mr. Butler is the former president and chief executive officer of AFIA Worldwide Insurance, which was purchased by CIGNA Corp. earlier this year. He will be based in Hall's Madison Avenue office in New York.

*Continued on next page*

# Asbestos producers mulling agreement

**By STEPHEN TARNOFF**

Asbestos producers are weighing the benefits of subscribing to a proposed agreement to end litigation with their insurers against the possibility that it will reduce their coverage.

Whether they lose or gain under the agreement depends in large part on how each asbestos producer's coverage is structured.

There are certain advantages to producers that sign the agreement, which was announced May 17 after 19 months of negotiations between asbestos producers and their insurers, which for several years have been in litigation over coverage for asbestos injuries.

The litigation stems from disagreements over when coverage is triggered for long-latent asbestos injuries—when the injured was exposed to the asbestos or when the disease is manifested.

If they sign, the asbestos producers could end the expensive litigation with their insurers and achieve a potentially cheaper, faster and more efficient way of disposing of the thousands of claims filed against most of them.

But, some asbestos producers and their attorneys, primarily those not involved in the agreement negotiations but who will be asked to also sign it, are concerned that the coverage provided under the agreement will not be as broad as that already granted policyholders by some court decisions.

> 'I'm not sure that major concessions of the insurance industry are contained in the agreement,' says attorney David Steuber.

Under the agreement, each producer selects a "coverage block," which can consist of some or all insurance policies issued to it prior to Jan. 1, 1973.

(After January 1973, insurance for asbestos producers largely became unavailable or was only written with high per-claim deductibles or as retrospectively rated plans.)

As each claim comes into the facility, each producer is assigned a predetermined percentage of liability for the claim, which becomes the producer's share of the settlement (see related story, page 79).

Thus, if a particular producer's share is 10%, and a claim is settled for $50,000, the producer's insurers have to pay $5,000.

That $5,000 liability, in turn, is allocated among all the insurers with policies in force during the coverage block.

If a company's coverage block covers 25 years and includes 25 different insurers, each insurer will pay 1/25 of $5,000, or $200.

If any particular policy within the coverage block is exhausted by payments, the policyholder still does not have to contribute anything toward claims payment until all the coverage in the block is exhausted.

"The other policies within that block would pick up that year's share of the claim," explains John F. Shea, vp and claims counsel for Aetna Life & Casualty Co., one of the insurers that negotiated the settlement.

"The manufacturer doesn't have to use his own money until he has exhausted his insurance."

An asbestos producer also may include or later add to its coverage block any post-1973 policies that might include deductibles, self-insured retentions and retrospective rating.

In that case, the policyholder does have to pay his share, but it is proportioned also.

For example, if the policyholder is responsible for 1/25th of a claim payment, then he would contribute 1/25th of the deductible toward it.

Both asbestos producers and insurers say this "comprehensive coverage" is similar to the coverage handed down by the District of Columbia Court of Appeals in Keene Corp.

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# Pension bill amendments propose new liabilities

**By JERRY GEISEL**

WASHINGTON—A bill passed by the House last week that is intended to give women a better chance to earn a pension benefit could also stick employers with unwanted pension obligations.

Amendments added to the Retirement Equity Act of 1984 by the House Ways and Means Committee in a special closed-door session just prior to its passage could have a severe effect on pension plan design, experts say. However, they aren't exactly sure how far the provisions will extend.

"Basically, the bill is not bad," pointed out Philip Alden, a vp with Towers, Perrin, Forster & Crosby, a New York-based employee benefit and management consulting company. "It is what has happened behind closed doors that is causing problems."

Benefit lobbyists and consultants last week were still trying to decipher the amendments to the legislation, H.R. 4280. But, they said the amendments apparently would:

- Prevent a pension plan from eliminating lump-sum benefit distributions as a benefit option.
- Indefinitely extend "early retirement sweeteners" that employers temporarily offer to encourage older workers to retire.
- Require companies to offer a survivors' benefit if a pension plan participant dies after vesting in the plan—regardless of the participant's age.

That provision would mark a radical change for most employers, whose pension plans don't offer survivors' benefits unless plan participants reach the plan's early retirement age, which is usually 55.

And, the provision would cover both a company's former and current employees. Thus, if an employee left in January 1980 after

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**A&P to receive $275 million by terminating pension plan**
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NEWSPAPER

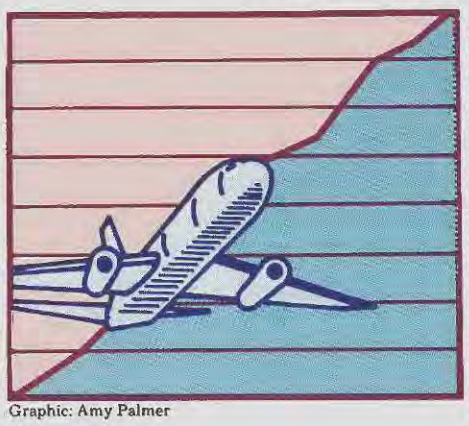
# London insurers' tough terms boost airline deductibles, rates

**By STACY SHAPIRO**

LONDON—Airlines that were warned earlier this year to be ready for sizable rate increases when they renew hull and liability coverages are getting a few extra thumps from the London market.

Not only are rates going up at least 30% (*BI*, March 26), but deductibles on partial hull losses are being increased and London underwriters are dictating terms to buyers without any room for negotiation, a major airline trade association says.

The combination of this dictatorial attitude of the market and the increased deductibles and rates is so angering a major airlines trade association that it will offer members a chance to move their hull and liability coverage out of the commercial market and into a Bermuda captive by next year.



Graphic: Amy Palmer

The market changes, confirmed by airlines, aviation brokers and underwriters, will greatly affect U.S. airlines, which primarily renew their insurance between July 1 and the end of November.

Delta Air Lines Inc. in Atlanta, Northwest Airlines Inc. in Minneapolis, Pan American World Airways Inc. in New York and Pacific Southwest Airlines Inc. in San Diego face July renewals.

So far, only PSA has placed any of its insurance.

"Everyone is hopping mad," said Tony Kelly, assistant director of industry monetary affairs for the International Air Transport Assn. in Geneva, Switzerland. IATA represents 126 international airlines, including the major U.S. airlines.

"Since the start of the year, the average premium rate increases have ranged between 30% and 190%," Mr. Kelly explained.

"We have had a series of meetings to discuss the situation in the past few weeks in Montreal, Washington and Zurich and airlines have expressed their dissatisfaction in the way in which underwriters have increased deductibles and rates—without consultation.

"Airlines have just been called into London and told to sit down and take what they have been told," Mr. Kelly continued. "The underwriters could have handled it differently," he added.

In response, the association has changed its mind about not insuring hull and liability risks through its two Bermuda captives and is reactivating them so airlines can place these risks there by next year.

Earlier this year, IATA reported that it might soon reopen two dormant captives—Air Transport Insurance Ltd. and Air Transport Guarantee Ltd.—to reinsure a group business interruption insurance progam it may offer to members. However, it said it did not plan to open up the captive for hull and liability risks even though the captives were set up in 1970-71 for that purpose (*BI* March 19).

IATA also offers a workers compensation insurance program and a hull insurance deductible program through its captives.

"We are dealing basically with a monopoly situation," Mr. Kelly said of the coverage restrictions imposed by the London market.

"London is squeezing the world markets and freezing out the fringe ones. Rates are only the first step

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## update

### Amex seeks dismissal of suit

NEW YORK—American Express Co. and Fireman's Fund Insurance Cos. are seeking dismissal of a class-action stockholder suit that claims Amex fraudulently reported profits after Fireman's Fund swapped loss reserves with another insurer.

In asking a U.S. District Court in New York to dismiss the case, the companies contend that the suit does not present a sufficient factual basis for the claim; makes no distinction between the participation of Amex and Fireman's Fund, its property/casualty insurance subsidiary, in the alleged fraud; and does not state when and at what prices the plaintiff purchased his stock, nor even how much he allegedly suffered as a result of the transactions.

The suit, filed Jan. 24 by shareholder Julius Levine, seeks an unspecified amount of damages, plus interest, for individuals who purchased Amex stock between March 3, 1983, and Nov. 28, 1983 (*BI*, March 5). The suit claims these shareholders paid too much for their stock because Fireman's Fund loss portfolio transactions created an "artificially inflated market."

### New Florida exchange president

MIAMI—Arturo Turo, executive vp and chief operating officer of the Insurance Exchange of the Americas, will become president of the exchange June 1.

Mr. Turo, who joined the exchange late last year, replaces Alan Teale, the British insurance executive who was recruited as its first president. Mr. Teale's three-year contract, which expires at the end of this month, was not renewed by the exchange's board.

"We feel our greatest need is for an operations man and not a promotional person," said the new chairman of the board, James Cordle, president of Whiting National Insurance Co. in Tampa.

Mr. Turo is former employee of American International Group Inc. and a former reinsurance brokerage executive.

The 15 syndicates on the exchange are generating $20 million in annualized premium volume, Mr. Cordle said.

Mr. Teale is becoming a director of the American & British Insurance Group in Miami, a managing general agent owned by Richard Dennis. He is also becoming president of British Insurance Managers Inc., a new subsidiary of American & British which will be forming syndicates on the exchange.

### Lloyd's chairman visits U.S.

CHICAGO—Lloyd's of London Chairman Peter Miller made a quick tour of Canada and the United States last week, meeting with major Lloyd's producers and regulators.

Half of Lloyd's $3.9 billion in annual premiums is related to U.S.-based risks and about 70% of its business is conducted in U.S. dollars, Mr. Miller noted.

Calling himself a "marine man," Mr. Miller said he was in North America to learn more about the property/casualty side of the business. Mr. Miller became chairman of Lloyd's earlier this year.

### Carnival accident suit settled

DALLAS—The family of two teen-agers involved in a carnival ride accident at the 1983 Texas State Fair will receive at least $20 million if a federal court judge approves a structured settlement reached earlier this month with the insurers for the ride's builder and its owner-operator.

William Phillips, 19, of Allen, Texas, died in the Oct. 17 accident when one of the gondolas on the fair's Enterprise ride disconnected from its base and fell onto a crowd below (*BI*, Oct. 24). His brother, Tim, 23, and another friend were seriously injured.

Under the agreement, which has a present value of $10 million, an initial cash payment of $2.5 million will be made to William Phillips' estate, his parents and Tim Phillips, said the family's Dallas attorney, Paul Gold.

The settlement guarantees the family $20 million, and they could receive as much as $31 million if Tim Phillips reaches normal life expectancy, Mr. Gold said, without releasing details of the payouts.

Lexington Insurance Co. of Boston, a unit of American International Group Inc., is the primary insurer for Huss Trading Corp. of America in New York and Heinr. Wilhelm Huss & Co. (GmbH & Co.) in West Germany, which built the ride, attorneys say. American Home Assurance Co. of New York, another AIG unit, is the primary insurer for Continental Park Attractions Inc. of Great Neck, N.Y., which owned and operated the ride.

The excess insurer on both risks is First State Insurance Co. of Boston and/or its affiliates, attorneys say. However, they would not comment on deductibles, limits or how much each of the insurers would pay.

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# A&P to receive $275 million by terminating pension plan

By JERRY GEISEL

MONTVALE, N.J.—The Great Atlantic & Pacific Tea Co. will receive $275 million by terminating its overfunded defined benefit pension plan.

In exchange, A&P employees will receive a new defined contribution plan, under which workers can receive tax deductions for some of the funds they contribute to the plan.

A&P told the federal Pension Benefit Guaranty Corp. last week that it will terminate its 36-year-old defined benefit plan on May 31 and set up the new defined contribution plan. The plan to be terminated covers salaried employees and some hourly workers who are not covered by multiemployer pension plans.

A&P already has purchased annuities from Prudential Insurance Co. of America to pay accrued benefits to the 27,639 participants covered under the terminated pension plan. But even after deducting the cost of the annuities, which were bought in December 1981, the plan still has $275 million in surplus assets.

A&P says it intends to use the surplus assets to modernize its stores.

Under the new defined contribution program, A&P each year will contribute an amount equal to 4% of an employee's salary to the plan.

Employees may make voluntary contributions of up to 16% of regular salary to the new plan. A&P will contribute 50 cents for every $1 an employee contributes.

In addition, employees will receive tax deductions of up to $2,000 a year for contributions that exceed 6% of salary under tax provisions permitting qualified voluntary employee contribution plans.

New and recently hired employees will be vested in A&P's contributions to the new plan after five years. Employees who have been with A&P for at least five years will be immediately vested in the new plan.

Under A&P's soon-to-be-terminated defined benefit plan, an employee who retired at 65 received 1½% of his or her final average pay times years of service, up to 33⅓ years of service, minus one-half of the Social Security benefit.

Final average pay is defined as the average of an employee's five consecutive highest-paid years of the 10 years before he or she retired.

Employees were fully vested in the plan after 10 years of service.

While A&P will reap $275 million from the termination—one of the largest reversions of surplus pension assets ever—it has taken the grocery giant a long time to recapture the funds.

A&P first announced in October 1981 that it intended to terminate its pension plan to gain control of what it then estimated to be some $200 million in excess assets (*BI*, Nov. 2, 1981).

At that time, A&P—which is more than 50% owned by Tenglemann Group, a West German company—was reporting significant operating losses. In 1981, for ex-

*Continued on page 82*

# M&M fiduciary funds used in bond trading

By DOUGLAS McLEOD

NEW YORK—Marsh & McLennan Cos. Inc. says members of its treasury department used client premium funds in the "unauthorized" government bond trading that produced $165 million in pretax losses for the company.

The apparent violation of New York insurance law was disclosed in an interim report sent to the state Insurance Department last week by Willkie, Farr & Gallagher, a New York law firm hired by M&M to help investigate the trading activity (*BI*, April 16).

In the report, M&M says fiduciary funds were used to make "certain unauthorized financing payments" on a portfolio of intermediate and long-term government bonds, which was valued at more than $2 billion before it was liquidated.

This use of fiduciary funds violated Regulation 29 of the state insurance code, which requires such funds to be deposited in banks or invested in bank instruments like certificates of deposit or money market accounts, an Insurance Department spokesman said.

Possible sanctions against M&M could range from a notice of violation to a fine that could amount to $100,000 or more, the spokesman said.

The sanctions will probably not include a suspension or revocation of M&M's brokerage license, the spokesman added. In recently released financial statements, M&M raised the possibility that a loss of its licenses may be one consequence of the bond trading.

The nation's largest insurance brokerage holding company recently announced that "certain personnel within its treasury department," acting against company rules, had accumulated the government bond position starting in 1983.

The bonds, bought entirely on margin and sold when M&M senior management discovered their existence, produced aftertax losses of $90 million, most of which were charged to first-quarter results (*BI*, May 21).

M&M's report indicates that fiduciary funds were used to meet margin payments on the bond portfolio. The company has said that the unnamed treasury department staffers involved in the trading "improperly reported" these payments to conceal the portfolio.

M&M also told the Insurance Department that "at no time were fiduciary obligations not met, nor were fiduciary assets used to absorb the $165 million loss."

The Insurance Department expects M&M to submit more information on the bond trading within the next few weeks, and hasn't yet decided whether to send its own investigators to the company, the spokesman said.

"We want to give them as much leeway as possible to conduct their own investigation," he said. "They have been very cooperative." ■

# Metropolitan's Baldwin plan called boon to industry image

By JUDY GREENWALD

NEW YORK—Analysts say the plan offered by Metropolitan Life Insurance Co. that would increase the return on annuities issued by troubled Baldwin-United Corp. will improve the industry's image.

Observers say the perception of the life insurance industry by regulators, policyholders and investors was tarnished when losses sustained in connection with Baldwin's single-premium deferred annuity business helped push the financial services conglomerate into reorganization.

"I think there's a real need for the industry to maintain its image of solidity," says Robert V. Brokaw Jr., senior analyst with Miller Tabak Hirsch & Co. in New York. "It's difficult to understate the significance of Met Life's move."

While regulators, stockbrokers and insurers tried to work out the final details of the Metropolitan proposal, in another Baldwin-related development, the management of MGIC Investment Corp., a Baldwin subsidiary, said it would make an offer for the unit, which includes property/casualty insurance subsidiaries.

In addition, Ford Motor Credit Co. would not comment on a report that it had made a $900 million bid for MGIC, which Baldwin put on the block last year.

Analysts last week said the Metropolitan proposal, under which stockbrokers and insurers would contribute funds to increase the yield paid by Baldwin annuities, would be a boon to the industry.

"I think Metropolitan Life is doing a definite service to the industry," says David Seifer, a vp at First Boston Corp.

"I think that it can't help but improve the image of the companies, at least with respect to the regulators," adds Norman L. Rosenthal, a vp at Morgan Stanley & Co.

Mr. Rosenthal describes the plan as a "play for the regulators. It is helping get a monkey off their back."

The feasibility of the Metropolitan plan should be determined by June 1, says William Poortvliet, Metropol-

*Continued on page 83*

## errors & omissions

- In a May 14 Letter to the Editor from risk management consultant David Warren, the sentence "Consider the first (and least accurate) component: insurance premiums" should have read "Consider the first (and least *inaccurate*) component."

- Rouse Co. in Columbia, Md., which manages or owns 60 shopping centers throughout the nation, including the Gallery in downtown Philadelphia, has a $5,000 deductible on its all-risk property policy with Arkwright-Boston Insurance Co., not a $500,000 deductible as reported May 14.

# Alternative medicine

Naprapath, homeopath, nutripath, naturopath.

If those terms are unfamiliar to you, it's not surprising. They are the names of just a few of the scores of different alternative healers that are offering consumers a variety of options to traditional medical care.

Some rely on manipulating or adjusting parts of the body.

Others rely on herbs, meditation or prayer.

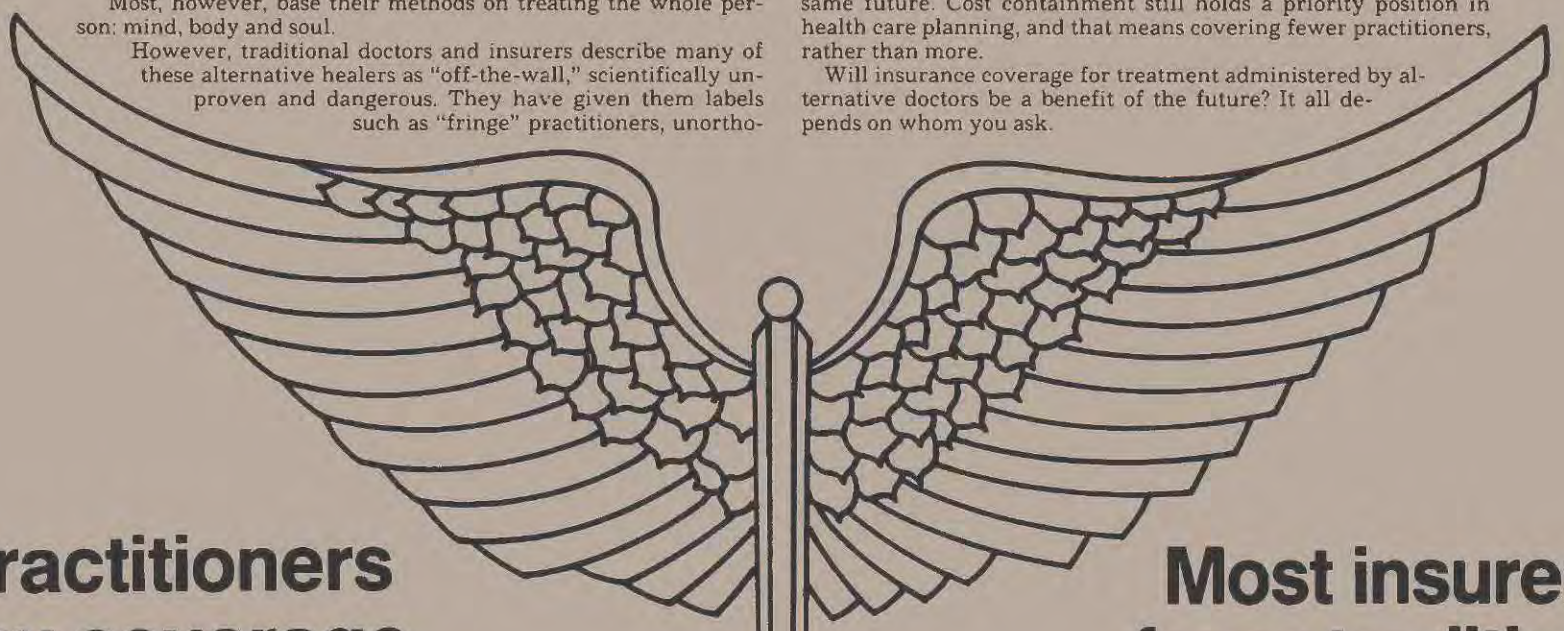
Most, however, base their methods on treating the whole person: mind, body and soul.

However, traditional doctors and insurers describe many of these alternative healers as "off-the-wall," scientifically unproven and dangerous. They have given them labels such as "fringe" practitioners, unorthodox healers and even witch doctors.

Often group health insurance plans will not reimburse employees for their use of such practitioners. But as more health-conscious Americans take charge of their lives and health, they will convince insurers to pay up for the doctor of their choice, these healers predict.

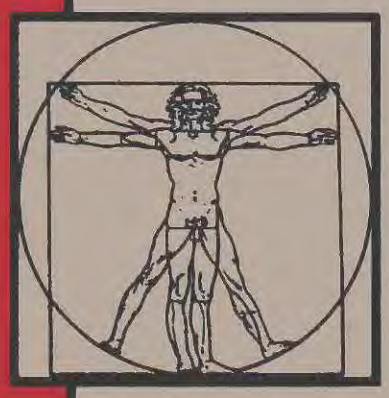
Insurers and benefit consultants, on the other hand, don't see the same future. Cost containment still holds a priority position in health care planning, and that means covering fewer practitioners, rather than more.

Will insurance coverage for treatment administered by alternative doctors be a benefit of the future? It all depends on whom you ask.



## Practitioners say coverage on the way

By CAROL CAIN



Alternative health care practitioners say the day will come when their services are routinely covered under employers' group health insurance medical plans.

Some of these services already are covered, but insurers and employers say that day of automatic reimbursement for them is still far off (see related story).

Homeopaths, naprapaths, acupuncturists and other alternative healers (see glossary, next page) say their way is safer and cheaper than those of traditional, licensed medical doctors.

But, because few alternative practitioners are licensed and they lack scientific proof of their procedures, valid statistics and political savvy, acceptance of their forms of treatment has been slow.

That is changing, however, as more and more consumers find they can be treated successfully outside the realm of traditional medicine, say alternative practitioners.

And it will be at the insistence of consumers that legislation is introduced at the state level to prohibit group health plans from excluding coverage for alternative healers, they predict.

Litigation over the unconstitutionality of excluding coverage for such treatment also is inevitable, they add.

Why the move back to the more natural, simpler and ancient ways of healing?

"People are frightened of antibiotics and their side effects, and babies born without arms and legs. The movement is growing," said Sumter Brawley, executive director of the National Center for Homoeopathy and the American Institute for Homeopathy, both in Washington D.C.

Homeopathy relies on the use of a remedy prepared a special way using substances found in nature to stimulate a person's "vital force," which in turn will help the body heal itself.

"People are discontent with American, Western medicine," said Harvard-trained physician Dr. Andrew Weil, who now practices, lectures and does research in alternative medicine in Tucson, Ariz.

He believes that as more people realize that today's traditional doctoring is too

*Continued on next page*

## Most insurers favor traditional health options

By CAROL CAIN


Employers and group health insurers, struggling to put a lid on rising health care costs and overutilization, are generally turning their backs on alternative health care practitioners.

Most large group health underwriters say employers are more concerned with cost containment than expanding their coverage to include alternatives to traditional medicine. Also, they add, these alternatives are not proven cost-containment devices.

"As far as we're concerned, we want to hold the line and cover as few practitioners as possible," explains John Vallance, senior claims consultant with Prudential Insurance Co. of America in Newark, N.J.

"Like a lot of the major carriers, we're into cost containment. We're not finding any policyholders asking for (additional practitioners). They're silent on (these practitioners) but screaming about the cost of current programs," Mr. Vallance says.

Aetna Life Insurance Co. in Hartford, Conn., maintains a similar position.

"Our general approach is that we're not going to cover anything we don't have to cover," says Katharine Worthington, manager of claims, policy and programs in Aetna's employee benefit division.

Consultants agree that employers are not seeking expanded coverage.

"...We're not seeing a trend of employers saying 'Let's go out and pick them (alternative practitioners) up,' because most employers are looking at cost-containment measures," says Edward Susank, a principal with benefit consultant William M. Mercer-Meidinger Inc. in Los Angeles.

He notes that employers are reporting large claims in some areas of treatment—like psychiatry—and are looking for ways to control those costs, rather than add new ones.

"We're not convinced that fringe practitioners really can do what they're telling you they can. They are unregulated and uncontrolled," Mr. Susank adds.

"People, for the most part, are not spending a lot of time planning or thinking about alternative practitioners. Flexible benefits and legislation—that's

*Continued on page 10*

### *High-tech benefit communication programs*

**Some benefit managers are now relying on electronics to help communicate programs to employees. At SFN Cos. in Glenview, Ill., workers can call a special hot line to hear recorded messages that explain the company's benefits. And, Miami-based Ryder System Inc. communicated the details of its new 401(k) savings plan to company officials in 14 cities via a three-hour teleconference. See stories, pages 20 and 23.**

### *Solving family problems at the workplace*

**Some employers are helping their workers become better employees and better parents through "work-and-family" seminars, which instruct employees, especially single parents and two-paycheck families, on how to cope with problems that arise at home. Other companies are helping workers find quality day care for their children through "resource-and-referral" programs. See stories, pages 26 and 34.**

Graphics: Amy Palmer & Roger Schillerstrom

# Glossary of alternative health terms

**Acupressure.** A finger-pressure technique that breaks through energy blocks by releasing muscle tension. It uses the same system of points and meridians—the invisible channels in which life energy flows—as acupuncture. Seldom covered by group health insurance.

**Acupuncture.** A Chinese healing system that works on a person's meridians. It attempts to balance this energy through stimulation or dispersement by the insertion of needles into specific points on the surface of the person's skin, by application of heat, by pressure, by massage or by a combination of these. Seldom covered by group health insurance.

**Chiropractic.** A method of treatment based on the theory that disease is caused by interference with nerve functions. Chiropractors manipulate body joints, especially those of the spine, in an attempt to restore normal nerve function. Almost always covered by group health insurance.

**Christian Science.** A religious belief that relies on Christian prayer, rather than medical treatment, for healing. Almost always covered by group health insurance.

**Homeopathy.** A medical system based on the works of Samuel Hahnemann, an 18th-century German physician and medical translator. Homeopathy uses small doses of medicines, called remedies, which are prepared from substances found in nature to strengthen a person's "vital force," which in turn will help the body heal itself—a basic homeopathic principle. Today, almost all homeopathic physicians also have degrees from traditional medical schools and in most cases their services are covered by group health insurance.

**Hypnotherapy.** A technique using hypnosis to assist a person in solving a problem, including health and health-related problems, like smoking and obesity. Sometimes covered by group health insurance.

**Naprapathy.** A system of manually applied movements, both passive and active, designed to bring motion with consequent release of tension into abnormally tense and rigid ligaments, muscles and articulations. It is based on the belief that all body processes are aimed at survival and that these processes are responsible for the healing of human organisms. Seldom covered by group health insurance.

**Naturopathy.** A system of healing—a philosophy, science, art and practice—that seeks to promote health through education and the rational use of natural agents and processes. Naturopathics include in their treatments hydrotherapy, botanical medicines, homeopathy, nutritional therapy, medical electricity, psychology and manipultive therapies. About 20 states recognize naturopaths as physicians for insurance reimbursement.

**Nutripathy.** Based on the concept that when the body has what it needs materially, emotionally, mentally and spiritually, it functions perfectly. Nutripaths do not diagnose and are not concerned with disease. Instead, they are concerned about health and try to pull together all the basic fundamentals of several natural healing theories. Nutripaths are trained in a four-year college program concluding with an internship. Seldom covered by group health insurance.

**Shaman/medicine man.** A Native American healer who utilizes songs, prayer, ritual and natural elements (like herbs and minerals) for treatment. Medicine men can be men or women and in some tribes are called "singers." They often work in conjunction with doctors and are usually welcomed at government-operated hospitals on or near Indian reservations. Seldom covered by group health insurance although some unions have won such coverage for American Indian members.



## Coverage urged

*Continued from page 3*

expensive, too invasive and too dangerous, they will revert to the old and natural ways used by homeopaths, acupuncturists, nutritionists and faith healers.

"For the first time, they're talking about preventative techniques and alternative techniques that are cheaper and safer," said Dr. Weil, author of the book "Health and Healing: Understanding Conventional and Alternative Medicine."

Instead of treating just the body, or just a symptom, alternative doctors pay close attention to the whole person—mind, soul and body. Consequently, they are often referred to as wholistic (or holistic) doctors.

An initial visit to one of these practitioners usually takes more than an hour, as the doctor and patient discuss all the things happening in the patient's life, and often things that happened in the past.

Such a visit can cost from $50 to $125. Follow-up visits or treatments—as many as 10 or 12—usually cost between $15 and $25 each. But alternative medicine advocates point out that $250 for this type of treatment is usually less expensive than even one day in the hospital.

Instead of drugs, X-rays and surgery, alternative doctors use herbs, body readjustment, meditation and botanical remedies to help a body heal itself. And nutrition, in almost all cases, plays an important role.

"All disease begins in the stomach," according to ancient Oriental medical literature, but the role of nutrition in health is one key area of debate when it comes to insurance coverage.

"We don't feel that nutrition and diet is a response to illness and injury," said Beth Cook, a product consultant in Hartford, Conn., for Connecticut General Life Insurance Co., a subsidiary of CIGNA Corp.

But Dr. Weil cites recent dietary guidelines issued by the American Cancer Assn. and the American Heart Assn. When he was in medical school in the late 1960s, popular and medical literature said that diet did not play any role in cancer. "But just recently, it says the reverse," he said.

"I don't think nutrition is everything in health, but it is important," he said.

"Regular medical education is really deficient in nutrition. Very few M.D.s will think about that or make referrals (to nutritional counselors)," Dr. Weil said.

"I recently referred a number of patients to a macrobiotic center in Tucson. It seems to me that's reasonable and should be covered by insurance, but it wasn't," he said.

Macrobiotic counselors, who are cropping up throughout the country, are wholistic practitioners who

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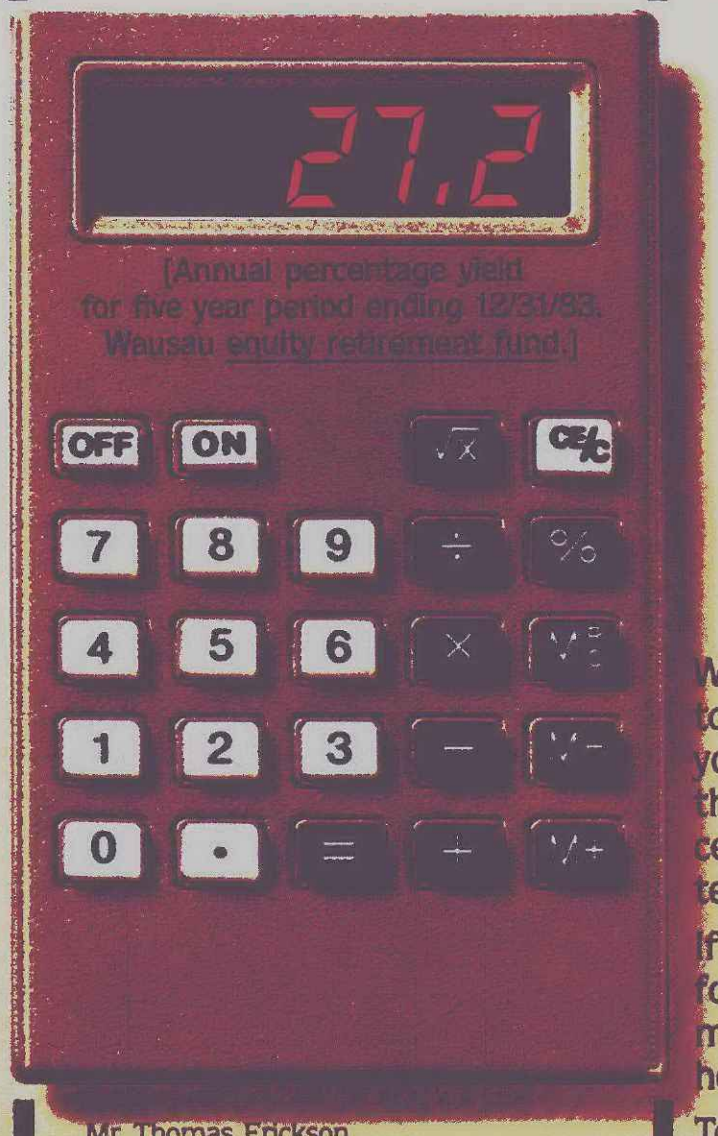
# We've done a number on retirement fund performance.




Wausau ... 27.2%! For the same period, Standard and Poors 500 has a number, too ... 16.9%. And for the past *ten* years, our average annual yield was 15.7% compared with the S&P 500 average of 10.4%. So, you can see, Wausau's results are worth knowing about.

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# Coverage urged

*Continued from page 4*
emphasize a grain-based diet to fight illness or achieve wellness.

Some insurers do cover fees from nutritionists when their services are part of a medical treatment.

Union Mutual Life Insurance Co. in Portland, Maine, for example, covers nutritionists' fees if they are part of a medical treatment, but not if the services are on an educational or consultation basis, said Kevin McCarthy, a vp in the group life medical product section.

But most insurers, like Connecticut General, deny coverage for alternative care based on nutrition.

"Wholistic doctors use all natural items to treat someone. . . .But there's really no provisions to guarantee that someone who is practicing has an education. There are no minimum licensing requirements. There is no way to accurately assure what kind of treatment is given," CG's Ms. Cook said.

But alternative practitioners aren't concerned about proving their methods. They believe their ways and traditional medicine are both valid.

"There's a lot of different ways to get the job done, not just those known in mainstream medicine," said Gary Martin, an executive trustee for the American College of Nutripathy in Scottsdale, Ariz. He said nutripathy, which is about 8 years old, draws on the fundamentals from every natural theory.

"A lot of what nutripaths do is subjective. . . .Sometimes we work on a higher level; we work with the power of thought. . . .There is a big gap between traditional and natural medicine, but both are valid. If I fall off my motorcycle, I want my M.D. there to set my bones," he said.

The college, which has graduated more than 500 students, including some M.D.s, teaches things like hair and urine analysis, iridology, reflexology, massage, acupressure, herbalogy and nutritional and individual counseling.

Hypnotherapists are another class of non-licensed practitioners. They use hypnosis for problem-solving and motivation.

"This doesn't follow the traditional medical model because the person is not 'sick' by those standards," said Gil Boyne, director of the American Council of Hypnotist Examiners, which has certified more than 5,400 hypnotherapists after 200 hours of training.

Hypnotherapists also help people quit smoking or lose weight, and often, if these services are prescribed by a medical doctor, they are reimbursed.

Other alternative healers use systems that have been used for centuries, though there is little or no scientific basis for their methods.

For example, acupuncture works on a person's invisible channels of life energy. And homeopathy works on strengthening a person's vital force with remedies made from natural sources.

The improving of invisible channels and vital forces is hard to document scientifically, practitioners admit, but they cite as proof the thousands of people who have been helped by these treatments.

Some alternative doctors rely heavily on prayer for healing.

"A Christian Science practitioner's help consists solely of Christian prayer. They approach healing through spiritual means alone from the standpoint of mental and spiritual factors, rather than as a strictly physical phenomenon," said a spokeswoman from the Church of Christ, Scientist, headquartered in Boston.

Insurers usually reimburse for payments to practitioners listed in the Christian Science Journal, in place of doctors' fees, she said.

"In order to be listed in the Journal, a practitioner must, in addition to meeting moral and spiritual qualifications, have offered evidence of his or her proven effectiveness in Christian healing and be devoting full-time to this healing ministry," she said.

But other alternative practitioners are not monitored like the Christian Scientists, and some don't want to be licensed.

"Our position is that in the orthodox, traditional mainstream, you don't have health care, you have disease care. We're not the least bit concerned about disease; we're concerned about health.

"We do not diagnose, we do not treat. Why should you be licensed to teach people sound practices of living?" asked Mr. Martin.

But there are several ways to monitor alternative practitioners other than by licensing, said Lorie B. Andrews, a staff attorney with the American Bar Foundation in Chicago and author of the book "Deregulating Doctoring: Do Medical Licensing Laws Meet Today's Health Care Needs?"

Registration is one approach that can be used for practitioners of treatments that are not hazardous, she said.

Ms. Andrews' book was published by the People's Medical Society, which was formed early last year by Prevention magazine, a monthly, non-traditional health magazine published by Rodale Press Inc., Emmaus, Pa.

"We were formed because doctors are organized, nurses are organized, and consumers should be organized," said Charles Inlander, executive director of PMS, which has 50,000 members and signs up about 1,000 more weekly.

Many states mandate that licensed practitioners be covered under group health plans, but PMS believes these laws give licenses that create monopolies, protecting the industry, not the consumer.

"People are writing to us suggesting that we start an insurance company to cover preventative measures, and when sick, the alternative, non-invasive procedures," Mr. Inlander said.

However, Mr. Inlander said PMS does not intend to enter the health insurance market. Instead, it will urge its members to talk to insurers about covering alternative services.

Mr. Inlander believes some of its members or other consumers will file lawsuits seeking to force insurers to cover alternative healers.

And the homeopaths' Mr. Brawley believes the future thrust may lie in legislation. "I would hope that the groundswell movement going on in this country will get through to the legislature," he said.

That pattern of consumer interest—with lobbying by the practitioners—helped prompt legislation in almost all states mandating group health coverage for chiropractic services in the 1970s.

It was a long fight, however, said Dr. Thomas Speer, director of professional relations for the American Chiropractic Assn. in Washington D.C. More than 27,000 chiropractors practice in the United States.

"We have a lot of doctors that have staff privileges at hospitals. In the past, we couldn't get close to them. And we also have M.D.s who are trained in chiropractic," Dr. Speer said, noting that surveys during the past year show that 9 million new patients received services from a chiropractor.

Chiropractors have been credited by many wholistic doctors with fueling the movement toward alternative medicine and reimbursement by insurers.

And as more consumers become aware of these healers and treatments and they get media recognition—and if the fees continue to be lower than traditional medicine—insurers and employers will have to listen, alternative practitioners said. ■

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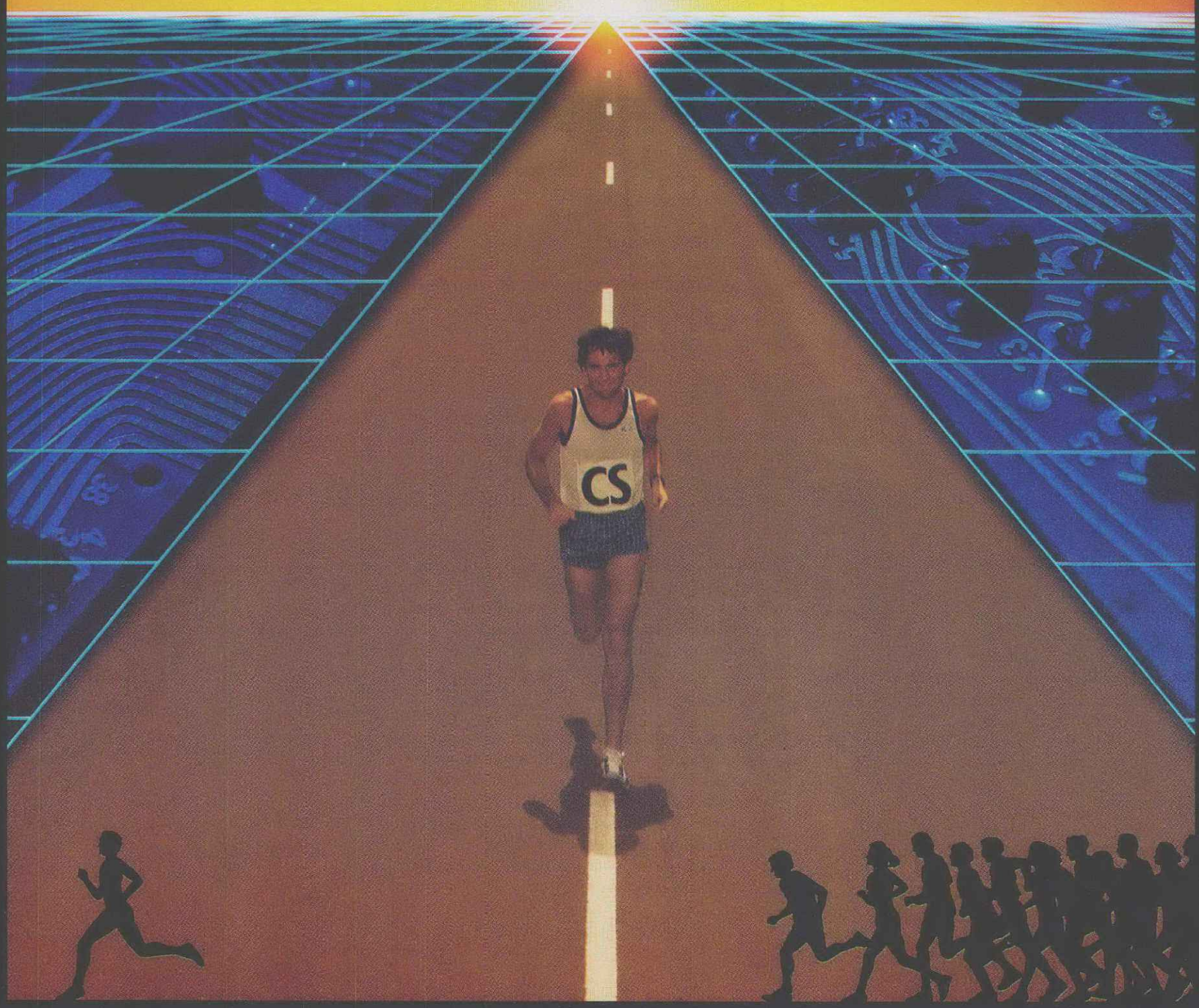


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# opinions

## Tell your employees, 'We care'

IN AN EFFORT TO control costs, one employer we know adopted a new policy: All personal calls from the employers' downtown Chicago office to the suburbs would be charged to the caller's personal account.

An uproar erupted, primarily from one group of employees: Working parents—mostly female secretaries—who were calling home every day to check on their children and to report when they would be working later than usual.

More disturbing than the money at issue was the message management had sent: "Your personal concerns aren't important. There is no room, or money, here for them."

The managers didn't really mean to communicate that message and, when they realized that they had, they rescinded the policy.

Like too many others, these managers were oblivous to the concerns of working parents and the difficulties they face in juggling the demands made on them by their jobs and their children. They, all men, had raised their families differently. Their wives worked at home, providing the round-the-clock nurturing, services and support the family needed.

Even among male managers whose wives worked, in their day a parent was defensive about choosing a lifestyle outside the accepted norm, and so they were careful not to mention their self-inflicted problems.

Managers who have never coped with a two-career family—or coped with it when it was not the norm—seldom have much sympathy for today's two-career households or single parents. They neglect or refuse to recognize the fundamental changes that have occurred in our society and economy that make working outside the home more psychologically attactive to mothers, as well as often financially necessary. And, they ignore the fact that more couples divorce today, leaving many more children cared for by one parent.

Some managements, thankfully, are more enlightened and have recognized working parents' problems. They are sympathetic and are trying to help employees solve their problems, as Editorial Assistant Diane Kastiel reports this week (see pages 26-30). These employers are sponsoring seminars in company conference rooms to give their working-parent employees the benefit of some expert advice on how to solve their problems and cope with the stress.

The seminars aren't expensive. New York-based publisher Time Inc. spent just $5,000 on a series of seminars it sponsored in the fall and spring, attended by 400 employees. Others have spent far less money.

More employers should make an effort to determine if their employees have problems juggling their working and parental lives. Many managers may think their employees do not have these problems because, even today, most parents avoid mentioning at work any difficulties juggling the demands on their lives for fear of


sounding unprofessional.

We think many employers would be surprised to find that their employees could benefit from programs that help workers cope with these difficulties. While experience shows that more women than men feel the stress of juggling two careers, men are beginning to share the responsibilities—and pressures—of raising children. So, even a predominantly male workforce could benefit from these programs.

We recommend that any seminars or counseling be offered on company time since, as one employer said, working parents are concerned with getting home to their children. Offering employees an opportunity for help with working-parent problems after working hours creates another time conflict—exactly what a working parent doesn't need.

An extensive list of sources of help to employers interested in pursuing assistance for their working-parent employees is provided in our report. Although we cannot endorse any of the services, we have included suggestions on how to evaluate them.

In addition to seminars that offer practical solutions to everyday work-and-family problems, referral services to help employees find day care for their children are another practical way that employers can help employees who are also parents (see story, page 34).

An employer who pursues these programs to help employees solve their child-care problems and ease parental stress will receive many benefits as well. If employees are less distracted by their personal problems, they will be more productive. If employees can structure a satisfactory balance between the demands of their jobs and their families, they will be less likely to find they must give up their employment, reducing employee turnover. And, programs that say to an employee, "As your employer, we care," are certain to build worker loyalty.

# letters

## Work comp offsets not widespread in California

To the editor: The article on Social Security offsets for workers compensation benefits (*BI*, April 30) implies that California is one state where the primary benefit is Social Security, with workers compensation paying an offset. That is true only for cases of payments under a subsequent injuries claim, which the next paragraph of your story emphasizes.

But, I think you mislead when including California in the group of states that has Social Security being the primary source. An extremely small percent of cases in California ever qualify for this category of offset and then the only savings is for the subsequent injuries fund.

Nowhere in the California labor code does it grant authority for offsets in regular permanent partial or permanent total disability payments.

**Greg Vach**
Regional Director
Workers Compensation Department
Ralston Purina Co.
San Diego

## Playing—and losing—the numbers game

To the editor: Your special issue on financial guarantees (*BI*, May 14) was well-written, comprehensive and most timely, but a misprint in the article regarding residual value insurance makes it appear that either *Business Insurance* or Residual Based Finance Corp. does not know basic multiplication.

The transaction I described involved 450 leased railroad cars insured to a value of $12,500 each—not $2,500 as printed—for a total insured value of $5,625,000.

You will intuitively determine that $2,500 multiplied by 450 does not equal the total you correctly noted in the article.

**Vincent A. Kolber**
President
Residual Based Finance Corp.
Chicago

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# Insurers are wary of alternative medicine

*Continued from page 3*
taking everyone's time," says another consultant who asked not to be named.

"Unless you can make a good case for cost savings it's hard to add these onto a plan in a cost-containment era," says Jan Peter Ozga, director of the coalition clearinghouse for the U.S. Chamber of Commerce in Washington.

"Normally, employers won't ask to have claims paid from these types of practitioners, unless there is a clear indication that it's a cheaper route," says Fred Hunt, executive director of the Society of Professional Benefit Administrators in Washington.

Employers usually take the advice of their plan administrator, insurer or consultant, who says, "Let's just offer the good old basic," Mr. Hunt says.

Even employers that self-insure their health care plans tend to go by rules from their old insurers, says Susan Hayes, an associate in the group benefits division of consultant Towers, Perrin, Forster & Crosby in Chicago.

In most cases, insurers say they will pay for charges from a "licensed" physician or a health care practitioner that state law mandates is to be covered.

"The law sets the minimum standards in most states," says Mercer-Meidinger's Mr. Susank.

But state laws are often contradictory.

For instance, in California, if a practitioner is licensed, insurers are required to cover their fees. And, licensed practitioners in California include chiropractors, marriage counselors and podiatrists, Mr. Susank explains.

But, in other states, there are no licensing requirements for marriage counselors, although psychologists are licensed and sometimes perform marriage counseling services.

Thus, there's a lot of gray areas and this can be a nightmare for insurers.

For example, 38 states require that psychologists' charges be covered, according to Aetna's Ms. Worthington. That means they may bill separately for their services—without a licensed physician's referral—and still be eligible for coverage.

"In other states, they may be covered if they work for a hospital or doctor and the bill comes through from that doctor or hospital," Ms. Worthington said.

But, because most states mandate coverage for psychologists, Aetna is close to the point where its contracts would cover this practitioner in all states, no matter what the law demands, she says.

Aetna, however, only covers other practitioners in those states where coverage is required. For instance, New Hampshire requires pastoral counseling to be covered, while physical therapists must be covered under the law in California, New York and Pennsylvania, Ms. Worthington says.

But even if certain practitioners are not covered directly, their charges often may be reimbursable if a patient is referred to them by a licensed physician, she says.

Connecticut General Life Insurance Co., a subsidiary of CIGNA Corp. in Hartford, Conn., is even more specific about which practitioners it covers.

For instance, it will cover acupuncture, but only if performed by a licensed physician or licensed acupuncturist to treat certain diagnoses, including arthritis, bursitis, migraines, inflammation of the joints, cervical back syndrome and rheumatism, says Beth Cook, product consultant for Connecticut General.

The insurer also will pay for hypnosis as a substitute for anesthesia, but only when performed by a licensed physician or dental surgeon, she says.

"All of our coverage is based on drugs approved by the FDA and any treatment recognized as acceptable by the medical community. It can't be considered experimental," Ms. Cook says.

Therefore, alternative doctors, like Chinese herbalists and Native American medicine men are not covered.

"But we can be more liberal if the policyholder wants," she notes. "There have been requests for Chrisian Scientists, acupuncturists and midwives, but there have been no requests for any other type of practitioners."

Besides following state laws and consumer demand, some insurers also base their coverage decision on their in-house medical staffs and consultants who track medical journals and research. They also seek advice from medical societies.

"But in general, the health insurance industry reimburses for health care services that are provided by an appropriate individual in an appropriate setting. . .a medically justifiable service," says Daniel R. Thomas, assistant director in the consumer and professional relations division of the Health Insurance Assn. of America in Chicago.

"And the traditional medical model is the acceptable model—when a service is provided by an M.D. or in a hospital, then it's paid for," Mr. Thomas explains.

"We have taken the position that if it's qualified care and controls cost for the employer, then we'll respond to the demand," says Kevin McCarthy, second vp in the group life medical product section of Union Mutual Life Insurance Co. in Portland, Maine.

"We're always going through this evaluation of balancing quality care with employers' needs and

*Continued on page 12*

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# Insurers are wary of alternative medicine

*Continued from page 10*
cost containment," he says.

Union Mutual was one of the first insurers that covered acupuncturists, primarily in lieu of anesthesia, Mr. McCarthy points out. The insurer also covers chiropractors, midwives at birthing centers, nutritionists and hypnosis if administered by a licensed physician, psychiatrist or psychologist as part of therapy.

But, the company does not cover Christian Scientists, medicine men, homeopaths or naprapaths, he said.

While some suggest alternative forms of treatment may actually help reduce health costs, others object to this notion.

"There's an honest disagreement nationwide—within the medical community, the insurance industry and the government—as to whether any of these items constitute cost containment. We give all the information to the policyholders and they decide," says John Festa, the supervisor of the guidelines unit for Metropolitan Life Insurance Co. in New York.

"We haven't seen a trend in this area because of this honest disagreement on whether they would be an additional benefit or a cost-containment move," Mr. Festa says, acknowledging that many alternative healers say their services cost less. "If it could be proven that they save money, then that would be our recommendation (to clients)."

"Those modalities are add-ons, in my opinion," counters Charles Cohen, director of cost containment administration for Metropolitan's health care resources and cost management unit.

He says many alternatives offer no cost savings, citing psychiatric social workers as an example.

"They often start off much cheaper in the unit charge, but they work their way up very rapidly and end up charging unit prices that compare with psychiatrists and psychologists. And they see more people, more often," Mr. Cohen says.

"We have an obligation to our public to assure quality care. Licensing varies for these practitioners and the scope of their practice is unclear.

"If we're going to pay for something, we want to be satisfied that we're getting quality care," he says.

"The insurance industry has to be responsible. One thing an insurance company tries to do is to spend money wisely. . .pay for services that have proven to be effective," says the HIAA's Mr. Thomas.

"The issue, I'm sure, that most employers face is a question of asking, 'Are we setting a precedent for a lot of con artists?' " adds David Glueck, vp and head of the group benefits practice for TPF&C in Chicago.

"There's a high risk that you're going to get taken by a quack," he says. "And the big problem is trying to separate the legitimate wholistic doctors from the quacks."

Even unions don't appear to be clamoring for coverage for alternative practitioners.

"Quite a number of unions had coverage for chiropractors for a long time, but I don't know if there has been any additional (practitioners). It's possible, but since the pressures are for cost control, I'd be surprised if (employers) are adding new coverages," says Bert Seidman, director of the department for occupational safety, health and Social Security at the AFL/CIO in Washington.

Some unions with large American Indian populations have received coverage for alternative doctors, specifically medicine men, in their group health plans.

For instance, the United Mine Workers of America recently secured for its Navajo employees at the McKinley mine in New Mexico an increase in medicine man coverage to $300 annually from $200 (*BI*, Feb. 27).

Some consultants say they believe that coverage for alternative treatments will increase as a result of state mandates.

"States will take the lead with insurance legislation. Then, it will be easier for insurance companies to follow and offer (reimbursement) for these practitioners universally," says Tom Marshall, group benefit consultant at Hewitt Associates in Lincolnshire, Ill.

The day also may come when states mandate that health maintenance organizations offer alternative treatments, though a spot check of leading HMOs across the country shows them to be conservative in their offerings.

"Our doctors are pretty well of the conventional style," says a spokesman from Kaiser-Permanente Medical Care Program, the nation's largest HMO chain, based in Oakland, Calif.

"Our people are more conservative than most of the medical establishment," says a spokesman from an HMO trade association. "We can't afford to be so far out; we're not the first one to jump on new technology. We're like the new kid on the block, still trying to prove ourself."

The debate over the use of these alternative practitioners will go on for many years, several experts note.

"They offer interesting concepts, and it may be the wave of the future," says a consultant, who asked not to be named. "But that wave is still way, way out in the ocean." ■

## FSAs may be used

Even though an employer may not cover alternative health care treatment under its medical plan, employees may be able to use company benefits to pay for this treatment.

Some consultants say that alternative practitioners may be covered through flexible spending accounts that permit employees to spend account funds on medical charges not covered under a group plan but allowed under Internal Revenue Service rules.

The IRS has ruled under Section 213 of the Internal Revenue Code to permit deductions for acupuncture expenses, an IRS spokesman says. It also has ruled that charges for medical care can be deducted even if that care was administered by non-licensed practitioners, he notes.

Section 213 of the code defines medical care to mean amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

H. Edwin Trusheim, President, at General American's National Service Center in St. Louis.

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# Emergency centers target group plans

CHICAGO—Free-standing emergency centers are looking toward group health plans to expand their patient base.

Until now, most patients have been attracted to so-called FECs as individuals, responding to media advertising and direct mail.

Only about one-quarter of FECs' business is directed to them by employers, and this is for treatment for workers injured on the job (see related story, page 16).

Now, many of the nation's 2,000 FECs, which generated fees of about $2.5 billion in 1983, are plotting strategy to expand their number of patients. They are thinking about linking up with preferred provider organizations and health maintenance organizations.

FECs are medical centers staffed by doctors to provide treatment for what are called episodic injuries—injuries related to a specific episode, such as breaking a bone—rather than continuing illnesses.

FECs generally are open 12 or more hours a day and patients do not need appointments.

**FECs do not treat** life-threatening conditions, except to stabilize patients for transfer to appropriate facilities. And, as currently designed, FECs are not equipped to provide continuing care for lasting medical conditions.

FECs have carved out as their specialty treating people with injuries that are not so severe they require hospital treatment but are severe enough to require immediate treatment that might not be available from a family doctor due to the hour of the day.

And, FECs provide treatment to people who don't have a regular doctor.

In addition to convenience, FECs offer care at a lower price than hospital emergency rooms but comparable to other physicians' charges. FECs can charge less than a hospital emergency room for the same service because FECs don't have the high overhead costs that hospitals must pay.

Group medical insurers generally cover most treatment provided at FECs as they would if the care were provided in any physician's office.

"The care FECs provide is very much like that physicians offer," a Blue Cross & Blue Shield spokesman said. "That's why most of our plans don't cover their costs like emergency rooms (which are usually paid for in full)."

FECs are relatively new. The first one was established in 1973, and only 60 were in operation by 1979.

**This year,** the almost 2,000 FECs now in business will serve some 14 million patients, according to projections made by the industry's trade association, the Dallas-based National Assn. of Freestanding Emergency Centers.

By 1990, the association estimates, the number of FECs will have risen to 4,500 and the patient volume to 61.4 million from 47.3 million.

FEC operators discussed how they can better tap the group health plan marketplace at the second annual conference of their association, held recently in Chicago.

To be successful, FECs will have to communicate their competitive advantage to employee benefit managers, said Dr. Ronald A. Hellstern, a director of NAFEC and president of Primacare Inc., a Dallas FEC operator with eight units.

Willis B. Goldbeck, president of the Washington-based Business Group on Health, a lobbying and information group representing about 200 large companies, suggested that FECs can emphasize three things to businesses.

"FECs' selling points are their convenience, quality of care and extended hours," he said.

Later, Mr. Goldbeck commented that employers would most likely refer employees to these centers because the FECs' extended office hours will mean less time off the job by employees seeking treatment for minor injuries.

"These systems will become increasingly attractive to employers—and employees—as a convenient system," he predicted.

"Business is looking for efficient delivery of medical services. And FECs have a chance to provide truly competitive medical care centers. This is one facet that contributes to employers' ability to gain control over their health care system," Mr. Goldbeck told the group.

While advising FEC operators about employers' needs and concerns in his prepared remarks to the group, Mr. Goldbeck observed later during an interview that employers would be wise to investigate FECs and how their employees can use them.

"The emphasis right now on getting hospital data to help guide employees and their families into more cost efficient and higher quality hospitals—that same effort will have to occur in confronting this full array of unbundled services," Mr. Goldbeck observed.

FEC operators are considering other tacks for reaching employee groups, including contracting with HMOs or PPOs to provide their specialized services.

FECs are "looking for a blend (with PPOs and HMOs)," said Dr. Stanley R. Gold, NAFEC's president.

FECs' most attractive feature, he said, is their convenience. "Because we're open longer, we can provide immediate emergency care for extended hours."

Convenient Health Care, an FEC in Wheaton, Md., contracted last September with a local HMO, and about two patients a day are from the HMO, said CHC President Dr. Joseph A. Fortuna.

Many of the nation's 340 other HMOs, which serve some 15 million people, could similarly benefit from such an arrangement, observed James F. Doherty, executive director of Group Health Assn. of America, the Washington-based HMO trade association.

In particular, he noted, HMOs must provide emergency care at any time of the day, and FECs can assist.

FECs are also discussing forming their own preferred provider organizations, contracting to provide care at reduced rates.

MediClinic Corp., which owns seven Houston FECs that serve about 2,500 employers' workers compensation accounts, is set to begin operating its own PPO, MediClinic Family Health Plan.

Among MediClinic's accounts are Coca-Cola Co. Inc. and the city of Houston. PPO services will be offered to current and new customers.

*Continued on page 16*

# J&H thinks employers can get tighter control of benefit costs and still keep employees happy.

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# FECs seeking patients from group plans

*Continued from page 1*

To provide non-emergency services, MediClinic has enlisted more than 200 physicians, according to Michael J. Cripe, corporate development vp.

"We're trying to direct customers to cost-efficient usage of service," Mr. Cripe said. To this end, they will provide employers with utilization reports.

"We'll report utilization by specialist and the per-employee costs of each service level," he said. 'And we'll provide individual utilization reports."

In addition to providing care for episodic injuries, some FECs also provide employee physicals and conduct employee health seminars at worksites.

And, some FECs provide referrals to other health-care providers for people who seek care for non-emergency conditions that the FECs can't handle.

As they expand, FEC operators are quick to add that they can't do everything. Rather, they say, they're seeking to enhance the distinctive services they've already developed.

Said MediClinic's Mr. Cripe, "We are trying to provide primary episodic care. Emergency rooms will continue to provide acute care."

According to Mr. Cripe, benefit managers investigating FECs should consider:

- The FEC's availability and the kind of services it will provide.
- The treatment reports that the FEC will offer.
- How much of an opportunity the company's managers will get to consult with the FEC on cost-control matters.
- The FEC's facilities for handling the medical demands that plan subscribers are likely to place.
- What the FEC's services will cost, in terms of cash expense and employees' time spent traveling to the center and waiting for treatment.

FECs expect to hear from benefit managers.

"There's a trend to health service systems," said Dr. Gregory Culley, operations director for the medical services division of MedFirst, a Louisville, Ky., FEC operator with 67 units. "FECs will be have to bid for employers' service contracts with other kinds of providers.'

# Emergency centers tapped to care for injured workers

CHICAGO—Free-standing emergency centers are earning a reputation for quick and less-expensive treatment of workplace injuries.

Corporate officials say sending injured employees to FECs has reduced their workers compensation costs by reducing the cost of care and the time the employee is off the job.

**About 25% to 30%** of the FECs' business is in treating injured workers, says Dr. Drennon D. Stringer, chairman of National Assn. of Freestanding Emergency Centers, a Dallas-based industry group.

That means these accounts generated from $625 million to $750 million of FECs' overall 1983 fees of about $2.5 billion.

Employer agreements with FECs aren't binding on employers to send injured workers to the facilities. Indeed, most state workers compensation laws reserve for the injured employee the right to choose his or her physician.

But, employers can recommend an FEC and many employees accept the recommendation. Employers recommend FECs to injured workers because the FECs are often more convenient than private physicians' offices and more accessible than hospital emergency rooms. They usually are open for longer hours and may be located closer to a company's place of business.

**Connie Brower,** store manager of the Christian Farmers Market in Anaheim, Calif., says that whenever one of the store's approximately 60 employees sustains a minor injury, he or she usually can receive treatment from the FEC that is a block and a half away, and be back at work within an hour.

Also, FECs often provide cheaper treatment than hospital emergency rooms.

Dr. Ronald A. Hellstern, a NAFEC director and president of Primacare, a Dallas FEC with eight units, says, "Eighty-five percent to 90% of (emergency room) patients shouldn't be there from a cost-efficiency standpoint."

FECs charges can be 40% to 80% less than emergency rooms, the NAFEC estimates. For example, treatment for a simple arm fracture would cost $157 in a typical emergency room and $71 in a typical FEC—a 54.7% reduction—according to the organization.

A recent survey conducted by the Indiana Hospital Assn. found that only 5% of the people seeking emergency room care had life-threatening problems.

FECs' charges are roughly the same as private physicians', NAFEC says.

Continuity of care and communication programs offered by FECs also have earned praise from employers.

"They'll call us while the employee is being treated, so the manager can ask questions and find out how long the employee will be out," said Judith A. Elkin, workers compensation specialist for U.S. Air Inc. of Pittsburgh, which uses an FEC for its Chicago operations.

**"This creates better** rapport and encourages confidence," she commented. "Managers feel so helpless unless they have someone they can talk to and have immediate contact with."

A spokeswoman for Midway Airlines Inc. of Chicago said that the FEC calls its personnel department the day after initial treatment to check on the employee's condition.

Some employers also rate FECs highly for more objective treatment and therefore less costly workers compensation claims.

"Family physicians can establish personal relationships with their patients," explained a workers compensation supervisor at a large retailing company that uses an FEC. "And if the employee says he wants a few extra days off for an injury, the physician will be more likely to advise they be given."

FECs are less likely to respond to this kind of appeal from a worker, therefore returning the injured worker to work sooner.

However, FECs are not equipped to deal with life-threatening problems, which employers direct immediately to hospitals. ■

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# Hospital chain designs health cost-control plan

By KATHRYN J. McINTYRE

NASHVILLE, Tenn.—The nation's largest hospital chain is testing a new group health program designed to control health care costs by controlling the use of health care.

Hospital Corp. of America is testing the product on its own employees in Nashville and Richmond, Va., and by the end of 1985 expects to implement the program nationwide for its 75,000 employees.

HCA also plans to market its yet-unnamed product to other employers around the country, after its own employees have been successfully enrolled in the program.

It is unclear whether the new HCA product will grab a share of the group health plan market in the future. But, it is clear that as a health provider, HCA is in a special position to control its employees' health care bills.

The HCA program combines all of the following health care cost-control elements:

- A cooperative network of doctors and hospitals that will contract with HCA to provide services on a fee-for-service basis, subject to utilization control.
- Incentives for employees to use the cooperative network of doctors and hospitals.
- A three-part utilization control program, encompassing preadmission certification, concurrent utilization review and retrospective utilization review of all cooperating doctors and hospitals.

When the HCA plan is offered to other employers it will incorporate:

- A guaranteed annual charge to employers for each covered plan participant.
- Deductibles and coinsurance levels to be selected by the employer.

The experimental HCA plan is a prepaid health plan, but it is not a health maintenance organization because the coverage provided more closely resembles that of an indemnity plan than an HMO with broad benefits.

The HCA plan will rely on a cooperative network of doctors and hospitals, but it's not a prefrerred provider organization because it is not negotiating discount rates.

"This is a brand new animal," says Robert Reeves, president of HCA's Health Services Division, which will market the program to other employers. Mr. Reeves is also HCA's risk manager.

The giant hospital chain—with 400 owned or managed hospitals worldwide—developed the health plan to control its own group health plan costs. Once it developed the plan, HCA thought it had a product to offer other employers.

"We decided to take a long-term view with regard to our business," Mr. Reeves said.

"We feel that we should work with the organizations in our society that are funding health care to bring the cost under control."

HCA began Oct. 1 testing its health plan with its Nashville-based employees and their dependents, 6,000 people in all.

In the first 120 days, Mr. Reeves said, HCA determined that the new plan saved the company $144,180.

The cooperative network of doctors and hospitals in Nashville are all HCA employees and doctors practicing in HCA hospitals. To encourage HCA employees to use the services of the cooperative network, HCA revised its health plan to cover 90% of all hospital and physician charges from network members, but only 70% of charges from other hospitals and only 80% of charges from other doctors.

Employees responded to these incentives and used the network doctors and hospitals for a savings to HCA of $104,340, Mr. Reeves said, adding that the three-phase utilization review saved an additional $39,840.

The plan was introduced in Richmond March 1.

So far, HCA has not placed a per plan particpant cost on the program for its own employees and it has not determined how much it will charge other employers.

In implementing the program nationwide, HCA will use HCA hospitals where possible, but will contract with other facilities where needed.

In offering the program to other employers, HCA will have to obtain licenses from state insurance departments. In some states, it will seek licenses under HMO-enabling legislation and in others under PPO-enabling legislation, depending upon the state law.

HCA plans to introduce its product to other employers on a step-by-step basis. After setting up the provider network to treat HCA employees and testing the program on HCA employees, HCA will offer the utilization review component to self-insured employers, who will agree to offer employees incentives to use the cooperative network.

Employers must offer employees incentives to use the cooperative network because these are the providers that have agreed to subject themselves to the utilization controls, Mr. Reeves explained.

Within the next month, this utilization control program will be available to employers in Nashville that self-fund their health plans.

After about a year of operation in an area with its own employees, HCA expects to be licensed and able to offer its prepaid health care product to employers in the area. HCA hopes to offer the program to employers in the Nashville area in about six months, Mr. Reeves noted.

HCA believes that it can properly price its health plan product on the strength of the utilization control and "the tremendous body of knowledge we have within our own company about the cost of health care across the United States," Mr. Reeves said.

HCA also is developing the claims management organization that it will need when it offers the program to other employers. The new claims group will include the workers compensation claims program administered by HCA's Parthenon Insurance Co., its Tennessee-based captive insurer.

For its own employees, HCA has contracted with Blue Cross of Tennessee to handle the Nashville plan claims and Blue Cross of Virginia to handle the Richmond employees' claims. It is also negotiating with Aetna Life & Casualty to handle claims for HCA's employees in the western United States.

Mr. Reeves stressed that the new HCA product is one of HCA's many cost-control efforts. Many of HCA's owned and managed hospitals also are working with HMOs, PPOs, business coalitions and individual employers, trying to control health care costs. ■

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# Tape device eases benefit manager's load

**By SALLIE J. DRURY**

GLENVIEW, Ill.—Would a benefits manager really like to be replaced by a machine?

The answer would be a qualified "yes" if you asked Anne N. Fish, manager of benefits for SFN Cos. in Glenview, Ill., a publishing and communications company.

Although neither Ms. Fish nor any of her staff have been completely replaced by automation, many a routine question has been answered electronically since a device called "The Communicator" was adopted as part of the company's benefits communication program.

"The Communicator" is really a type of tape player that responds to electronic signals from a touch-tone telephone to play a pre-recorded message when a certain numerical code is pressed by the caller.

Several messages are recorded on one tape, and "The Communicator" scans the tape until it comes to the message requested and then plays it.

What it amounts to is an electronic benefits administrator, answering basic questions about SFN's benefits plan so benefits department personnel do not have to spend what might be several hours each day answering similar questions.

"I think we are going to be seeing more and more of such electronic means of getting our benefits messages," said Stephanie L. Certain, consultant with Hewitt Associates in Lincolnshire, Ill.

"It's not going to replace the written word," she said, "but I think it's going to expand the way we communicate with employees."

An interaction between an employee and The Communicator at SFN would be something like this:

If an employee of the Glenview office, living in the Chicago area, was at home and had a question on who is an eligible dependent under the benefits plan, he or she would dial a seven-digit number. (He or she would use a different number if calling from a company phone.)

The employee would then hear Ms. Fish's recorded voice thanking the employee for dialing in. Then, after a recorded tone, the employee would press 211, the code for information on eligible dependents.

After the machine scans the tape to find the appropriate message—which takes an average of 15 seconds—an explanation of dependent eligibility is played.

SFN calls this communication tool the "P.S. Hotline," part of the "P.S." theme for communicating its newly revised benefits program. "P.S." stands for protection and security, which is the purpose of the benefits program, Ms. Fish said.

"We have seen versions of a hot line in the past, with live phone answering," Ms. Certain said. "But, with a preset tape which can give different messages, we've never seen something this organized."

**The reception** for this innovation-both from SFN employees and benefit department personnel—has been warm.

"The P.S. Hotline was extremely well-received," Ms. Fish said. "People seem to like the idea of picking up the telephone and calling for information rather than looking through their books (of written benefits information).

"There is also some hesitation for employees to come (to benefits personnel) with a question, especially after group meetings. They don't want to look like they slept through the meeting," she continued. "But people don't feel that hesitation with the Hotline.

"I liked it because it helped people get to know me, since my voice was recorded," said Ms. Fish, who joined the company just a few months before the hot-line program was put into place. "After hearing my voice, people felt free to call me, people from other locations.

"And, although we never actually measured to see if it saved us, say, half a person, I strongly suspect it did save us time," she said.

"Even more valuable is that we had a Communicator at each of our companies (across the country), and by telling the same story at each location, we avoided a lot of inconsistencies and misinterpretations that can happen when you have a lot of different benefits administrators explaining the program."

**Another convenient** plus for SFN is that The Communicator cost the company practically nothing to install, since the machine is manufactured by an SFN subsidiary, Data Acquisition Services Inc. of San Marcos, Calif.

"We're family," said DAS President George J. Ravazzolo.

As "family," SFN was able to buy a $5,900 Communicator for approximately $3,000. Then, Ms. Fish spent three hours in a Chicago recording studio to tape the benefits messages.

While costs vary by geographical area, benefit managers should plan to budget from $750 to $1000 to tape benefit messages, including studio time and a fee for a professional narrator, according to Hewitt Associates. If a professional is not hired —as SFN chose to use Ms. Fish's voice—the cost would be lower, since union scale for a narrator is $250 per hour.

"A professional would take approximately two hours of recording time or less, and if you're not working with a professional person you'll need more studio time," said Marcia Smith, consultant with Hewitt Associates. "And, a

*Continued on page 22*

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# Tape device helps benefit manager

*Continued from page 20*

lot of people work for more than scale, like $300."

The tape for The Communicator is a regular 90-minute cassette tape. Only one is needed for each machine because DAS has a patent-pending method of slowing the tape's recording/playing speed, which, along with other engineering changes, enables a 90-minute tape to carry 15 hours of messages.

For SFN, this meant they could record all 44 of its messages on one tape.

The script for the messages was written by Hewitt, SFN's consultant on the project. Hewitt was hired when the company wanted to make a transition to a uniform benefits plan among all its companies.

"We had six different plans before, but as of Jan 1, we had one, self-funded (plan) with Prudential as the administrator," Ms. Fish said. "A good communications program was extremely important to us, because frankly we were taking away benefits from an employee's perspective. We were asking for them to share some of the costs the company had paid for before.

"The whole communications program went over extremely well," she added.

Besides the Hotline, the P.S. program included a flyer that let the employees know a change would take place and information would be forthcoming. That was followed by a letter from SFN's chairman, explaining the need for the change.

Next came small-group meetings. Following a question/answer session, the employees received brochures describing the new plan, including a list of Hotline message subjects and their codes.

At first, Hotline activity was heavy. "We have 1,250 people in the Glenview office, and we averaged between 10 to 15 calls a day," Ms. Fish said. "Now, we might get 10 to 15 a week."

One plan modification that will not be communicated for the moment are changes in SFN's new flexible spending account. The company's FSA does not meet proposed IRS regulations for FSAs because it allows employees to choose at year-end to take unused funds as cash or deposit into a savings plan.

SFN has not finalized plans to modify its FSA, and the Hotline still carries the original message. But, if and when changes are made, SFN will communicate those changes in writing and the Hotline message will be modified.

While SFN is pleased with the Hotline, "we have not yet made a decision on removing it or making it permanent," Ms. Fish said. "We probably won't make it a permanent item because it's really most active around the time of change.

"Then again, it is appropriate for a lot of areas," she added. "I think it would work well in a wellness program."

The only drawbacks of the electronic benefits administrator, Ms. Fish said, are that some employees expected very specific information for their unique claim, "and we recorded general information, explaining the plan," she said. "It is the question on a unique situation that you ask of a real person."

And, she said, some of the messages were not as detailed as she would have liked. "But Hewitt said people are only willing to listen so long."

The Communicator has been used by other companies for marketing and training purposes, "but SFN was the first to use it for benefits," said Mr. Ravazzolo of DAS, the SFN subsidiary that makes it. The machine has been on the market for about five years, he said.

However, a new machine is available that not only plays messages, but also asks questions so that responses can be recorded on another tape. This question/answer machine is now being piloted at a giant retail store chain for its catalog orders.

The question/answer machine opens new horizons for benefits use, Mr. Ravazzolo said, since employees could use it to phone in changes in dependents' status, and possibly claims information.

"This is just the beginning of a new wave. I think we'll see personal computers used as technology become less expensive and more accessible to employees," Hewitt's Ms. Certain said.

"Some clients of mine are looking at it now, and I know several people in our offices who are looking at it for their clients.

"Although it's a one-time expense, it's probably not worth it to a small company," she continued. "But for a large company, it is worth considering." ■

# New technology helps sell savings plan

By STEVE TARAVELLA

MIAMI—A young truck mechanic clad in overalls glances toward his older co-worker, tools in hand, and speaks with enthusiasm about their company's new employee savings plan.

"This guy was telling about this new savings plan," he tells the older worker. "I thought, 'Hey, that's just great for older people like my parents.' Well, it turns out this plan isn't just for older people —it's for yourg guys like me, too. I figure if I start putting away $5 a week now, in 30 years I could have $150,000.'

**The scenario** is one of several video vignettes Ryder System Inc. used recently to introduce its 401(k) savings plan in an unveiling worthy of today's increasingly sophisticated telecommunications industry.

To explain the new benefit to managers and supervisors at the company's 18 subsidiaries nationwide, on May 1 Ryder broadcast a three-hour teleconference live to 24 U.S. cities.

The telecast was seen by more than 400 of Ryder's upper field-management personnel, who are responsible for conveying the new plan to employees at Ryder's various subsidiaries and many locations.

"This is a real step forward for the company," notes Joseph G. Charles, director of employee benefits at Ryder, the Miami-based truck-leasing giant with more than $2 billior. in annual revenues.

Under a 401(k) plan, named for the section of the Internal Revenue Code that authorizes them, employees can choose to defer a portion of their pay toward retirement savings. The amount deferred is subtracted from the employees' pretax income, generating substantial personal income tax benefits.

**The deferrals** are not taxed until they are actually paid to the employees or their beneficiaries (*BI*, Dec. 19, 1983).

Ryder's sales managers, district managers and regional managers convened at the nearest Holiday Inn hotel, where they received the broadcast over the Holiday Inn Video Network (HI-NET), a wholly owned telecommunications subsidiary of Holiday Inns Inc. in Memphis, Tenn. Members of Ryder's corporate personnel department attended the conference in person at the Miami hotel from which it was transmitted.

HI-NET began in June 1980 as an outgrowth of the hotel chain's desire to receive cable television transmission for its guest rooms, a Holiday Inns spokeswoman explains. Since its inception, the service has arranged teleconferences for about 100 business meetings of various sorts, she estimates.

**Mr. Charles says** that one of the biggest advantages of using the telecast is that all the managers received the explanation simultaneously.

"Everybody got the same message. There was no loss in translation due to second-hand information," he points out.

Another benefit from telecasting the program is what Mr. Charles calls "a philosophy of synergy." Some of Ryder's subsidiary companies have no reason to contact each other, even if they are located in the same city. The telecast provided a reason for employers to cross corporate lines and meet one other.

The telecast also allowed the managers to interact with representatives from the investment firms participating in the new savings plan. Investment company representatives would have been unable to meet with Ryder employees personally at all the company's locations, Mr. Charles points out.

But the telecast really was born to avoid dispatching about a dozen personnel department employees from Miami to locations across the country, where they would introduce the plan to local management officials, who would then, in turn, present the new benefit to the employees.

Senior management at Ryder, including M. Anthony Burns, president and chief executive officer, and Ross Roadman, assistant treasurer, participated in the teleconference, "which lent it a certain aura of importance," Mr. Charles says, noting that a new benefit has a greater chance for success with support from top management.

**The teleconference** was somewhat reminiscent of a professional charity telethon. Speakers took turns before the camera, microphones changed hands often, music entertained in the background, viewers were addressed with such lighthearted greetings as "You out there in 'televisionland,'" and a telephone number flashed across the screen periodically.

The number was a hot line to the telecast headquarters, where nearly 100 calls were received, many of which were answered on air so other viewers could benefit from the responses.

*Continued on next page*

# New technology helps sell savings plan

Continued from previous page

"In a word, we were estatic," Ryder's savings plan coordinator, Judy Webb, said of the number of phone calls received.

"It (the telecast) was an experiment, but I think it was a successful one. We just couldn't get enough raves."

She says the company's goal is to enroll between 4,000 and 6,000—or as many as 60%—of its approximately 10,000 eligible employees in one of the five new investment opportunities.

"If we get up to 50%, we'll be elated," Mr. Charles says.

Organizing the teleconference was no easy task.

Ms. Webb estimates that about 60% of the work required for the polished product was accomplished by Ryder employees, some of whom volunteered to act in the three pre-recorded vignettes.

The other 40% of the project was accomplished with help from outside production sources, a professional narrator, HI-NET and the communications consulting department at Johnson & Higgins in New York, she says.

"They (Ryder personnel) worked like Trojans," says Joan Korn, a J&H senior consultant and assistant vp who spearheaded the technical end of the production.

"What they did with the telecast was superb—one of the most modern means of communicating with a variety of poeple," she notes.

J&H wrote the script for a 12½-minute videotape that managers will use when conveying the plan to employees and supervised the tape's editing and mixing in New York. The three skits, which J&H designed, also appear on the videotape.

Ryder commissioned between 150 and 180 of the videotapes, which are being distributed to regional and other non-corporate managers.

**J&H also organized** production of about 20,000 booklets, brochures, enrollment forms and other literature addressing Ryder's plan. In addition to the literature and videotape, managers will also have the benefit of a phonograph record Ryder asked J&H to design, explaining savings options to employees.

"It was an interesting production for us," Ms. Korn says. The videotape, in particular, was a departure from the style J&H tupically designs. Ms. Korn points out that Ryder's tape features sophisticated special effects techniques and an on-camera narrator, as opposed to off-camera narration.

The telecast production cost Ryder an estimated $48,000, Mr. Charles says. A Holday Inns spokeswoman says HI-NET charges vary greatly, according to such factors as the number of locations that will receive the telecast, the length of the transmission and the distance between the point of broadcast and the receiving stations.

Ryder spent an additional $108,000 to cover the costs of producing the video, phonograph records, brochures and literature and other expenses associated with introducing the new plan, whose slogan is "a better way to save."

"I think it's really important for the employees," Mr. Charles says of the 401(k) plan. The company is focusing on primarily younger employees, whose salaries are on the low end of the earnings scale, because IRS regulations limit the contributions of the one-third higher-paid employees to a percentage of that of the two-third lower-paid employees.

**Because many** of the company's employees are blue-collar workers, Mr. Charles estimates that the average Ryder employee earns between $20,000 and $24,000 a year.

The savings plan, which starts July 1, gives employees five investment options:

- A guaranteed investment contract with Hartford Life Insurance Co. with an initial interest rate of 12.22%.
- The Ryder System Federal Credit Union Fund, with a quarterly interest rate that is the average of the previous quarter's Treasury bill rate plus 0.5%.
- A conservative-growth mutual fund, manged by Lord, Abbett & Co. under its Affiliated Fund.
- An aggressive-growth mutual fund, managed by Putnam Management Co. Inc. under the Putnam Voyage Fund.
- Ryder System Inc. common stock.

Regardless of the savings plan an employee chooses, he or she can contribute between a maximum of 10% of each paycheck or $2,000 a year, whichever is greater. Or, an employee may contribute a specific dollar amount, as long as it's at least 1% of each paycheck.

Employees may elect to participate in any or all of the five investments, but they must split their contributions into 20% or 25% sections. An employee can change the amount of his or her contribution, redirect the contribution or transfer funds from one fund to another only twice a year.

**Employees can join** the plan during any May or November enrollment period.

Ryder will match 50% of the first $200 that employees save annually. For example, it was explained during the teleconference that an employee who contributed $400 really would receive $500 because the company contributes $100.

Employees will vest in the company contributions at a rate of 25% a year; after four years, they will be 100% vested.

After two years, employees may receive a loan of up to 50% of his or her vested account balance. The minimum loan is $1,000 and the maximum loan is $50,000. It may be paid back over 54 months through payroll deductions, with the interest—also tax-deductible—credited back to that account.

"You'll actually be borrowing from yourself and paying yourself back with interest," the telcast narrator touts.

Like most 401(k) plans, Ryder's permits an employee access to the funds only if he or she is retiring, leaving the company, has become totally disabled or shows evidence of a strong hardship case.

The trustee for the plan is New York-based Bankers Trust-Investment Management Group, the fourth-largest manager of tax-exempt assets in the United States, according to Pensions and Investment Age magazine.

Ryder will administer the plan itself, Mr. Charles says, using a ImpleFacts, a computerized record-keeping system manufactured by ERISCO Inc. in New York. ■

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# Work-and-family seminars help parents cope

By DIANE KASTIEL

To help their employees be better workers and parents, a growing number of employers are crossing the time-honored line that has kept employees' family problems out of the workplace.

Corporate giants like Time Inc., Digital Equipment Corp. and Philip Morris are sponsoring "work-and-family" seminars in company conference rooms—and often on company time—to help working parents cope with their dual roles. Some medium-sized firms are getting involved, too.

And, as the number of single parents and working mothers continues to rise, experts expect the need for this kind of employer support to become even more urgent.

The U.S. Bureau of Labor Statistics reports that 21.5 million working women have children under the age of 18.

**"The question is,** how can a person have a good, solid family life and raise good kids and, at the same time, give to the job what they need to progress?" asks Michael Blanco, assistant vp of human resources at Banker's Trust in New York. "We just know that it is more and more an emerging concern. Skills are needed to manage both ends."

Employers are finding that helping their employees cultivate these skills does not have to be prohibitively expensive and can benefit companies through improved employee productivity, heightened employee morale that can hold down staff turnover and reduced health care costs.

Outside experts usually conduct the actual seminars, although a company can use in-house experts.

Time Inc., the New York-based publishing company, has sponsored several work-and-family seminars during lunch hours as part of its "Resources for Working Parents" program.

Last fall, seminars were sponsored on finding time to handle both a job and family, managing the holidays, returning to work after having a baby and living with a teen-ager.

**Time hired** a psychiatrist for one session and staffers from the Work and Family Life Study at Bank Street College of Education in New York and the Center for Parenting Studies at Wheelock College in Boston to conduct the other seminars.

This spring, Time offered two three-session workshops on managing maternity leave and single parenting.

Both were conducted by outside consultants and Carol Kirsch, Time's employee relations coordinator.

A total of about 400 employees participated in the fall and spring workshops, which cost Time a total of about $5,000, said Margery Sobelman, Time employee relations associate.

**Early this year,** Digital Equipment Corp. hosted two work-and-family fairs for the 2,300 employees at its Westminster, Mass., and Salem, N.H., facilities.

The fairs, designed and produced by the Managing Work and Family Systems division of Coping with the Overall Parent/Pregnancy Experience (COPE) in Boston, lasted an entire workday and featured information tables, films and a noontime panel discussion.

Staffers from COPE were available to answer questions, and employees could visit the fairs throughout the day.

According to Joseph Jacquet, senior buyer at Digital, the fairs cost about $700 each.

The Defense Communication Agency of the U.S. Department of Defense sponsored its first two work-and-family seminars in April of this year at a cost of $900. About 45 employees participated in the three-hour seminars, conducted by Philadelphia-based Resources for Parents at Work.

Thomas C. Billet, a benefit consultant at Johnson & Higgins in New York, says this type of benefit is here to stay.

**"Until now,** employers didn't want to get involved in their employees' lives out of the office. Now they're starting to realize that what happens out of the office affects their employees' performance."

Actually, corporations were "acutely aware" of this phenomena by the mid-1970s, according to Sheila Akabas, director of the Industrial Social Welfare Center at the Columbia University School of Social Work in New York. They responded by launching employee assistance programs, which include the work-and-family seminars along with other programs like drug and alcohol rehabilitation.

"Companies were beginning to understand that the welfare of workers was closely tied into the welfare of the company," Ms. Akabas says.

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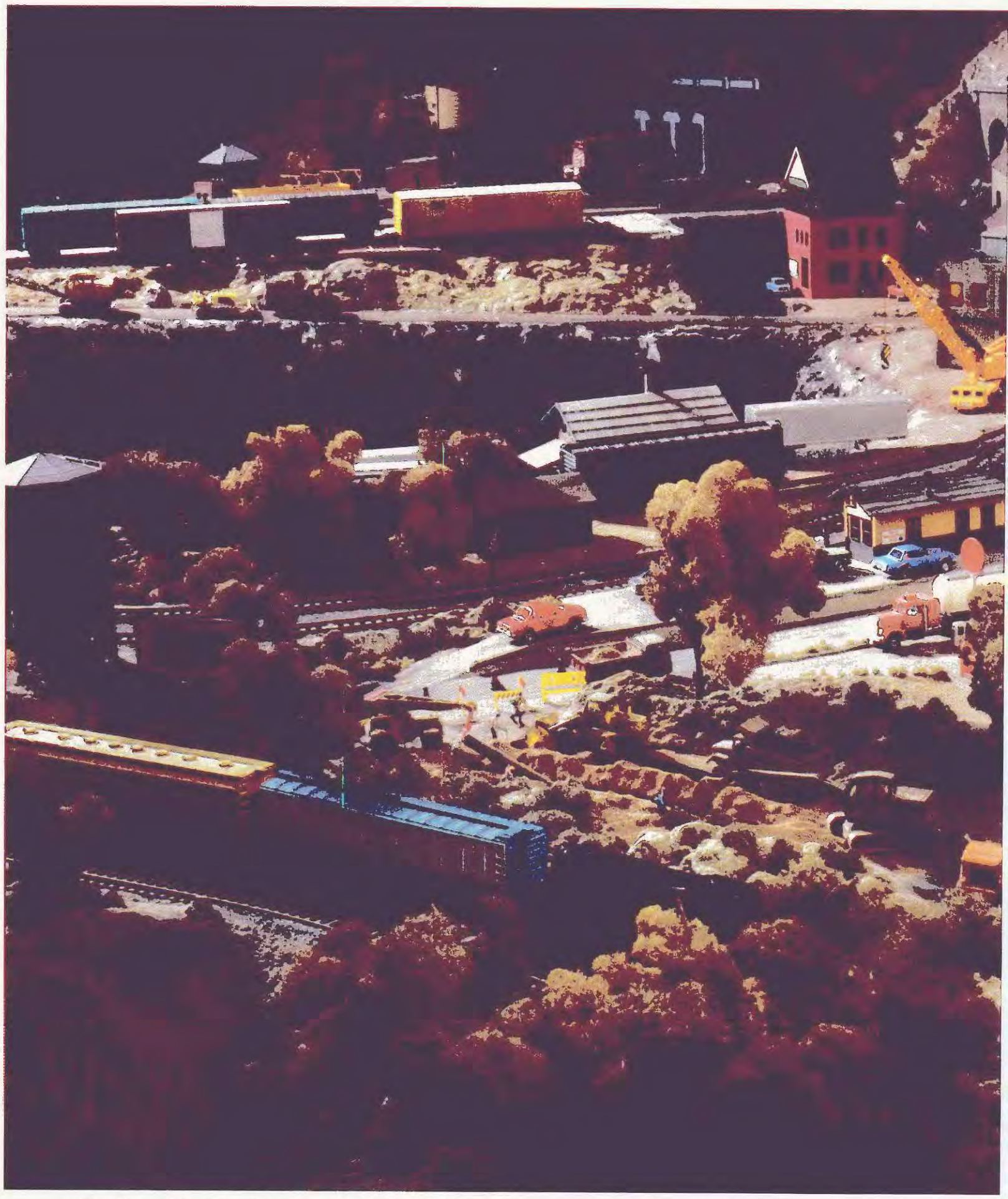

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"And unions were beginning to understand that they alone could not provide all the things that workers needed. It was essential to cooperate with the company to be totally responsive to the multiple needs workers were presenting."

The first work-and-family seminars were conducted in 1976 by the Texas Institute for Families, a now-defunct non-profit research organization in Houston. It offered them free to corporations as part of the Bicentennial celebration.

According to estimates from researchers in work-and-family studies, at least 50 to 100 major corporations, military units and professional organizations have since held work-and-family seminars.

However, only in the last year and a half did these seminars attract much interest, as corporations began to respond to the needs of a work force consisting, in large part, of two-career couples and single parents who daily juggle their jobs and families.

The forerunners are either in the "growth industries," like high-tech corporations, which are improving their benefit packages to recruit workers, or in organizations with large numbers of female employees, like hospitals and banks.

> "They came to us and said, 'Hey, I really liked that,'" says Lynn Hall of Data General.

Data General Corp., a computer research and development corporation in Research Triangle Park, N.C., sponsored a half-day "working parent" seminar last July. It was conducted by Workplace Options of Raleigh, N.C., a consulting firm specializing in child-care issues.

According to Lynn Hall, personnel assistant for Data General, the company didn't have to do a post-seminar survey of the 12 employees who participated to find out if their effort was worthwhile.

"They came to us and said, 'Hey, I really liked that,'" Ms. Hall says.

Earlier this year, Phoenix Mutual Life Insurance Co. in Hartford, Conn., conducted seminars for their employees' "latchkey" children who are responsible for their own care after school while their parents are at work.

Both the children and their parents participated in workshops at the Hartford and Greenfield company headquarters.

Sessions for the children included advice on getting home safely from school and what to do in an emergency. They also provided a forum for the children to discuss their frustration over a home situation that forces them to accept more responsibility and often limits their after-school activities.

The program, called "I'm in Charge," was five 90-minute sessions. It was designed by the Kansas Committee for Prevention of Child Abuse and facilitated by Parents Anonymous of Connecticut.

Phoenix Mutual also sponsored two seminars last year on handling the stress of being a working parent and finding quality day care for infants and toddlers. The Capital Region Education Council, an educational service center in Hartford, conducted the workshops.

"We intend to offer, in the future, any kind of services to help our working parents," says Cynthia Williams, director of Equal Employment Opportunity for Phoenix Mutual. "We want to keep it up, but it depends on the needs of the parents."

Banker's Trust has sponsored three work-and-family seminars since November 1982 and plans to offer them every six months.

*Continued on next page*

## Men less likely to participate

Women employees are more likely to participate in work-and-family seminars than are male employees, but there is some interest among men.

Stephen Segal, president of Philadelphia-based Resources for Parents at Work, says that in an organization with an equal number of male and female employees, mothers will outnumber fathers 5-to-1 in most work-and-family seminars.

"Even though it's changing, the woman in the house is often the responsible person for child care," says Farley Bernholz, president of Workplace Options, a child-care consulting firm in Raleigh, N.C., that offers work-and-family seminars.

Mike Blanco, assistant vp of human resources at Bankers Trust in New York, says that although men usually comprise only about 10% of the participants in the seminars his company has offered, those that have participated are enthusiastic.

"It's heartening for me to see that the men are as involved as the women and are as effective as parents," he says.

In an article in the March 1984 issue of Personnel Journal, Mr. Segal wrote, "...a growing number of men are becoming familiar with the difficulties associated with fulfilling responsibilities to both work and children. Just as role definitions are becoming blurred in the workplace, they are also broadening at home....

"These working fathers appreciate and use employer-sponsored family supports."

# Firms avoid seminars for several reasons

Although some employers are enthusiastic about work-and-family seminars, others are still holding back.

The primary reason for their skepticism is lack of information on the relationship between work and family.

Such research is usually buried in journals on psychiatry and behavioral science—publications not often found on the benefit manager's desk.

"Unless a manager has a Ph.D. and academic training, they won't even know to go to those publications," says Dana Friedman, senior research fellow at the Work and Family Information Center of The Conference Board, a non-profit organization in New York that provides information to 15,000 managers in 4,000 corporations.

The board expects to publish three reports this fall on work-and-family topics.

Other organizations doing research in this area include Catalyst, a national non-profit organization that advocates the full participation of women in business and the professions; the Social Welfare Center at the Columbia University School of Social Work; and the Work and Family Life Study at Bank Street College in New York.

Many companies shy away from work-and-family seminars because of a traditional belief in the separation of work and family.

This attitude stems largely from a push from unions in the 1930s to stop corporations from interfering in an employee's personal life.

Even today, Ms. Friedman notes, "there's a fine line between support and interference."

Proponents argue that the voluntary nature of the seminars clearly keeps them on the support side of the line. They also point to participants' reactions to the seminars.

"There's a lot of enlightened parents coming out of this thing," says Michael Blanco, assistant vp of human resources at Banker's Trust in New York.

Some employers back away from the seminars to avoid opening what they may feel is a can of worms.

"Once you open the door, there are problems you have to deal with," concedes Farley Bernholz, chief executive officer of Workplace Options, a child-care consulting firm in Raleigh, N.C.

But, opening the door may open up communication about employees' needs—communication that may save the employer money.

In one company Ms. Bernholz visited, a pre-seminar survey showed that employees didn't need or want the $50,000 day-care center the company was about to build. They wanted support from the employer in the form of work-and-family seminars. So the company sponsored a seminar—for $2,500.

In many cases, employers have not responded to their employees' needs because the employees have not asked for help.

Stephen Segal, president of Resources for Parents at Work, a Philadelphia-based firm that offers work-and-family seminars, says about half the firms that have declined to sponsor a seminar say the working parents they employ haven't asked for help in balancing their two worlds.

A report of the Conference Board's Working Parents Project says, "The most direct way for parents to receive consideration of their familial needs by management is by asking management for assistance. Unfortunately, this most obvious and direct strategy is rarely used."

Ms. Bernholz says this is only partly the employees' fault.

"In a lot of cases, people haven't really spoken up about what they need. But the employer has to provide a conducive atmosphere for that dialogue. You have to be an open type of company to allow that kind of dialogue to take place." ■

## Groups can help with seminar plans

The following organizations offer free or inexpensive information on work-and-family seminars.

- American Assn. of University Women, 2401 Virginia Ave. N.W., Washington, D.C. 20037; 202-785-7700.
- Catalyst Career & Family Center, 14 E. 60th St., New York, N.Y. 10022; 212-759-9700.
- Center for Parenting Studies, Wheelock College, 200 Riverway, Boston, Mass. 02215; 617-734-5200, Ext. 214.
- The Conference Board, 845 Third Ave., New York, N.Y. 10022; 212-759-0900.
- Family Matters Project, Department of Human Development and Family Studies, Cornell University, Ithaca, N.Y. 14853; 607-256-7610.
- Family Study Center, 114 Home Economics West, Oklahoma State University, Stillwater, Okla. 74078; 405-624-6696.
- Home and School Institute Inc., Special Projects Office, 1201 16th St. N.W., Washington, D.C. 20036.
- Industrial Social Welfare Center, Columbia University School of Social Work, 622 W. 113th St., New York, N.Y. 10025; 212-280-5173.
- Kansas Committee for the Prevention of Child Abuse, 214 W. Sixth St., Suite 301, Topeka, Kan. 66603; 913-354-7738.
- Coping with the Overall Parent/Pregnancy Experience, 37 Clarendon St., Boston, Mass. 02116; 617-357-5863.
- National Committee for the Prevention of Child Abuse, 332 S. Michigan Ave., Suite 1250, Chicago, Ill. 60604-4357; 312-663-3520.
- Parents in the Workplace, 906 N. Dale St., St. Paul, Minn. 55103; 612-488-7284.
- Project Enlightenment, Wake County Public School System, 501 S.Boylan Ave., Raleigh, N.C. 27603; 919-755-6935.
- San Antonio Coalition for Children, Youth and Families, 1101 W. Woodlawn, Room 205, San Antonio, Texas 78219; 512-732-1051.
- Vocational Education Work and Family Institute, 524 Capitol Square Building, 550 Cedar St., St. Paul, Minn. 55101; 612-296-6516.
- Work and Family Life Study, Bank Street College of Education, 610 W. 112th St., New York, N.Y. 10025; 212-663-7200.

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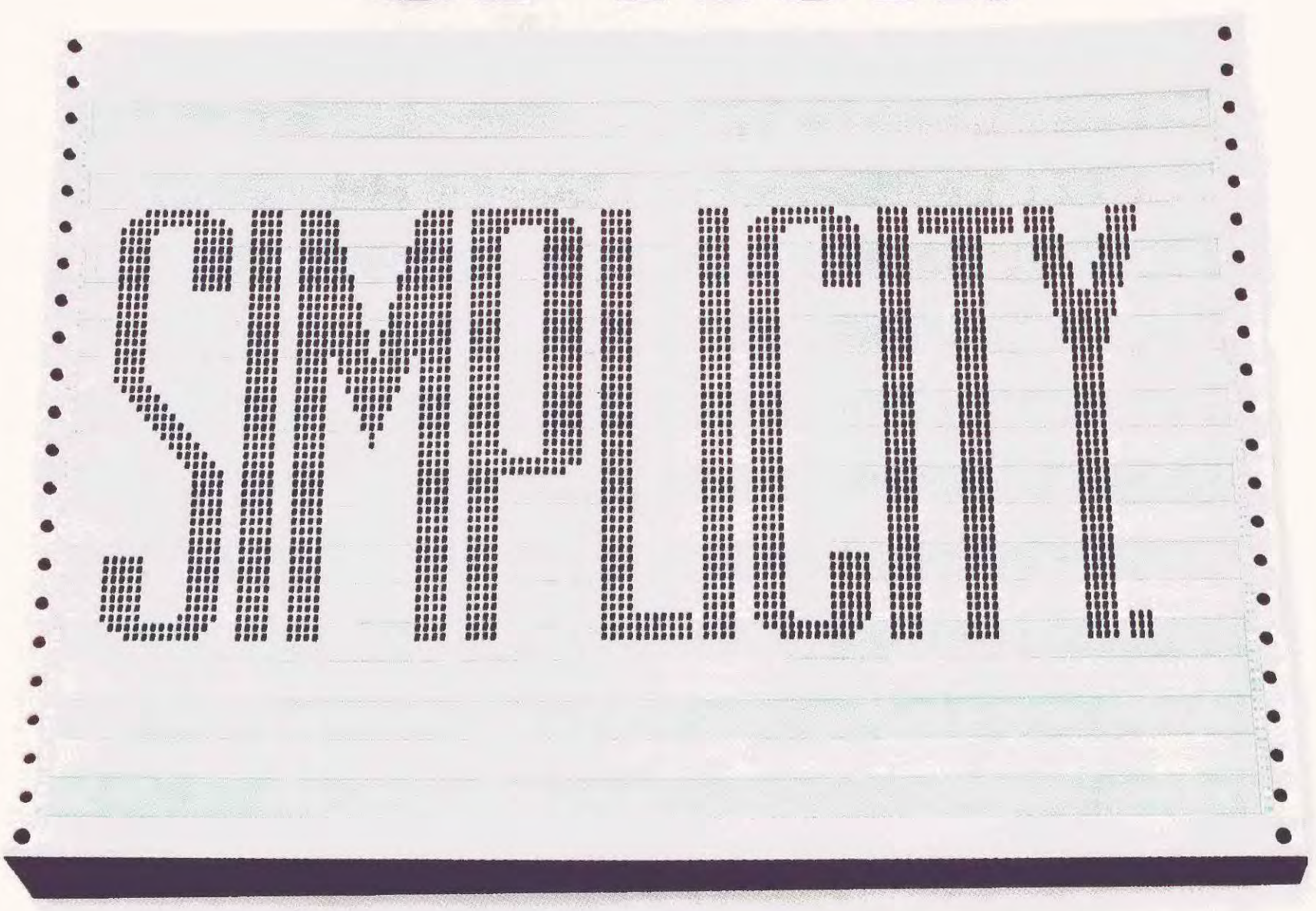

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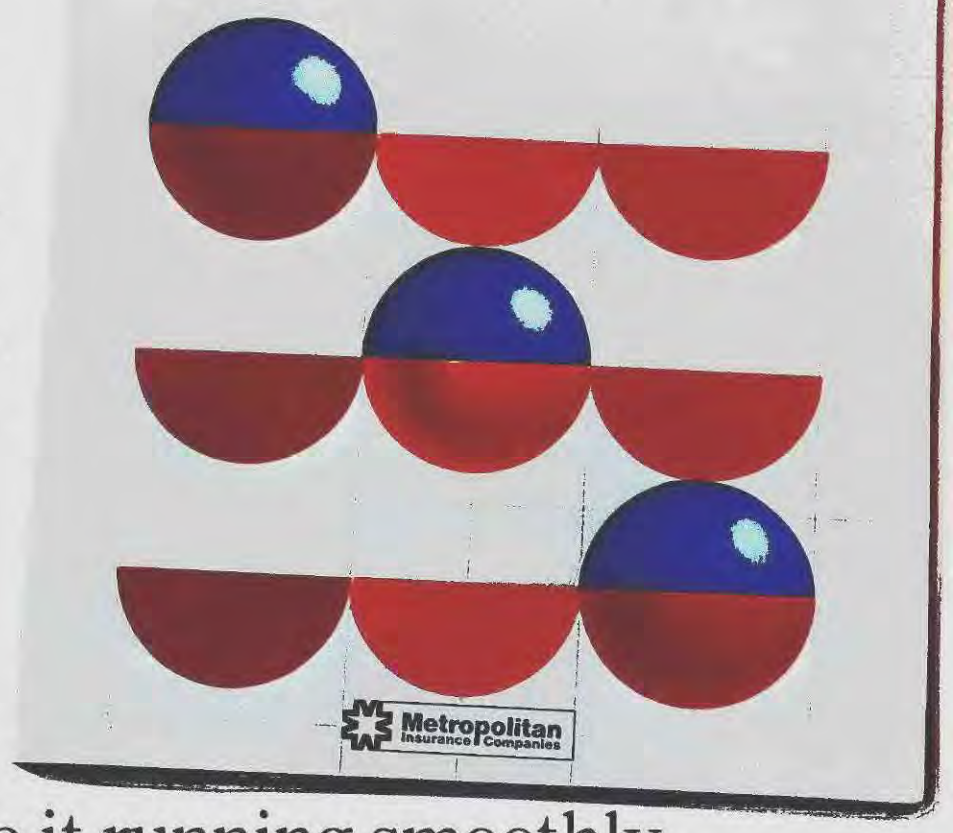


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# Child-care referral benefits coming of age

**By MARGARET LeROUX**

While few employers provide child care as a benefit, an increasing number of them are helping employees find care for their children by establishing information and referral services or purchasing the information from community services.

Sometimes referred to as resource and referral, these services give employees up-to-date information on child-care providers with openings available, location and cost of the services as well as other pertinent information.

Most services don't guarantee a perfect fit between parents and providers, but virtually all offer employees help in determining what is or is not a good child-care situation.

"Information and referral services are the hottest thing in child-care benefits right now," said Florence Glasser, child-care policy adviser with the North Carolina state Division of Policy Development.

Ms. Glasser noted a "hunger for information and child care that we never imagined existed" when she received more than 8,000 requests for a booklet she and her division prepared on child-care options for businesses after it was mentioned in a *Business Insurance* article on child-care benefits two years ago (*BI*, June 21, 1982).

"A lot of companies didn't know how to approach the whole issue of child care two years ago," she said. "Now a lot of them are easing into it through information and referral services; they've become very trendy."

Frances Rogers, head of Rogers & Associates, a Cambridge, Mass., consulting firm that works with employers in finding child-care information, says, "It's no longer scary for employers to be involved in child-care issues. There are now women executives and men who are in decision-making positions have wives or daughters who are working mothers.

"Interest in the subject has increased hugely in the five years we've been in existence," Ms. Rogers continued, predicting that national networks of child-care information will soon be common.

Several child-care consultants noted that a "major Fortune 500 company with operations across the country" will announce the establishment of a child-care information hot line for employees in all its locations later this summer.

The company is said to be working with Rogers & Associates, but Ms. Rogers declined to identify it.

Among employers that are already veterans in the field of child-care information assistance is Steelcase Inc., Grand Rapids, Mich., the world's leading manufacturer of office furniture.

Started as a part-time service in 1980, the Steelcase Child Care Service has developed into "a Cadillac program," said Bonnie Negen, child care coordinator.

In the past year the service has referred more than 200 employees in finding child care through telephone and in-person interviews.

A staff of four coordinators is available during working hours to Steelcase's 7,000 employees in the Grand Rapids area.

"When we first started, a survey determined an on-site day—care center was not what employees needed; rather, they needed information on care for infants, for school-age children before and after school and for night care," Ms. Negen said.

The Steelcase coordinators work with 100 licensed in-home child-care providers and 10 licensed day-care centers in the Grand Rapids area. Providers must comply with state regulations, meet EEOC requirements and follow the company's guidelines for discipline (no spanking allowed) and must participate in training workshops the company provides.

"Once we've completed an interview with an employee, we'll give them three referrals to pursue," Ms. Negen explained. "Since we've done all the legwork, investigating the providers, they won't be wasting their time with providers that don't have an opening."

Because Steelcase has a night shift that runs until 2 a.m., there also is a need for night-time care. "We had a hard time finding child-care homes in the community who were willing to take children during those hours, so we recruited care givers among Steelcase employees," Ms. Negen explained.

The company communicates information about the service through employee newsletters and meetings with supervisors.

To help some child-care providers get started, Steelcase lends them equipment such as cribs, highchairs and car seats.

The service "is a cost-effective way of expressing our desire to be a good neighbor and offer a service that strengthens the child-care community," states a brochure Steelcase has prepared about its child-care service.

Calvin Jeter, director of communications and employee services, said that Steelcase views child care "as both a company and an employee need. Having good child care available for employees maintains their level of job satisfaction and does have a relation to their job performance," he said.

"Child care isn't a women's issue, it's a people's issue," Mr. Jeter continued. "We find two-parent families are our biggest users of the service and last year male employees made use of the service more than any other group."

Steelcase funds the child-care services program with a budget described as "generous" by Ms. Negen, though she declined to give a dollar amount. For its part, the service provides the company with annual as well as monthly usage reports.

"We're getting a computer soon, so we'll be even more efficient," the child-care coordinator said.

A computer containing information on more than 2,000 child-care providers is what makes the Child Day Care Assn. a popular information and referral service wth employers and employees in the St. Louis area.

Twenty-five local employers, including Anheuser-Busch Co. Inc., the St. Louis Cardinals baseball team and several banks and hospitals, have contracted with the service to assist their employees with information over the phone.

An employee who calls will get information on three providers who have openings on the same day the request is made or on the next day, said Don Checkett, director of the service.

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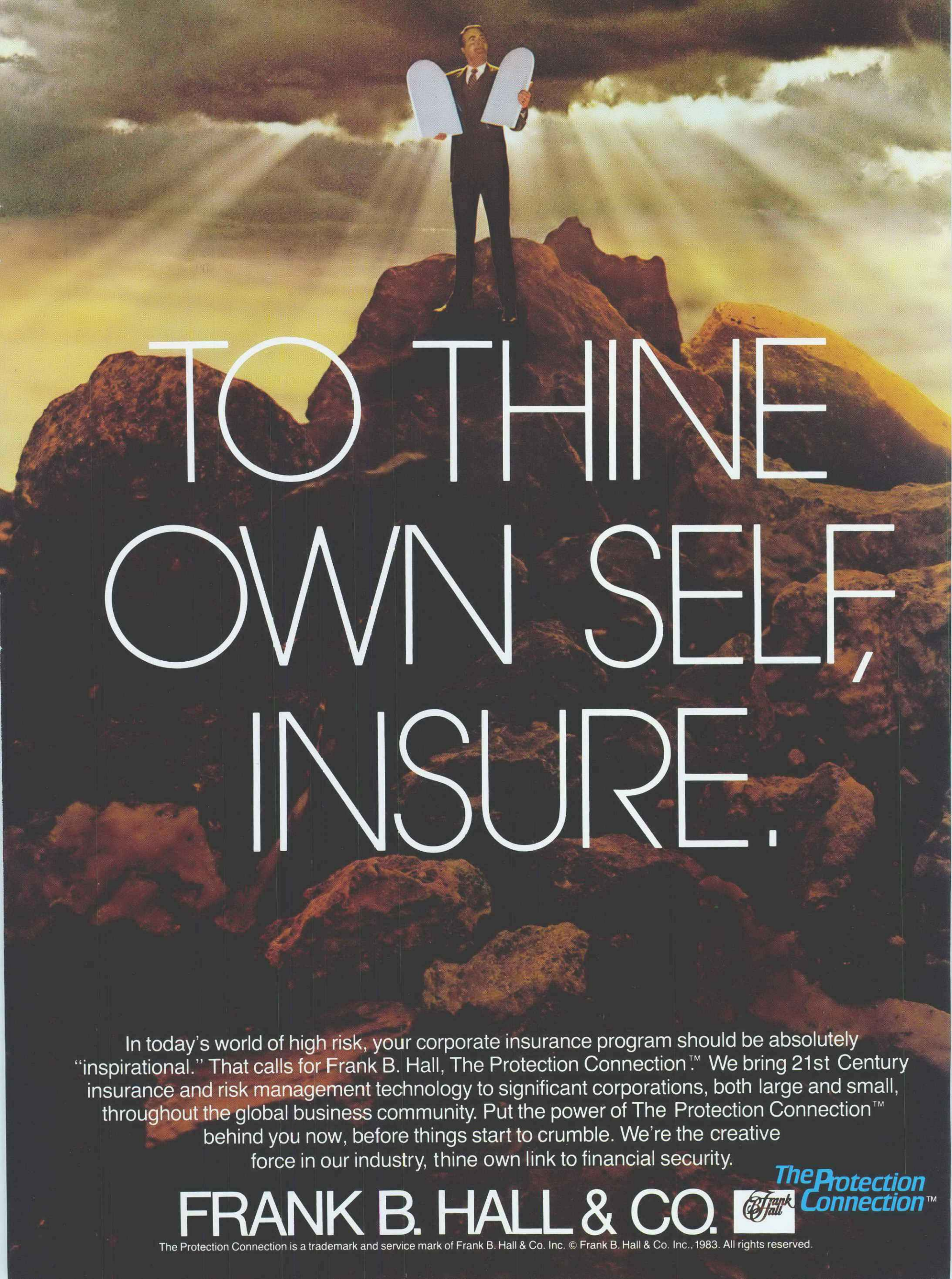


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• The "Certified Financial Planner" is a **portfolio designed to keep insurance documents in order** by consolidating information on all policies—group life/health, disability, umbrella and property/casualty—for quick reference and review. This planner also has forms for pension and profit-sharing investment and budget preparation. The 20-page planner is available for $8 from the Certified Financial Planner, 40 Bluebird Lane, Plainview, N.Y. 11803.

• "Executive Compensation: The Role of Junior Stock" is the topic of the February issue of the Kwasha Lipton newsletter. The six-page newsletter tells how **junior stock** works, discusses accounting treatment of and tax issues relating to junior stock, and compares junior stock to other stock vehicles. For a free copy, write Department M, Kwasha Lipton, P.O. Box 1400, Fort Lee, N.J. 07024.

• **OSHA standards for construction, longshoring, shipyard and general industry** are outlined in four booklets from the Occupational Safety and Health Administration. "Longshoring Industry" is a 256-page book that contains all the industry safety and health standards applicable to marine terminals and longshore operations. "Shipyard Industry" contains 143 pages and includes the complete industry safety and health standards for shipyard operations, both on vessels and onshore. The 83-page "General Industry" and the 69-page "Constructon Industry" contain selected safety and health standards that are most frequently overlooked and standards covering situations that are particularly hazardous. For free copies, write OSHA Publications Office, 200 Constitution Ave. N.W., Washington, D.C. 20210.

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• A four-page guide to **selecting fire detectors** focuses on infrared and ultraviolet units, detailing how they work and pointing out advantages and limitations of each. The guide also includes data about black-body radiation and how it affects detector sensitivity. Free copies are available from Detector Electronics, 6901 W. 110th St., Minneapolis, Minn. 55438.

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# Child-care referral benefits coming of age

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If none of the three openings is satisfactory, the employee gets a computer printout of all the available services that have openings for child care.

"The questionnaire we complete with employees over the phone contains sections on location, hours care is needed and type of care, so that the referrals are customized for each employee," Mr. Checkett said.

"We also advise them on how to be good child-care consumers; we teach them how to conduct an interview with a provider and what to look for at the provider's home or at the center," he said.

Employers get a quarterly report on usage of the service that includes a profile of employees who use it.

"This kind of information will be helpful to companies in planning for the future," Mr. Checkett said.

Although there's no limit on how often an employee can use the service, they are asked to give an employee number when calling, to prevent abuse of the service.

The cost to employers ranges from about $1.07 per employee per year for those with 3,000 or more employees to $2.25 per employee per year for employers with fewer than 500 employees, who must pay at least $100.

Since the service lists such a large number of child-care providers, "there is no way we can visit and evaluate them all," Mr. Checkett said. The service does require all its listed providers to meet state regulations.

"We coach parents in selecting a provider, and after the child has been placed, we ask them to rate the provider," Mr. Checkett said. "As we collect reports on the providers, we'll make that information available to parents who are looking for care."

A citywide information and referral service also is operating in Cleveland, where four employers pay for information on child care from the Center for Human Services, Childcare Information & Referral.

Ameritrust Bank, St. Vincent's Hospital, the Cleveland Board of Education and the University Hospital are the employers that use the service.

Working part time—someone from the center conducts interviews at employer sites weekly—the center has served 167 employee families and placed 200 children in the past year, said Mary Kerrigan, the center's director.

"We interview employees, give them some child-care consumer information and get back to them with a referral within a day," she said.

The center plans to expand its activities beyond the Cleveland area in the future.

"That way we can serve people who may work in Cleveland and live in Akron," the director explained. "We're finding among our employer clients a need for child-care information for employees being recruited or relocated."

A corporation that's testing information and referral services in New York is Equitable Life Assurance Society of the United States. The insurance company had tested a program with Kinder-Care day-care centers providing space for children of Equitable employees in three cities, but found it to be unworkable, according to Philip Rivera Jr., director of employee relations.

"Even though Kinder-Care is a mass provider of day-care centers, it's not all in the locations we are, and to offer equal access to all employees, Equitable would have to be in the day-care business itself," Mr. Rivera said.

Instead, the company is now offering child-care information to all employees and day-care referrals in New York City on a trial basis. The company signed a one-year contract with Child Care Inc. to provide information on day-care openings by telephone.

"We may look at the feasibility of offering such information on a nationwide basis," Mr. Rivera said.

> 'Child-care isn't a women's issue, it's a people's issue,' says Calvin Jeter of Steelcase Inc.

The child-care information program distributes articles on a number of related issues to any Equitable employee who requests it.

Another approach to information and referral services, an employer consortium founded two years ago in Hartford, Conn.. has since expanded its operations.

"The consortium is alive and well and has sensitized a lot of people about child-care issues," said Frances Roberts, director of Connecticut's Office of Childcare.

Besides information and referral to day-care providers in 40 communities in the greater Hartford area, the consortium also provides parenting seminars for employees and day-care training for providers.

Each employer in the consortium has trained an employee to handle requests for information about day care, and at one of the five consortium members, Aetna Life & Casualty Insurance Co., the day-care coordinator is a fulltime position.

**Other members** of the consortium are Hartford Steam Boiler Inspection & Insurance Co., Travelers Insurance Co., Hartford National Bank, Connecticut Bank & Trust Co. and Connecticut Natural Gas Co.

The consortium's first-year budget of $35,000 for information, referral and parent-education seminars has grown to $46,000, apportioned among employer members.

The consortium has provided companies "an opportunity to get some strength in numbers in terms of our ideas," said Brenda Berardy, who represents Hartford Steam Boiler on the consortium's board of directors.

The consortium's new projects include production of a videotape on how to establish a consortium and how it works, some legislative lobbying on establishment of child-care facilities for state employees and a bond issue to fund child-care centers. ■

# PAYSOPs are popular, despite questions

**By ANDREA BROX**

Although it's no T-bone steak, experts agree Payroll-Based Employee Stock Ownership Plans are giving a lot of companies a free lunch. But the verdict is still out on whether a PAYSOP is worth the wait in line.

"It's a freebie, so it's hard to find a reason why you wouldn't want one," said Lloyd Kaye, principal at benefit consultant William M. Mercer-Meidinger Inc. in New York.

"But I've seen a few companies just ignore it because it's not worth much. They figure it's just not worth fussing with," he said.

In a PAYSOP, the employer is given tax credits that are used to set up individual company stock accounts for employees.

Through 1984, the credits equal 0.5% of annual payroll. This will increase to 0.75% of payroll for 1985 through 1987.

PAYSOPs replace Tax Credit Reduction Act Stock Ownership Plans—or TRASOPs—that based available tax credits on annual capital investments rather than payroll.

Because of this, TRASOPs almost exclusively benefited high-capital companies and often provided employees with company stock equal to 12% of annual pay, said Louis Granados, managing director of the Employee Stock Ownership Plan Assn. in Washington.

The switch in 1983 from capital-expenditure to payroll-based tax credits for these defined contribution plans was allowed under the Economic Recovery Tax Act of 1981. The new law reflected a congressional effort to redress what many saw as longstanding discrimination against labor-intensive companies.

Although PAYSOPs have only been around for a little more than a year, they have piqued substantially more employer interest than their predecessor.

More than 62% of 384 Fortune Directory companies have or are planning to establish a PAYSOP, compared with 48.7% that had TRASOPs. And an additional 11.2% are considering implementing a plan, according to a survey released this spring by Hewitt Associates, a Lincolnshire, Ill., benefits consulting firm (see story, page 40).

But even though more employees may be getting a slice of the pie, the pieces are being cut thinner.

"People who were getting 12% of pay (under TRASOPs) are now getting one-half a percent," Mr. Granados said.

A PAYSOP currently provides the average employee with about $125 worth of stock annually, according to the Hewitt survey.

And although not many employers are complaining about the additional tax credits, some are wondering if the PAYSOP benefits are large enough to be meaningful to workers and make them feel like they have a share in the company.

"Any service company that doesn't have a PAYSOP is behind the times. It's free money, so why not take it?" said Jack Aalseth, president and chairman of the board at Evaluation Research Corp., a Vienna, Va., engineering and software service company.

"But when you take the PAYSOP contribution, it's so small it's hard to sell. Anyone likes what they didn't get before. But someone that makes $15,000 doesn't fall all over himself for an extra $75 (a year)," Mr. Aalseth added.

Another service organization, Lowe's Co., has tripled its tax credits under the payroll-based plan, according to Edgar Spears, director of personnel operations at the North Wilkesboro, N.C.,-based company that operates a chain of home center stores.

"We like it because it's funded by tax credits, and we couldn't in good conscience pass it up because it's a benefit to our employees," Mr. Spears said.

Although Lowe's clearly has benefited from the PAYSOP switch, Mr. Spears added, "The PAYSOP in the near term will not do anything for productivity. People just don't notice it yet. The benefits are not quite big enough to get people excited yet."

Several benefits consultants also are skeptical about the PAYSOP's role in increasing job productivity.

"I don't think it will be a negative. But I don't think it will be substantive in making employees feel like they own part of the company," said Thomas Barratt, a consultant at the Wyatt Co. in Detroit.

That's not to say PAYSOPs won't increase productivity; they just may not live up to expectations, he added.

"They give employees such a trivial amount of stock. If the economy could afford it, it would be nice to see the percentages a lot higher. Now, that could be meaningful," Mr. Kaye said.

Others think PAYSOPS can provide a meaningful benefit in the long run.

Benefits, including dividend allocations, add up over time; therefore it's important to look at more than just the initial contribution, said Ray Maddock, a lawyer for Hewitt Associates, who has worked extensively with PAYSOPs.

For example, an employee who makes $20,000 a year, and whose employer started a PAYSOP in 1983, can expect to make about $1,000 by 1987, Mr. Maddock said.

"Transform that into taxes that the employer would otherwise pay to the government and you have a worthwhile aggregate benefit," he said.

"Over time it can be a reasonably good supplemental benefit," said Michael Ryan, vp at the Boston office of Towers, Perrin, Forster & Crosby. "But when they (the employers) look at the relatively small numbers it generates in the first few years and they balance that against the administrative costs, they scratch their heads."

Administrative costs will vary depending on the complexities of the PAYSOP and whether an individual account plan is already in place in the company, Mr. Ryan said.

Start-up expenses—including a legal plan document—for an employer with an already established individual account plan generally will be between $5,000 and $10,000. Ongoing costs will run about $2 to $3 per employee. "But it could cost five times that," he added.

At MCI Telecommunications Corp. in Washington, administrative expenses of starting up a PAYSOP were significantly defrayed by an existing plan.

"There was no real additional cost with administrating the PAYSOP because we already had an

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ESOP," said Paula Cartner, manager of MCI's treasury department.

The biggest reason experts and one-third of the Hewitt survey respondents cite for not implementing a PAYSOP is not being able to use the additional tax credits.

"The tax credit only does you good if you make a profit," said Hewitt's Mr. Maddock. And if the company can't take the tax advantage or it doesn't want employee ownership, a PAYSOP serves no purpose.

**In addition,** privately held companies may not want a PAYSOP because it would require the additional expense of having an appraiser annually determine the fair market value of the stock, said Christine Seltz, a consultant at Hewitt.

And although proxy statements are public documents, Mr. Barratt at Wyatt said some companies may not be comfortable distributing proxy statements to all employees since they often contain sensitive material.

Companies that have a lot of ups and downs in the stock market also may be reticent to start a PAYSOP, said Stephen Pollak, a vp and senior consultant at Johnson & Higgins in New York.

If the stock is volatile, at some point the benefits' value may approach zero, he said. "And employees would think, 'What are they giving me but a few pennies?'"

**Employers may** also be slow to start up PAYSOPs because of their uncertain future. The tax credit will expire in 1987 if it's not renewed by Congress, said John Dirlim, principal at Towers, Perrin, Forster & Crosby.

"I hope that it would be continued. It has created a set of accounts and if it's canceled, the administrative burden may end up costing more than what the benefit might have been," Mr. Spears said.

However, some consultants aren't too optimistic about the fate of PAYSOPs.

"I don't see any great future. The PAYSOP is not much more than a gimmick. It's really a tax giveaway with a limited objective," said Mr. Kaye of William M. Mercer-Meidinger Inc.

"I don't think the social justification is that great—in effect, everyone else is paying for it. The game is not worth the candle," he said.

**Mr. Pollack** added, "PAYSOP activity has been minimal. I don't know if there would be a significant lobbying effort to continue this. But that's sheer speculation. That's three years down the road."

One signal that may bode well for PAYSOPs is that consultants believe a PAYSOP contribution can be factored into determining whether a 401(k) salary reduction plan passes the non-discrimination test.

A 401(k) plan is named for the section of the Internal Revenue Code that allows employees to defer part of their pay on a pretax basis and invest it in a company profit-sharing plan.

The average percentage contribution of the employees in the top third according to pay is limited by the participation levels of employees in the lower two-thirds based on pay.

Although PAYSOP contributions are not made to the 401(k), in the absence of any IRS ruling to the contrary, companies may calculate the salary percentage value of the stock allotted to individual employees under a PAYSOP and factor the contribution into the 401(k) test.

As a result, employees who earn too little to defer salary but are receiving PAYSOP contributions can be credited with a salary reduction via the PAYSOP benefit when calculating the discrimination test.

When PAYSOPs are allocated on a per capita basis—providing all employees with the same amount of stock—the value of the stock for lower-paid workers is a higher percent of salary than for the higher paid employees.

When those figures are used in the non-discrimination test, the percentage of contribution by the lower two-thirds of the employees rises and so boosts the percentage of salary the higher-paid one-third can defer in a 401(k) plan, Mr. Maddock said.

Although Mr. Kaye said 401(k) coordination is not essential to the success of PAYSOPs, a lot of employers have been establishing PAYSOPs under the assmption they will be able to coordinate it with the 401(k).

"If we didn't have 401(k), we wouldn't have as many PAYSOPs. And if they come down and clarify the 401(k), it would be a significant boost to PAYSOP development," Mr. Dirlim said.

However, Richard Houser, manager of employee benefits planning and development at Dart & Kraft Inc. in Northbrook, Ill., says PAYSOPs don't mean a lot to the non-discrimination tests.

"If you take the time to figure it out mathematically, you're not adding much at all," he said. ■

# Most large firms have PAYSOPs: Study

**By ANDREA BROX**

CHICAGO—More companies are dishing out pieces of the corporate pie to employees, thanks to the 1981 legislation creating Payroll-based Employee Stock Ownership Plans, or PAYSOPs, a recent survey shows.

Almost two-thirds, or 63%, of the 384 Fortune Directory companies responding to the survey have established PAYSOPs.

An additional 11.2% of the respondents are considering implementing a PAYSOP, according to the survey, which was conducted by the benefits consulting firm Hewitt Associates of Lincolnshire, Ill.

That 63% involvement is a big increase over the 48.7% of the companies that had offered the forerunner to PAYSOPs: TRASOPs, otherwise know as Tax Reduction Act Employee Stock Ownership Plans.

In a PAYSOP, the employer earns tax credits equal to the value of the contributions creating individual company stock accounts for employees.

Through 1984, the available tax credits equal 0.5% of annual payroll. This amount will increase to 0.75% of payroll for 1985 through 1987.

> Only 26% of the surveyed companies decided not to implement a PAYSOP.

PAYSOPs replace TRASOPs, which based available tax credits on annual capital investments rather than payroll.

TRASOPs were created in 1975, but in an effort to strike a more equitable balance between capital and labor-intensive companies, Congress switched the tax credit basis from capital investments to the annual payroll of participants. The legislation, passed in 1981 as part of The Economic Recovery Tax Act of 1981 (ERTA), became effective in 1983.

Hewitt compiled its study of the prevalence of PAYSOPs and their characteristics between December 1983 and January 1984. The survey includes responses from 224 industrial Fortune 500 companies and from 160 non-industrial Fortune service companies.

The Hewitt survey found that TRASOP companies are leading the way in establishing PAYSOPs. Of companies with TRASOPs, 84% converted their plans to PAYSOPs.

However, for many of the companies that sponsored TRASOPs, a switch to a PAYSOP will reduce the benefit for employees because the amount of tax credit available generally is based less on payroll than based on capital expenditures.

By industry, the most interest is shown by pharmaceutical, paper/fiber/wood, soaps/cosmetic, and petroleum/crude oil/mining companies. At least 80% of the surveyed companies in each of these industries have created PAYSOPs.

PAYSOPs have not caught on in diversified financial companies or life insurance companies, where only 36% and 20%, respectively, have formed PAYSOPs.

Only 100 of the surveyed companies, or 26%, decided not to implement a PAYSOP. Of these, 87 explained their reasons. One-third said their companies didn't make enough money to use the additional tax credits.

Metal manufacturing, for example, is an industry in which profits among some companies are not strong enough to use the tax credits. Only 36% of the 11 companies in this industry responding to the survey sponsor a PAYSOP.

Insignificant benefits to employees under a PAYSOP was cited as a primary reason for not establishing a plan by almost 29% of the 87 employers.

Indeed, the median 1983 PAYSOP benefit provided the average participant with $125.

The range of benefits provided the average participant was $24 to $250. Hewitt notes that this range was wider in 1983 than it will be in the future because those companies whose fiscal year-end was other than Dec. 31 had only a partial year of payroll for tax-credit purposes.

An additional 26.4% of the 87 that decided against forming a PAYSOP cited prohibitive administrative costs as preventing them from using a plan.

Start-up and ongoing expenses of a PAYSOP, however, may be paid with the tax-credit contributions to the PAYSOP, within specific limits. The PAYSOP can cover start-up expenses up to 10% of the first $100,000 contributed for the first year, plus 5% of the contribution in excess of $100,000. Ongoing administrative costs can be covered up to 10% of the first $100,000 of dividend income paid on securities held by the trust, plus 5% of excess dividend income up to an annual expense maximum of $100,000.

Almost half, or 49%, of the companies sponsoring PAYSOPs take advantage of this opportunity to cover expenses out of the PAYSOP contributions.

However, when expenses are paid from the PAYSOP, the amount of money available for benefits shrinks. And the study found that almost as many companies, or 45% of the respondents sponsoring PAYSOPs, pay administrative expenses themselves.

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An additional 6% use other means, most often paying for the start-up expenses but using PAYSOP funds to cover ongoing administrative expenses.

The survey suggests that interest in PAYSOPs spreads across all sizes of industrial companies, although the top 100 respondents, with 1982 sales exceeding $3.8 billion showed the most interest. Among these 51 companies, 77% have or are establishing a PAYSOP.

In the next size category, the 69 companies with 1982 sales of $1.3 billion to $3.8 billion, 73% have established PAYSOPs. Among the 104 companies with sales of $400 million to $1.3 billion, 64% have or are establishing a PAYSOP.

Among the respondents sponsoring PAYSOPs, nearly half include all their employees in the PAYSOP. About an additional 28% include salaried and non-union hourly employees. Only 19.2% allow only salaried workers to participate.

Although rules preclude companies from discriminating in favor of officers, shareholders or highly-compensated employees, it is also in an employer's interest to maximize participation because the bigger the payroll represented by PAYSOP participants, the bigger the tax credit.

Under the TRASOP, companies preferred to limit participation because with the tax credit based on capital expenditures, the fewer the people in the plan, the more stock each person got.

About two-thirds of the companies with PAYSOPs have eligibility requirements of one year of service or less.

Although available tax credits determine the employees' benefits, companies can choose the form and the timing of the stock allotments.

PAYSOP contributions can be made in stock or cash. But the cash must be used within 30 days to purchase employer stock. More than 66% of the companies prefer this method. Only one-quarter make their contributions solely in stock. And 8.8% use a combination of stock and cash.

Employers have until the due date (including extensions) for filing their federal income taxes to establish a PAYSOP, and 30 days thereafter to make the contributions.

Nearly 72% of the PAYSOP sponsors make their contributions within 30 days after the due date for filing income taxes. An additional 21% contribute immediately following the end of the plan year.

Companies also choose how the PAYSOP benefit is allocated up to the $100,000 annual compensation limit set by the Internal Revenue Code.

More than 59% of the employers allocate the PAYSOP up to the $100,000 limit. In other words, each employee receives about 0.5% of salary, except those who make more than $100,000 who receive 0.5% of $100,000.

About 7% of the companies set a contribution limit of less than $100,000, but usually no higher than $75,000.

About one-third of the employers choose a per capita allocation. In this case, all employees receive the same amount of stock.

Regarding the allocation of dividends, nearly all employers make payments into the PAYSOP, rather than paying the employees directly.

Amounts allocated to PAYSOP participants can't be distributed for seven years, except in cases of death, disability, termination or certain sales of corporate stock or assets. Most PAYSOP sponsors—86%—distribute benefits only at termination, including death or disability.

The frequency with which PAYSOPs process distributions to employees who leave or retire varies from annually at 42% of the companies to quarterly at 29% to monthly at 16% to semiannually at 4%.

Distributions can be in the form of stock, cash or a combination of both. About 45% distribute stock only. About 24% distribute cash unless stock is demanded, while 6% distrbute stock unless cash is demanded. The other quarter issue a combination of stock and cash.

> The survey suggests that interest in PAYSOPs spreads across all sizes of industrial companies.

The survey also gathered information concerning employers' interest in coordinating the PAYSOP contributions with 401(k) salary reduction plans, which allow employees to defer part of their pay on a pretax basis and invest it in a company profit-sharing or savings plan.

Absent official disallowance by the Internal Revenue Service, it appears that PAYSOP contributions can be used in calculating the 401(k) non-discrimination tests. These tests are used to determine what percentage of salary the higher-paid third of the employees can defer based on deferrals made by the lower-paid two thirds of employees (see related story, page 38.).

Unless disallowed by the IRS, 37% said they would coordinate the PAYSOP with the 401(k) plan. Another 46.8% either don't have a 401(k) arrangement or have decided against implementing the coordination. And 16% are undecided.

Hewitt also found that the employers establishing PAYSOPs are more likely to offer other company stock ownership plans as well. More than 87% of the 232 respondents to this question have other such plans.

Among the most popular other stock ownership plans are matching savings/thrift plans (48%), nonqualified stock purchase plans (34%), and profit-sharing plans investing in company stock (20%).

Only 12.5% offer no company stock plan other than a PAYSOP.

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*Copies of the "1984 PAYSOP Survey of Fortune Directory Companies" are available for $25 each from Greg Martin, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015.*

# Firms promote health care competition: Study

By ALISON KITTRELL

Employers are taking a larger role in the battle to control rising health care costs, according to a recent survey by a benefit consulting firm.

However, the survey of 328 clients of consultant A.S. Hansen Inc. shows that the companies' attempts still lack consistency and direction.

The most suprising finding in the study, according to Joseph Rosmann, a consulting principal at Hansen and head of the firm's health care cost-containment unit, is the number of companies that are aggressively promoting the use of health maintenance organizations and preferred provider organizations.

"A rapidly growing number of companies are moving in the direction of promoting price-competitive health care markets" through the use of HMOs and PPOs, Mr. Rosmann said, adding that more than 30% of the respondents said they are encouraging the use of the HMOs and PPOs among their employees.

In addition, some employers are even pointing out low-cost hospitals or physicians to their employees.

According to the survey, the employers noted they experienced a 18% median annual increase in health care costs during 1982-83, with only 2% of those surveyed reporting a decrease in health care costs. However, during the previous year, the employers reported a median increase of 19%.

Health care inflation in 1982-83 varied according to the size of the employer, the survey notes. For instance, the median increase in 1982-83 for small employers—those with 1,000 employees of fewer—was 20%, while medium-sized employers, with 1,000 to 4,000 employees, reported a 15% hike. The large employers surveyed, with more than 4,000 workers, reported an 18% median increase.

The survey suggests that medium-sized employers were able to best hold the line on health cost increases because they do a better job of gathering and using data than the other employers.

While more than half the reporting firms (56%) receive periodic data reports on health care cost trends and 57% say they receive reports on health care utilization, medium-sized companies get more-detailed reports on cost comparisions.

For example, 53% of the medium-sized companies reported that their reports include information about the average length of stay by diagnosis group; only 27% of the small companies and 38% of the large companies said they receive such information.

A higher percentage of medium-sized companies reported they receive reports on a variety of other topics, including:

- The distribution of surgery done on an outpatient basis.
- Total hospital days per 1,000 insured lives.
- Average length of stay according to diagnosis groups by hospital or doctor.
- Pre-surgical lengths of stay by hospital.
- Average hospital charges per admission.

However, about the same percentage of employers in all three groups said they recieved data on average charges for outpatient and inpatient elective surgeries.

Besides polling the companies on the type of data they receive, employers were also asked by Hansen to list what they thought were the culprits behind rising health care costs.

Hospital costs was the top-ranked cause of health care inflation listed by the employers, followed—in order—by inflation, physicians' costs, increased utilization, medical technology, administrative costs, government regulation, employee lifestyles and benefit changes.

Thirty-two percent of the surveyed employers noted that they had developed a corporate strategy for health care cost containment, while 41% said they had begun significant cost-containment efforts in the past two years. These strategies were bringing measurable results in the opinion of 19% of the responding firms, which estimated their savings at 16% of their health care expenditures.

The employers noted they used a variety of strategies to enlist employees' help in controlling their health costs. For instance, 48% said they plan to increase their employees' awareness of health care expenses by cost sharing. Thirty-four percent say they either encourage the use of low-cost health care providers or plan to do so, while and 31% either encourage or plan to encourage the use of HMOs and PPOs.

> '(More) companies are. . . promoting price-competitive health care markets,' Mr. Rosmann says.

Efforts are being made or will be made to reduce chronic illness and mental health problems by 22% of the respondents, and 10% reward or plan to reward employees who use less health care service.

**Employers say** they are also taking steps to control the charges by providers. The most common of these methods cited in the survey is the application of reasonable and customary, which was used by 76% of the responding companies.

Some 85% of the employers using R&C reviews say they periodically update their screens, while 74% adjust them for different geographic locations of physician specialties.

However, only 22% of the employers note they have hold-harmless provisions that prevent physicians from billing patients for charges that exceed reasonable and customary limits.

Only 9% of the responding companies said they used a well-publicized cost-containment tool: mandatory second surgical opinions. Another 11% said they encouraged second opinions by offering employees who use them increased coverage incentives. The remaining 80% said they only had a voluntary second opinion program.

Fifty-seven percent of the respondents said they cover third opinions, while 14% provide a list of physicians available to give second or third opinions.

Ten percent of the employers require pre-certification for elective hospital admission by 10% of the

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respondents, while 5% require them for inpatient or outpatient surgical procedures. Twenty-nine percent require pre-certification for dental care.

While relatively few companies require pre-certification, a greater number of respondents said they have utilization review programs. About half the companies (48%) said they have a utilization review procedure to determine whether the treatment given to an employee conforms to current medical practices. Forty percent review whether the diagnosis merits the type of treatment given before payment is made.

If the treatment is found to deviate from the normal standards, 39% of these employers said they would reduce payment to the provider, while 32% said they would negotiate with the provider. Twenty percent rely on remedial action through peer influence, including talking to the local medical society or hospital.

Cost savings through coordination of benefits provision proved popular with the surveyed employers. More than four-fifths (81%) of the survey respondents said inquire whether employees have duplicate health care coverage. Sixty-one percent routinely update their dupicate coverage files, and 69% say they help their health insurers gather the coordination of benefits information.

But, only 47% audit their claims administrators periodically to see how efficiently coordination of benefits programs are being handled.

Forty-four percent of the respondents say they subrogate claims with liability insurers when possible, but only 26% had a system for isolating claims that could be subrogated.

Companies are beginning to provide information to their employees on where to find the best health care bargain, the survey reveals.

For example, 13% of the respondents say they inform their employees about the locations and advantages of lower-cost providers. But, only 5% told their employees which hospitals charged lower rates and only 3% gave the same information regarding physicians.

Thirty-six percent inform their employees of alternate delivery systems, like HMOs and PPOs; 22% inform them of the cost savings of outpatient services; and 13% let them know about various alternatives to treatment.

But, companies don't seem to be making a concerted effort to keep their employees from becoming ill. For instance, the surveyed employers listed employee lifestyles quite low on the list of factors behing health costs increases, and the amount they spend on trying to promote healthy lifestyles reflects this belief, according to the survey.

However, Hansen's Mr. Rosmann notes, "Studies in the last three years have repeatedly shown that 80% to 85% of hospital care cost is incurred by the 13% to 20% of the population with chronic diseases affected by smoking, overweight, genetic disease and alcoholism."

Only 15% of the respondents said they offered reimbursement or incentive programs to encourage the use of preventive medicine. But, a larger number offer some type of preventive treatment program in-house.

Of these, the type of programs offered covered a wide range, including:

- Cardiopulmonary resuscitation programs, offered by 58% of the respondents.
- Periodic physical exams, offered by 40%.
- Hypertension or blood pressure monitoring, offered by 36%.
- Physical fitness programs, offered by 33%.

> 'Studies. . .have shown that 80% to 85% of hospital care cost is incurred by the 13% to 20% of the population with chronic diseases affected by smoking, overweight, genetic disease and alcoholism,' Mr. Rosmann says.

- Counseling services, offered by 33%.
- Stress managment programs, offered by 29%.
- Smoking cessation programs, offered by 28%.
- Substance abuse programs, offered by 23%.
- Immunizations, offered by 23%.
- Medical consumer education programs, offered by 18%.
- Weight-loss clinics, offered by 17%.
- Nutrition programs, offered by 13%.
- Well-baby care, offered by 12%.
- Glaucoma screening, offered by 9%.
- Cancer screening, offered by 8%.

Off-site exercise programs were reimbursed by 7% of the respondents, while lifestyle or behavioral analysis surveys were conducted by 7% of the respondents.

Finally, the survey notes that companies are becoming more involved on a corporate level in health care affairs.

Thirty-two percent of the respondents say they had company representation on a hospital or health provider board, local or state health system planning agency or other similar group, while 33% said they belonged to a local health care employer coalition.

Only 22% of the respondents said they had met with union representatives within the past year to discuss health care costs, and 37% said they had met with health care providers to discuss cost containment. Of these, 54% had met with the provider as an individual employer, and 43% had met in cooperation with other employers.

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*Free copies of the survey results may be obtained by writing Bonnie Ellis, A.S. Hansen Inc., 1080 Green Bay Road, Lake Bluff, Ill. 60044.*

# Allendale announces the only sprinkler in the

It's called ESFR, Early Suppression Fast Response—a remarkable breakthrough in sprinkler technology, designed to respond to a fire faster and more effectively.

Under "high-challenge" fire conditions, flames must be knocked down quickly. If they aren't, everything goes to hell. And you get burned.

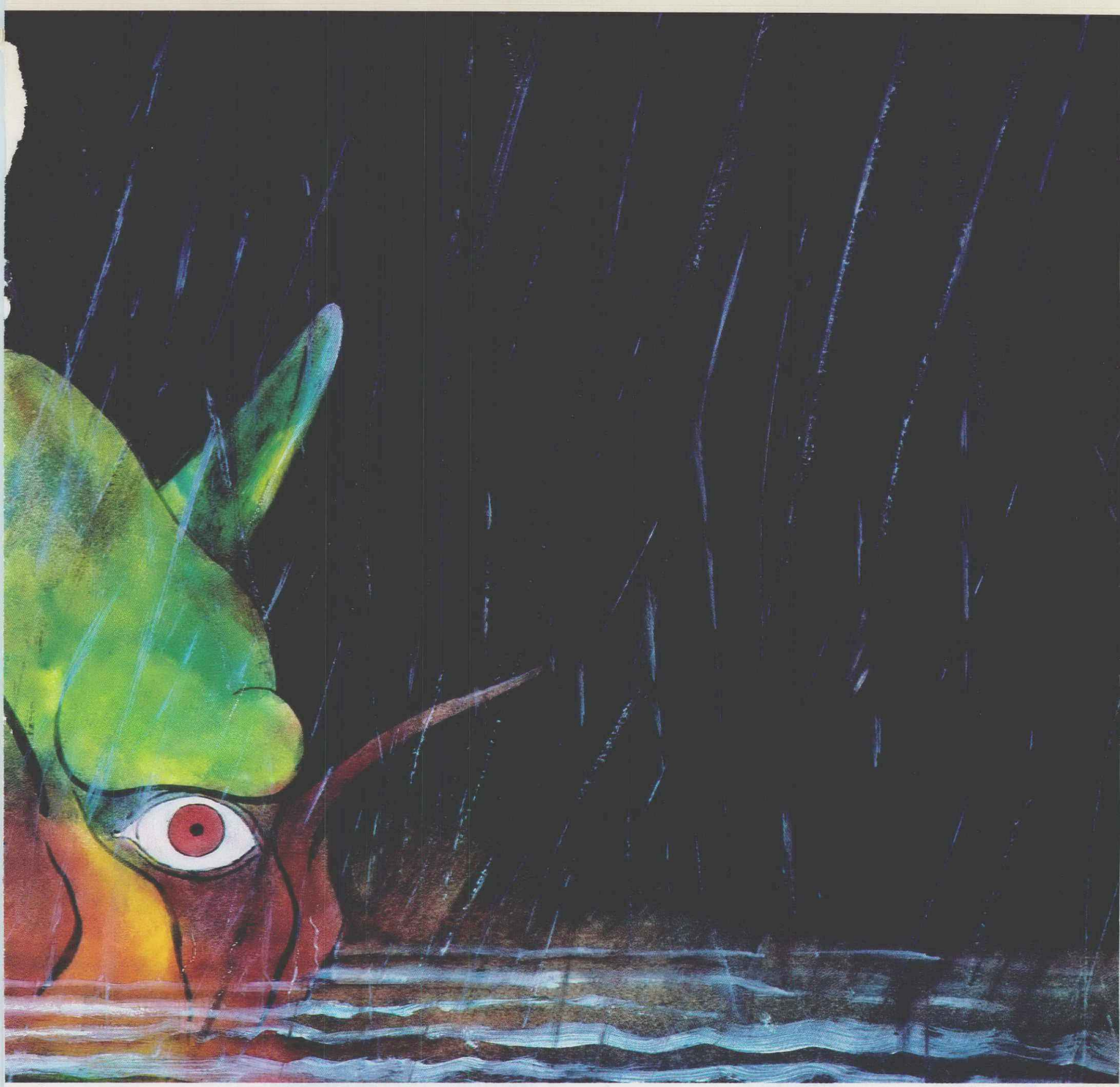
Or, present sprinklers can stop the flames but may operate in areas beyond the fire, flooding your inventory. Your company runs the risk of losing its share of the market. And you take a bath.

Either way, you can get hurt.

At Allendale, we've thought a lot about these problems. Enough to fund an extensive research program through the Factory Mutual System to develop ESFR sprinklers.

Entirely new testing methods were used in an effort to better understand the characteristics of high-challenge fires and how to suppress them. Years of research produced the ESFR program. These new sprinklers will be capable of meeting the task of a high-challenge fire, typical of highly-combustible materials. And capable of greater cost-effectiveness.

ESFR's performance is designed to be twofold:



# world designed to prevent hell and high water.

Early Suppression means this sprinkler will produce larger water drops resulting in better fire penetration. Fewer sprinkler heads should operate, so less water is needed overall.

Fast Response means the sprinklers have a greater thermal sensitivity and activate much earlier. So a fire is doused before it even has a chance to spread.

No hell or high water.

Prototype ESFRs are currently in development by several major sprinkler manufacturers and will soon be available for installation.

ESFR is just one way Allendale is showing you that we're more than an ordinary insurance company. Our concern for the companies we insure goes well beyond the property coverages we provide.

This is the Allendale approach. Working to take more of the risk out of risk management.

For an update on the ESFR program, write on your letterhead to Michael C. McIntyre, Sr. V. P. Marketing Staff, P.O. Box 7500, Johnston, Rhode Island 02919.

**Allendale Insurance/Factory Mutual System**

World leaders in risk management.

**perspective**

# Paying for post-retirement health care benefits

*Continued from page 48*

Medicare is frequently thought of as paying the medical bills of older Americans. In fact, a substantial amount remains to be paid after Medicare has paid its share, and that amount is growing.

When Medicare started in 1966, the individual had to pay the first $40 of hospital expenses; today that's $304. The individual, or the employer through the employer plan, pays the $304 deductible for the first 60 days of hospitalization.

When the program started, the individual had to pay $10 a day as coinsurance for the 61st through 90th days. Today, the individual's share is $76 a day for the 61st to 90th days. The monthly premium of Medicare B (medical services) has increased from $3 to $13.50 per month.

Employer-sponsored retirement plans generally pay for a substantial part of the amount that Medicare does not cover. The increases in these costs to employers reflect the fact that the Medicare payment is decreasing as a percentage of the total bill.

The part Medicare does not pay for, according to its provisions, has increased 760% since 1966. In addition, for those items where reimbursement is on a reasonable and customary basis, the charges allowed by Medicare are decreasing in relation to the prevailing level of charges, so that Medicare benefits are decreasing on a de facto basis. These types of changes are referred to as cost-shifting.

The taxes to finance Medicare, payable by both employer and employees, will probably rise in order to strengthen the weak financial condition of the Social Security Health Insurance Trust Fund. At the same time, the share of the health care bill paid by Medicare probably will keep decreasing. As older Americans are required to pay a larger portion of their health care expenses, retired workers will increasingly rely on health insurance coverage.

If employers are to provide such coverage to valued former employees, they must plan *now* for costs, which will increase in the future.

If the Financial Accounting Standards Board requires companies to recognize the expense of future retirement medical benefits for current employees, plan sponsors will be recognizing newly segregated liabilities that are growing at an alarming rate. Accounting for the cost of these benefits will identify this annual expense and spotlight its future growth.

It is time that plan sponsors consider investigating ways in which medical benefits for retired employees may be financed effectively.

Even though the FASB recommendations on post-retirement medical are only proposals, and any specific requirements are unlikely before 1986, it is important for employers to take action now. The proposals serve to remind employers of the real long-term costs of these benefits.

An employer's action plan should include an inventory of all benefit plans that include post-retirement features, a cost analysis, including a cash flow forecast and actuarial evaluation, and provision of relevant information to interested parties. This will enable a company to make plans to deal with the costs and, if necessary, change the benefits. Costs will be higher than expected for many companies because medical costs have risen dramatically since plans were first adopted. ■



## legal briefs

### Business interruption is sudden event

The CBG Co. sued Insurance Co. of North America under the business interruption provisions of its all-risk insurance policy for losses sustained as the result of an alleged accident in March 1974.

According to the claim, a boom on a piece of equipment failed and collapsed, resulting in extensive damage. CBG suffered a business interruption loss. At issue was whether the damage constituted a "sudden fortuitous and accidental event." The boom was new and failed early in its life.

The court concluded that no recovery was in order because the boom collapsed as a result of design flaw. The court said that all-risk insurance policies cover only losses arising from a fortuitous circumstance or casualty.

"The damage or loss must result," the court emphasized, "from an extraneous cause, and not from an inherent defect in the subject matter. . . ."

Therefore, no sudden event occurred, the court said, which gave way to a business interruption loss. *Compagnie des Bauxites vs. Insurance* Co. of North America, U.S. District Court for the Western District of Pennsylvania, June 21, 1983 (*BI*/03/My.-$5).

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

# Large industrials pay generous pensions: Study

By JERRY GEISEL

WASHINGTON—Despite tough times in the steel industry, U.S. Steel Co. continues to pay the most generous retirement benefits to salaried workers of any major industrial corporation, according to a new survey.

A salaried employee at U.S. Steel who retires this year at age 65 after 35 years of service and with a final salary of $35,000 will collect pension and Social Security benefits of $26,033. That compares to the $24,773 benefit that a 65-year-old who retired from U.S. Steel last year could expect to receive.

Right behind U.S. Steel in awarding generous retirement benefits is General Motors Corp., where a similar 65-year-old worker retiring this year with 35 years of service can expect to receive combined pension and Social Security benefits of $25,468, compared with $24,380 last year.

A detailed look at pension benefits provided by corporate giants, like U.S. Steel and General Motors, is provided in a survey by The Wyatt Co., an employee benefit and risk management consulting firm.

In the survey, Wyatt analyzed pension programs provided by the nation's 50 largest industrial companies to their salaried employees.

In compiling the survey, Wyatt calculated the pension benefits provided by the 50 companies for employees retiring after 35 years of service by assuming the employee started work with a salary of $4,146 and retired with an annual salary of $35,000. Wyatt also assumes the employee retired with an annual Social Security benefit of $8,512.

With these assumptions, Wyatt found that a 35-year employee at Tenneco Inc. can retire at 65 with a benefit of $24,951, up from $23,787 in 1983, while those retiring at R.J. Reynolds Corp. will receive $24,613, up from $23,289.

Other companies where employees who retire this year will collect high retirement benefits include Philip Morris Inc., $24,581, up from $23,442; and Atlantic Richfield Co., $24,357, up from $23,359.

When pensions and Social Security benefits are combined, employees at American's major corporations have a high percentage of final pay replaced by retirement benefits.

For example, that $26,033 average retirement benefit at U.S. Steel replaces 74.4% of final pay, while the $25,468 benefit at General Motors replaces 72.8% of final pay.

Not all major corporations, though, replace such a high percentage of salary with retirement benefits. At the other end of the scale, a 65-year-old who retires this year from General Electric Co. after 35 years of service will receive pension and Social Security benefits of $18,007. That will replace 51.4% of his or her final pay.

Similarly, new retires who worked for 3M Co. for 35 years can expect to receive Social Security and pension benefits of $18,065, which replace 51.6% of final pay.

Some 40 of the 50 surveyed companies require their employees to work 10 years before they are first and fully vested—what is known as cliff vesting.

But a number of other companies have taken a different approach to vesting. Employees who participate in Dow Chemical Co.'s pension plan become 50% vested after five years and then vest at the rate of 10% a year thereafter. At Philip Morris, employees are 20% vested after six years and then vest at a rate of 20% per year.

And at Standard Oil Co. of California, the pension plan provides 25% vesting after five years. In an employee's sixth through 10th years, he vests at the rate of 5% per year, and between his 11th and 15th year vesting continues at a rate of 10% per year.

While big companies may offer generous pension benefits, they have become increasingly reluctant to sweeten benefits to current retirees. For example, while 86% of companies have increased retirees' benefits at least once since 1980, only 16% made an adjustment during the last two years.

"This is due primarily to lower inflation and a recessionary economy—and may prove temporary," said Sylvester Schieber, director of Wyatt's Research and Information Center.

Companies that have implemented recent post-retirement increases include International Business Machines Corp., which increased benefits 3.84% per year of retirement, up to a maximum of 8%, for those who retired prior to Dec. 31, 1982, and Standard Oil of California, where employees who retired prior to Jan. 1, 1977, received increases of 9% to 91%, while those that retired between Jan. 1, 1977 and Dec. 31, 1978 got boosts between 2% and 4%.

A majority of the surveyed companies allow employees to retire at age 55 under early retirement provisions in their pension plans. But some companies offer even more liberal early retirement provisions.

For example, employees at Union Carbide Corp. can retire at age 50 with 10 years of service, while Standard Oil of California employees can retire at any age after they have put in 25 years.

On the other hand, salaried employees at companies like Dow Chemical Co., General Electric Co., Mobil Oil Corp. and Sun Oil Co. must wait until 60 before they qualify for early retirement.

Those employees that do retire early pay a financial penalty. At Western Electric Co., accrued benefits are reduced by 3% for each year a worker retires prior to age 55 if the employee has worked 30 years. The benefit reduction is 6% per year if the employee has worked less than 30 years.

At United Technologies Corp., accrued benefits are reduced 2.4% per year prior to age 62, while at Pepsico. accrued benefits are reduced 6% per year prior to age 62.

The survey reveals that 401(k) savings plans have increasingly become part and parcel of major corporation's benefit programs. A 401(k) plan, named for that section of the Internal Revenue Code, allows employees to contribute pretax dollars—up to a maximum of $30,000 a year—into a savings plan.

Some 32 of the 50 companies now include 401(k) provisions, up from the 13 offered them in 1983.

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*Copies of "A Survey of Retirement, Thrift and Profit Sharing Plans Covering Salaried Employees of 50 Large U.S. Companies as of Jan. 1, 1984," are available free from any Wyatt office or from The Wyatt Co.'s Research and Information Center 1990 K St., N.W., Washington, D.C. 20006; 202-857-9217.*

# *BI* conference tackles benefit problems

The current economic climate may leave benefit professionals with the feeling that they are sinking in a sea of new regulations, rising costs and other changes. But, the *Business Insurance* Employee Benefits Communication Conference can offer a lifeline.

The conference, "The Dollars & Sense of Communicating Employee Benefits," scheduled for July 30 and 31 at the Grand Hyatt Hotel in New York City, will look at effective ways of communicating the value of benefits to employees in a changing benefit environment.

General sessions will focus on planning and implementing communication efforts. Concurrent sessions will offer close looks at specific communication programs.

A highlight of this year's conference will be the 12th annual Employee Benefits Communications Competition awards presentation by *Business Insurance* Publisher Alfred Malecki.

Entries to the competition will be available for review in the EBC Gallery, and the latest information from consultants, insurance companies and service organizations will be available in the Benefits Literature Gallery.

The registration fee for the conference is $545, with a 10% discount for additional registrants from the same company. The fee includes sessions, workbook and educational materials, breakfast, coffee breaks, luncheons and a cocktail reception.

A block of rooms has been set aside at special rates for conference participants at the Grand Hyatt Hotel. The rates are $95 for a single room and $120 for a double.

Travel Headquarters Ltd. has been selected to help coordinate money-saving flights to New York for the *BI* conference. Travel Headquarters will provide travel arrangements at substantial discounts for registrants from every major city in the United States and Canada.

Advance conference registration will begin at 7 p.m. on July 29. There will be a cocktail reception at which conference participants will get a chance to meet speakers and other participants. The EBC Gallery and the Literature Gallery also will be open for browsing.

On July 30, the conference will begin with registration at 8 a.m. A continental breakfast will be served, and the EBC Gallery and Literature Gallery will be open.

The general sessions will begin at 8:30 a.m., with opening remarks by Kathryn J. McIntyre, editor of *Business Insurance*.

The conference's first session is entitled "Washington Vs. Employee Benefits," by Jerry Geisel, *BI's* Washington editor. Mr. Geisel will discuss legislative developments that affect the corporate benefits departments and explain the recent attacks on employee benefit plans by Congress and the Internal Revenue Service. He will also talk about what kinds of things to expect in the future from the nation's capital.

The next session, on strategic planning, will be led by Richard M. Coffin, vp of Towers, Perrin, Forster & Crosby. Mr. Coffin will define "strategic planning" and explain why it's especially needed in benefits communication. He'll focus on the principles and components needed as well as the specific steps to be followed in developing a strategic plan.

"It's a real kind of churning time for the benefits community, so this will take a longer-range view," Mr. Coffin said.

A session on budgeting will be led by Julio Estaban, vp and manager of creative services at Benefacts Inc. Mr. Estaban will review how the former EBC winners put together their successful programs and find the common elements. He also will talk about how to work on a budget for benefits communication, and how to "sell" the budget to corporate officials.

From this, Mr. Estaban says, "I will recommend a marketing approach to budgeting for employee benefit communication."

Polly Carpenter, president of Carpenter Graphic Design Inc., and Mary Anne Pakosta, in sales & client services with Frame One Inc., will lead a two-part session on media selection. They will offer innovative ideas for print and state-of-the-art audiovisual communication, and give some ideas about how to find the right medium for any communication need. The session will continue after lunch.

At the Monday luncheon, Mr. Malecki will honor the winners of the 12th annual EBC Competition. One of the winning audiovisuals entries will also be shown at the luncheon.

Concurrent sessions will begin Monday afternoon and be repeated Tuesday morning, so that participants will be able to attend all three sessions. These smaller, work-group sessions are designed to give participants a chance take an in-depth look at specific communications problems and solutions.

A session on flexible benefits will be led by Robert E. Mathieu, assistant vp of benefits for Mellon National Corp., and David M. Kieffer, senior vp for William M. Mercer-Meidinger Inc. In 1983, the judges of the EBC Competition called Mellon's award-winning communications program "one of the most effective descriptions of flexible benefits ever seen."

Mr. Mathieu and Mr. Kieffer will concentrate on how to communicate a clear understanding of flexible benefits to employees so that employees can make choices.

A session on "Communicating On Your Own" will be led by Russ Ringl, personnel director for Playboy Enterprises. He will explain how Playboy set up its own system for communicating benefits to employees and keeping them updated and informed on the benefits offered.

The third session, on "Flexible Spending Accounts & the IRS," will be led by Ed Dewees, director of the Department of Human Resources at Thomas Jefferson University in Philadelphia. Mr. Dewess will talk about the shock waves from the Internal Revenue Service's recent publication of proposed rules that severely restrict flexible spending accounts and tell how he went ahead with a program that anticipated the restrictive IRS regulations.

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Also on Tuesday morning, marketing and communications consultant Herb Zeltner of Herbert Zeltner Inc. makes a return visit to the conference. He will present a two-part program, called "A Look at This Year's Winners," that takes a close-up look at what makes a winning benefits communications program.

**This lively,** entertaining and informative program has been the highest-rated part of the conference by past participants.

The second part of this program will be held after lunch on Tuesday.

A session on "Management Training," by Mr. Kieffer of William M. Mercer-Meidinger Inc. also will be held Tuesday afternoon. Mr. Kieffer will focus on interpersonal communications and other skills essential in training the people who are needed to have a successful program of communicating benefits: managers, meeting leaders, counselors, human resource personnel and sometimes even employees.

**Ms. McIntyre,** *Business Insurance* editor, will give the closing remarks, and the conference will adjourn at 3:30 p.m.

To register for the conference, write to *Business Insurance*, Communication Services Department, 220 E. 42nd Street, New York, N.Y. 10017. Payment is required with registration.

All cancellations must be received in writing. A full refund will be made on cancellations that are received before July 1. A $100 service charge will apply to cancellations that are received after July 1. No refund will be made on cancellations that are received in less than five business days before the conference begins.

However, at any time the name of another person from the same company may be substituted for the registrant without penalty.

All registrations will be confirmed in writing.

Registrants taking advantage of the special rates at the Grand Hyatt Hotel must mention the *Business Insurance* conference when making a reservation.

Hotel cards will be included with conference registration confirmation, or registrants can call the hotel at 212-883-1234 or toll-free at 800-228-9000. The special rates will be honored only until July 15.

**To take** advantage of the air fare discounts offered by Travel Headquarters, registrants also must mention the *BI* conference when making reservations. Air fare information and reservation cards will be included with conference registration confirmation.

Travel space is limited, and reservations will be accepted on a first-come, first-serve basis. In Illinois and Canada, call 312-641-3088; from anywhere else in the United States, call toll-free 800-621-1676.

For additional information on the conference, call Ann Vazquez at 212-210-0137. ■

# Kezer named acting regulator in Colorado

DENVER—John Kezer is serving as interim acting insurance commissioner in Colorado until voters decide this November whether to change the way the state's insurance regulator is selected.

Mr. Kezer recently replaced Daniel J. Colaiannia, who had served as interim acting commissioner since the retirement of J. Richard Barnes, who had held that post for almost 20 years (*BI*, Nov. 21, 1983).

Mr. Barnes was the last insurance commissioner in the nation who was a civil service employee. In Colorado, the commissioner is selected from among the top civil service test scorers by the executive director of the Department of Regulation.

However, voters will be able to change that selection process through a referendum ballot that calls for the commissioner to be appointed by the governor.

Mr. Kezer, 37, comes to the state Insurance Division from the Department of Employment and Training, where he was director. He also has been an assistant in the attorney general's office. It's expected that he will continue in the insurance post until after the November election.

## around the states

### Auto claims

NEWARK, N.J.—A new provision in New Jersey's no-fault automobile insurance law is being challenged in federal court by a state employers association.

The suit, filed in U.S. District Court in Newark, N.J., focuses on a clause in New Jersey's Automobile Insurance Freedom of Choice and Cost Containment Act—the state's no-fault law—that permits motorists to file up to $2,500 in medical claims arising from an automobile accident with their employer's medical insurance plan.

This provision took effect Dec. 3, 1983. Previously, employees could only file such claims with their own auto insurers.

Requiring employers to pay these claims will increase their annual insurance costs by as much as 3%, alleges the 700-member Employers Assn. of New Jersey, which filed the challenge.

"The individual will save money, because his auto insurance premiums will be reduced," said Harold R. Hawkey, the association's executive director.

"But costs will just be shifted from one pocket to another. There's no real saving," he added.

A spokesman for the New Jersey Insurance Department, named as the defendant in the suit, would not comment on the legal action.

In issuing the challenge, the employers' association alleges the state law is pre-empted by the federal Employment Retirement Income Security Act, which has jurisdiction over employee health insurance matters.

Mr. Hawkey said he did not expect the suit to be resolved quickly.

### Statute of limitations

ALBANY, N.Y.—The statute of limitations for lawsuits on behalf of workers injured or killed as a result of exposure to harmful substances would be extended by bills being considered in the New York Legislature.

Assembly Bill 3547A, which passed the state Assembly March 12, would allow suits to be filed for two years after a person becomes aware of an injury caused by exposure to a harmful substance. The state's current law requires suit to be brought within two years of exposure.

An Assembly memo explaining the bill notes: "For decades, New Yorkers who have been injured or who have died due to exposure to asbestos, radiation, chemicals and other toxic or carcinogenic materials have been denied relief because of archaic statutory time limitations for filing injury claims. . . .This legislation corrects that injustice."

The bill also authorizes punitive damages to be awarded "when an injury or death was the result of the defendant's reckless disregard for the safety of consumers."

A similar bill—S.B.9158, introduced in the Senate May 3 by Sen. Ronald B. Stafford, R-Plattsburgh—would permit claims to be filed for two years after the time injuries should have been discovered.

A spokesman for Sen. Stafford said he expected the Senate to take action on the bill before the end of its 1984 session, in July.

### Idaho commissioner

BOISE, Idaho—Trent M. Woods is stepping down as Idaho's director of insurance at the end of May to join the George Washington Corp., an insurance holding company in Jacksonville, Fla.

Wayne L. Soward, 46, who has been the department's administrator of regulation, was nominated by the governor to replace Mr. Woods. The Senate is expected to confirm his nomination early next year when it goes into session.

Mr. Soward joined the Idaho Department of Insurance in 1973 as an investigator. Since then he has been a supervisor in the public service and consumer protection divisions of the department.

As administrator of regulation, which is like a chief deputy in other juridictions, Mr. Soward has been in charge of 10 insurer liquidations in Idaho.

Before joining the department, Mr. Soward worked in the insurance industry as a claims representative, field adjuster and salesman. He has an undergraduate degree in general studies, with a minor in business and history, from Eastern Oregon State College in La Grande.

Mr. Woods said he is leaving the regulator's post, a job he has held since 1980, because George Washington Corp. "made too good an offer" and because it allowed him to move to Florida, where he was born.

In the new position, Mr. Woods will handle internal administration.

### Curiale promoted

NEW YORK—Superintendent of Insurance James P. Corcoran has announced the appointment of Deputy Superintendent Salvatore R. Curiale as first deputy superintendent of the New York Insurance Department.

Mr. Curiale replaces Donald D. Gabay, who resigned as first deputy after more than six years in the post. ■

# Hancock unit may acquire Unigard Mutual

Hanseco Insurance Co. of Boston, a property/casualty subsidiary of John Hancock Mutual Life Insurance Co., says it is discussing the possible acquisition of Unigard Mutual Insurance Co. of Seattle.

The two companies have signed a letter of intent to negotiate the acquisition, but apparently have not reached a definitive agreement.

Any acquisition would be subject to approvals by regulatory authorities and Unigard policyholders.

A Hanseco spokesman said that the insurer's business is focused primarily in the East and that Unigard would give it a greater West Coast presence.

Unigard writes a variety of personal and commercial property/casualty lines.

## HMO partnership

HealthAmerica Corp. says it has raised $25 million for the formation of five new health maintenance organizations through a limited partnership offering.

HealthAmerica Partners L.P., a limited partnership organization, was formed to sell 500 partnership units to individual investors for $50,000 each. Individual investors typically receive tax and other benefits through such arrangements (*BI*, May 14).

The partnership will be managed by another HealthAmerica Corp. subsidiary, and HealthAmerica will have the option of buying the partnership's HMOs after four years.

The five HMOs will be opened within the next 12 months. Four will be located in Birmingham, Ala.; Omaha, Neb.; Hampton Roads-Norfolk, Va.; and Little Rock, Ark. A fifth location is yet to be selected.

## 401(k) plans

The Life Insurance Co. of Virginia, a Richmond-based subsidiary of Continental Group Inc., plans to market 401(k) salary reduction plans for small employers in conjunction with Barclay Group, a Philadelphia-based employee benefit plan administrator.

The plans, administered by Barclay, are for firms with fewer than 500 eligible employees.

## New brokerage

Repath Associates, a new insurance brokerage, has been formed in Tennessee.

The new firm, headed by Derek J. Repath, is located at 4301 Hillsboro Road, Suite 214, Nashville, Tenn. 37215; 615-297-1739 or 800-621-2517.

## Branch office

Insurance & Financial Consultants Inc., a risk and insurance management consulting firm based in Austin, Texas, has opened a new office in Cleveland.

The office will be directed by May Lou Kirk, who is a vp and principal of the company. Ms. Kirk had been a consultant with Crain, Langer & Co. in Rocky River, Ohio, and is a past president of the Insurance Consultants Society.

The new office is located at 8905 Lake Ave., Cleveland, Ohio 44102; 216-631-2004.

## Agency name change

Ancel Earp, McEldowney & McWilliams Inc., an insurance agency based in Oklahoma City, changed its name to McEldowney, McWilliams, Deardeuff & Journey April 1.

## Illinois exchange

The Illinois Insurance Exchange says that direct premiums and reinsurance assumed by its eight syndicate members rose 293% in 1983, to $7 million last year from $2.39 million in 1982.

About one-third of this growth came from Travelers Illinois Syndicate, a unit of Travelers Indemnity Co., according to James M. Skelton, the exchange's executive director.

The number of insurance contracts issued rose by 454%, to 581 in 1983 from 128 in 1982.

Meanwhile two new brokers have been approved as Exchange participants, bringing the number of broker members to 45.

The new brokers are Bryson Associates Inc. of Jenkintown, Pa.; and Lodderhose & McGinn Inc. of Chicago.

## markets

## Office reorganization

Interstate Insurance Group of Chicago has reorganized its underwriting operations.

The group's all-risk property department has been consolidated with other property underwriting functions into a new property underwriting department. The new department is headed by Ronald L. Kuczynski, a vp.

A separate casualty underwriting department has been formed, headed by Vp Thomas E. Long.

## Acquisitions

**ISU/Gold Insurance Agency Inc.** of San Diego has acquired **Preferred Risk-Insurance Agency**, a Los Angeles-based agency marketing the products of **Preferred Risk Mutual Insurance Co.** of Des Moines, Iowa.

## New offices

**McNeary Insurance Consulting Services Inc.**, the property/casualty consulting division of the actuarial consulting firm of **Booke & Co.**, has opened a new office headed by Arthur L. Fuller III, at Northwest Office Park, Atlanta, Ga. 30339; 404-955-0324.

**Tindall Associates Inc.**, an insurance consulting firm, has moved to new offices at 3041 Woodcreek Drive, Suite 150, Downers Grove, Ill. 60515; 312-810-1330.

**Richard L. Jarrett Sr. Inc.**, a Dallas-based excess/surplus lines broker, has opened a new branch office at 2727 E. 21st St., Suite 614, Tulsa, Okla. 74114; 918-742-2176. The new office is headed by James E. Christie.

**Captive & Self Insurance Services Inc.**, a captive insurance company consultant and manager based in San Bruno, Calif., has opened a Southern California office headed by Chris De Sales, assistant vp. The new office is located at 11827 Ventura Blvd., Studio City, Calif. 91604; 213-509-0885.

**Mattei-Webber Inc.** and **The Underwriters Alliance** have moved to new offices at 1405 Fifth Ave., Seattle, Wash. 98101; 206-682-0991. ■

# American General promotes William Dandy

**William E. Dandy** has been named senior vp and director of underwriting at American General Fire & Casualty Co. in Houston, a subsidiary of Maryland Casualty Corp.

Mr. Dandy was previously a senior vp of commercial lines underwriting with the company. He joined the company in 1949.

Also, **William C. Alexander II** was promoted to vp and director of claims at American General in Houston. He had been a field claims administrator in the Atlanta office. And, **Kenneth D. Javor** named vp and director of marketing and branch operations for American General in Houston. He was most recently vp of marketing for the company in its Houston office.

**Other insurer changes:**

**Dan Francis** named vp in the business insurance division of California Casualty Insurance Group in San Mateo, Calif. Mr. Francis joined California Casualty in 1979.

**Catherine Barr** named president of Independence Health Plan of Southeastern Michigan Inc., a health maintenance organization. Ms. Barr now has complete responsibility for the HMO, a wholly owned subsidiary of Independence Health Plan Inc., based in Southfield, Mich. Also, **Manilal S. Porwall** named vp of operations for Independence Health Plan. Before joining Independence Health Plan, Mr. Porwall was associate executive director of Group Health Plan of Southeastern Michigan.

## comings & goings: industry

Hanesco Insurance Co., the property/casualty unit of John Hancock Mutual Life Insurance Co., promoted **Stephen F. Kraysler** to executive vp from senior vp. Also, **E. Frederick Fossa** named senior vp-corporate operations. He had been vp and actuary. Also, **Harry W. Wilcott** promoted to senior vp-insurance operations from vp.

**William E. McCool** appointed vp of Indiana Insurance Co. and Consolidated Insurance Co., based in Indianapolis. Mr. McCool will be property/casualty manager in the home office claims division.

**Steven W. Wozniak** named regional vp and regional underwriting manager of Allendale Insurance's Midwest region, based in Oakbrook, Ill. Mr. Wozniak joined the firm in 1976.

**Daniel J. Begley** named president of Attorneys' Liability Assurance Society Ltd., a Bermuda-based insurance company. He succeeds **Thomas S. Chittenden**, who had been president of the firm since it was founded in 1979. Mr. Chittenden will remain as a consultant to the company. Mr. Begley had spent 29 years with Allstate Insurance Group, most recently as field executive vp of the Eastern zone.

**Loren Alter**, senior vp of finance for Zurich-American Insurance Cos., appointed chief operating officer and elected senior vp of Zurich Holding Co. of America. He joined Zurich-American in 1979.

**Richard D. Given** named vp and director of underwriting at Maine Bonding & Casualty Co., a subsidiary of Maryland Casualty Co. in Baltimore. He had been vp and property manager.

### Agents/brokers

**Timothy Molloy** named resident vp of Alexander Howden Insurance Services of Texas Inc. in Dallas. Mr. Molloy will handle all Southwestern operations. He had been assistant vp at Risc Inc.

**Peter J. Volpe** joined the risk management department of Marsh & McLennan Inc. in Seattle as vp. Mr. Volpe joined M&M in 1971.

**Brad Stammler** named vp and manager of the construction division at Corroon & Black of Ohio in Columbus. Mr. Stammler has been with the company five years. Also, **Stuart H. Reynolds** joined Corroon & Black as vp and manager of the surety and fidelity division. And, **Lynn E. Larson** joined the company as vp and manager of the corporate division.

**William P. Martz** elected senior vp of Rollins Burdick Hunter Agency of Ohio Inc. Also, **Louis H. Bauman** elected vp of the firm.

### Excess/surplus

**Bobby Maes** appointed senior vp of commercial underwriting for Guaranty National Cos. in Englewood, Colo. Mr. Maes was most recently assistant vp of casualty underwriting with Reliance Insurance Co.

**Phillip J. See** and **George Tsui** elected vps at Atwater McMillian Inc., a specialty risk/surplus lines unit of St. Paul Fire & Marine Insurance Co. in St. Paul, Minn. Mr. See was elected vp-underwriting services. He had been a claims service manager with St. Paul Fire & Marine. Mr. Tsui was named vp-major accounts underwriting. He had been Atwater McMillian's financial underwriting officer.

**Doug Larson** appointed vp of American Agrisurance, a managing general agency and special crop and hail insurer, in Council Bluffs, Iowa. He will direct the operations of the special risk division.

**Kenneth J. Peterson** named executive vp at Gainsco Inc., a surplus lines underwriter headquartered in Fort Worth, Texas. He joined the company in 1982 as senior vp and as executive vp of the company's computer software subsidiary, Agents Processing Systems Inc., a position he will retain. Also, **Jack L. Johnson** named senior vp of underwriting for Gainsco. He will manage all underwriting activities at the company. He joined Gainsco in 1979.

### Other suppliers

**John J. Connelly** joined Yaffe & Offutt Associates Inc. in Baltimore as manager of group insurance/flexible benefits. Y&O is an employee benefit and actuarial consulting firm.

**Frederick E. Wicks** named president and chief executive officer at Self-Insurers Service Inc., a claims administration firm. He had been vp of Virginia Surety Co. Other changes at Self-Insurers Service include **Thomas P. Beresky**, named vice chairman, and **Herbert J. Carlson**, named executive vp. Mr. Beresky had been president of the firm, and Mr. Carlson had been senior vp. The moves follow the retirement of the company's chairman and chief executive officer, **R. Raymond Muller.**

**Walter B. Kendall** named president of Chicago-based Certified Claim Corp. He had previously been a vp with the company. Before joining Certified, Mr. Kendall was claims director for Stewart Smith Mid-America Inc. ■

# Conable FSA proposal would cut revenue: EBRI

By JERRY GEISEL

WASHINGTON—Enactment of a proposal to place a ceiling on the amount of reimbursement offered through flexible spending accounts would lead to a small revenue loss for the federal government, a research group says.

The Employee Benefit Research Institute estimates that enactment of the proposal by Rep. Barber Conable, R-N.Y., would cost the federal government $61.8 million in income and Social Security taxes between 1985 and 1989.

The Conable proposal, which may be attached to tax legislation to be considered by a House-Senate conference committee, would require employees to choose in advance the benefits they want to fund, would place a cap on the value of benefits offered in an FSA and would require employees to roll over unused benefits into a benefits bank for use the next year (*BI*, May 7).

In its calculations, the EBRI assumes that the number of employees eligible for FSAs will jump from 1.5 million in 1985 to 9.4 million in 1989.

The EBRI also assumes that the average employee will have his or her salary reduced by $600 a year and that employers will, on average, contribute $400 per employee to their FSAs.

The $61.8 million cost estimate compares to an $11.5 billion revenue loss between 1985 and 1989 projected by the Treasury Department if FSAs continue to expand without limitation.

Under the Conable proposal, the maximum amount of benefit options, except for dependent child care, offered through an FSA would be limited to $2,000.

For dependent child care, the cap would be set at $2,400 for participants with one child and $4,800 for employees with two children.

In a related development, more employers are using newspaper ads to lobby Congress on rules affecting flexible spending accounts.

In an "Open Letter to Congress," published in The Washington Post, the Employers Council on Flexible Compensation says federal legislators must act to overturn proposed Internal Revenue Service rules on FSAs.

Under those rules, which will apply retroactively, "employees in nearly every state and congressional district will be forced to pay back taxes, interest and penalties on medical and child-care benefits they have already received," the council notes.

While Congress authorized flexible benefit plans six years ago when it added Section 125 to the Internal Revenue Code, the IRS has refused to provide guidance—until now—on the types of plans that will be allowed.

"Under the circumstances, to apply these new rules retroactively is arbitrary and unjust," according to the council, whose 150 members sponsor or are interested in flexible benefit plans.

The council says in ad that it favors the proposal by Rep. Conable.

Four other trade associations—the U.S. Chamber of Commerce, the National Assn. of Manufacturers, the ERISA Industry Committee and the Assn. of Private Pension Plans—also recently advertised in The Washington Post to protest proposed limits in legislation passed by the House, H.R. 4170, on reserves held by 501(c)(9) trusts and experience-rated benefit plans (*BI*, May 21).

## Multiemployer law

The National Assn. of Stevedores says it is time to change the Multiemployer Pension Plan Amendments Act of 1980.

The Washington-based trade association, whose 49 members are engaged in stevedoring and marine terminal operations, says Multiemployer Amendments Act should be overhauled so that multiemployer plans cannot increase benefits until the plan is substantially funded.

In addition, uniform accounting rules, actuarial assumptions and a single interest rate should be set by the federal Pension Benefit Guaranty Corp. and not by the multiemployer plans.

Furthermore, the stevedoring group says employers that are involuntarily forced to withdraw from underfunded multiemployer plans should be exempt from paying a share of the plan's unfunded vested benefits.

## OSHA hearings set

The Occupational Safety and Health Administration will hold hearings this summer in Washington, Casper, Wyo., and Dallas on its proposed safety standards for oil and gas well drilling and servicing.

The workplace safety hearings will begin at 9:30 a.m. on these days and locations: July 24-26 at the Department of Labor Building Auditorium, 200 Constitution Ave. N.W. in Washington; July 31 and Aug. 2 at Ramada Inn, Mardi-Gras Room, Interstate 25 and Center Street in Casper; and Aug. 8-10, at the Sheraton-Dallas, Junior Ball Room, 400 N. Olive St in Dallas.

Issues to be discussed at the hearings include:

- Testing of equipment to prevent blowouts.
- Hearing conservation for workers.
- Emergency escape devices.
- Fire prevention measures.
- Design of control knobs and equipment levers.

Those that want to participate in the hearings should contact Tom Hall, U.S. Department of Labor, OSHA Division of Consumer Affairs, Room N-3662, 200 Constitution Ave. N.W., Washington, D.C. 20210; 202-523-8024.

## Work comp premiums

Employers spent $22.9 billion in workers compensation premiums in 1981, up 2.9% from 1980, the Social Security Administration reports.

However, employer costs for workers compensation, as a percent of payroll, dipped slightly, declining to $1.84 per $100 of payroll in 1981 compared with $1.96 per $100 of payroll in 1980.

The Social Security Administration also reports in an article in the April issue of the Social Security Bulletin that injured workers collected $15 billion in workers compensation benefits in 1981, up from $13.6 billion in workers comp benefits in 1980. ■

# Use all available cost-control tools: Expert

## CEBS designees discuss benefit issues

HERSHEY, Pa.—Certified Employee Benefit Specialists gathered in Hershey from April 29 to May 2 to discuss the current state of employee benefits at the third annual symposium of the International Society of Certified Employee Benefit Specialists.

The annual symposiums are open only to those who have received the CEBS designation, which is conferred after the successful completion of a 10-course program co-sponsored by The Wharton School of the University of Pennsylvania in Philadelphia and the International Foundation of Employee Benefit Plans in Brookfield, Wis.

To date, 871 have received the designation, while an additional 16,000 people are enrolled in the program.

Of those certified, 85 attended the conference held at the Hotel Hershey. And, while benefits was the key topic of conversation, the subject of chocolate was often discussed, as many a sweet dessert and candy treat was provided by the hotel, built by Milton S. Hershey of chocolate bar fame.

For more information on the CEBS degree or the ISCEBS, contact ISCEBS President Robert B. Jones, assistant vp and manager of the executive benefits division, Equibank, Pittsburgh, Pa.

**By SALLIE J. DRURY**

HERSHEY, Pa.—Employers should make sure they are taking advantage of every health care cost-containment opportunity, one benefit manager says.

Speaking at the annual symposium of the International Society of Certified Employee Benefit Specialists in Hershey, Edward J. Myatt, benefits planning and compliance consultant with Atlantic Richfield Co. in Los Angeles, summed up the areas on which benefit managers should focus in their battle to fight health care costs.

One of those areas, he said, is wellness incentives.

"In wellness programs, the people in the corporate benefits planning and medical departments are teaming up to develop programs to encourage their employees to change their lifestyle," Mr. Myatt said.

> '(HMO) participation is increasing by about 10% each year," Arco's Mr. Myatt explains.

"Health enhancement programs —which include stop-smoking, nutrition, weight-control, physical fitness, stress management, cancer detection, hypertension screening, periodic physicals and psychological counseling—encourage the employees to change their lifestyle" to a healthier one, he noted.

Plan design changes are another area of concern to benefit managers, Mr. Myatt said.

Comprehensive health care plans that include some cost sharing, in contrast to first-dollar medical plans, "will convince our employees to use their medical plans effectively and cut down on the over-utilization of medical facilities.

"Our company mailed a copy of the book "Take Care of Yourself—A Consumer Guide to Medical Care," written by Donald M. Vickery, M.D., and James F. Fries, M.D., to all of our employees and retirees, along with their comprehensive medical plan enrollment package.

"We had a Cadillac plan and then we said, 'You people will start making choices,' " Mr. Myatt explained.

Since the additional cost-sharing of a comprehensive medical plan gets employees more involved in "shopping" for medical coverage, the book assisted them with this new task. "We said, 'Read the book. Join the team.' "

Employee assistance programs are another tool through which employers can help control costs that costs relatively little. These programs help "reach employees at the early stages of their (psychological or financial) problems and refer the employee to the proper facilities for help," he said.

And, absentee-control programs are another cost-cutting area. "Many employers have become aware of the fact that excessive absenteeism has become an unacceptable cost. Absentee-control programs are being implemented and they are showing a reduction of 25% to 35% in lost time due to absenteeism."

One way to reduce absenteeism is to keep a close check on short-term and long-term disability plans, Mr. Myatt said. "Some employers are involving their supervisors in the absentee-control programs with the possibility of termination of employees who have unacceptable attendance records or who have abused the sick-pay plans," he said.

Supervisors can keep closer contact with individual employees and can more easily determine abuse of sick time, short-term or long-term disability benefits than can a corporate claims examiner or benefits manager, he explained.

Similarly, workers compensation is another area that can be abused and thus should be examined for cost-containment opportunities.

"Employers have seen the costs of their workers compensation claims increase considerably with no relief in sight, with all types of illnesses now being accepted as compensable," Mr. Myatt said. "The employers must set up strict review procedures for claims," making sure the illnesses cited fall under workers compensation.

For medical care, alternate delivery systems—such as health maintenance organizations, preferred provider organizations and surgicenters—can save money for an employer who builds incentives into the company plan to encourage employee use.

"Many employers. . .have offered HMOs to employees and the participation is increasing by about 10% each year," Mr. Myatt said. "In California, the participation in HMOs ranges from 10% in the oil industry, 35% in the aerospace industry and 75% for the employees of the city of Los Angeles.

"PPOs are beginning to take hold" as well, he continued. "With effective utilization controls, the PPOs can reduce medical plan costs by reducing the length of hospital stays and by using outpatient facili-

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ties."

Some of those outpatient facilities are medical clinics, surgicenters, skilled nursing facilities, hospice and health care in the home.

"These settings are cost-effective and provide quality medical care," he said.

Utilization review is a necessary requirement to get the most mileage out of a PPO, but it is also a useful cost-containment tool apart from the preferred provider organization, Mr. Myatt noted. The types of utilization review that can help control costs include:

- Pre-admission certification. This takes place prior to hospitalization, and prevents one-day hospital stays for procedures that could be performed on an outpatient basis. Pre-admission certification can also determine in advance the expected length of stay for a particular diagnosis.
- Concurrent review. This is conducted while the patient is hospitalized, and guards against inappropriate or unnecessary procedures, as well as encourages discharges as early as possible. "A reduction of one day for each patient results in a savings of $600 to $700 per patient, which is a considerable savings to the medical plan," Mr. Myatt said.
- Retrospective review. After a period of hospitalization, this type of review can reveal which health care providers are the most cost-effective.
- Hospital audits. "Employers, through specialized (hospital auditing) firms, are making use of hospital audits (to determine necessity and efficiency of care), which are returning $5 to $10 for every dollar invested," Mr. Myatt said. "Employees will also be looking at their hospital bills more closely now that they are responsible for paying a portion of it."
- Data collection. Computer-generated data can reveal where health care dollars are being spent —on what employees, at which hospitals, with which physicians and for what procedures. With this data, employers can develop benefit plans and cost-containment strategies that will be most effective in their unique situation.

**The reimbursement** of hospitals and physicians is another area where both the federal and state governments and the private sector see cost-containment opportunities, Mr. Myatt said.

The national diagnosis-related group or DRG program for Medicare reimbursement is designed to give hospitals an incentive to operate more efficiently (see story, page 63). Meanwhile, "state Medicaid programs may follow California, which has negotiated per-diem payments to selected hospitals," while other states may follow the DRG reimbursement system, he said.

Mr. Myatt also said he anticipates that both federal and state governments will contract with health maintenance organizations for Medicare/Medicaid payment.

As a result of these federal cost-cutting programs, the private sector "has had to bear the cost shift and pick up those costs that should have been paid by federal Medicare and state Medicaid if they had paid their fair share," Mr. Myatt said. HMOs and PPOs are, in part, reimbursement systems employers hope will tackle costs while increasing hospital competition.

Employer coalitions are another tool benefit managers can use to help bring health care costs under control.

**"I'm convinced** that the employer coalitions will have the greatest impact in changing the health care delivery system to become cost effective and meet the real needs of the purchasers who are the employers, employees and retirees," Mr. Myatt said.

Benefit managers need to be mindful not only of their own high health care costs, but also of federal government intervention, since the government wants to contain its own health care expenditures and generate additional tax revenue.

"The federal government, through many different pieces of legislation, is attempting to generate tax revenue, which in many cases is working at cross-purposes with the private sector initiatives for cost containment," Mr. Myatt said.

"If the private sector—through the employers' efforts and the providers' cooperation—does not obtain solutions to the medical care (cost) crisis, then the government is ready (with its own solutions) and, like England and Ireland, we can all purchase private insurance on the side to avoid waiting nine to 12 months for elective surgery" in a government-paid clinic. ■

# Flexible programs increase workers' interest in benefits

By SALLIE J. DRURY

HERSHEY, Pa.—Flexible benefit plans are not only a way to reach diverse segments of the employee population while using health dollars more efficiently, they also heighten employees' benefits consciousness, one benefit manager says.

"I just received a memo from an employee asking if we would add an Individual Retirement Account as an option on our flexible benefit plan," said Mary Jane Klansky, director of employee benefits for Educational Testing Service, based in Princeton, N.J.

"That tells me employees really care and get involved, and that kind of communication you can't buy," Ms. Klansky explained.

Speaking before a session of the annual symposium of the International Society of Certified Employee Benefit Specialists, held recently in Hershey, Ms. Klansky shared with other ISCEBS members the 10 years of experience ETS has had with flexible benefit plans.

The flexible plan at ETS has been in place since 1974, when a limited-option plan gave employees choices among non-taxable benefits, like dental insurance and savings plan options. Since then, the flexible plan has grown to include taxable benefit options and other new benefits (*BI*, Sept. 5, 1983).

However, the plan is still very structured, providing a "core plan" that includes medical and life coverages. Options are restricted to savings plans, dental insurance, additional vacation days, day-care benefits and other benefits "above and beyond the core.

"We are looking ahead toward total flexibility, though," she said. "That is, a totally flexible benefits and compensation package which would give employees a choice for every benefit they receive—but that wouldn't be until 1986."

Ms. Klansky allayed some of the common fears benefit managers have regarding flexible benefits.

"We had no trouble writing flexibility in with our carrier (Prudential Insurance Co. of America)," she said, "and they were very willing to work with us and what we wanted to do.

"We were also concerned with adverse selection when we offered the dental insurance option. We thought only those employees anticipating a big dental expense would take out the coverage," Ms. Klansky continued.

"But, we put in incentives for continued enrollment, so that a larger percentage of dental expenses are paid for as you continue in the plan. And, we were surprised to find that most people were purchasing the insurance for maintenance.

"We also did not increase staff," she said. "I have four people reporting to me and we have four nurses on staff. Actually, this year I decreased (staff) by one position."

However, she admitted that flexible benefits are so different from conventional benefit plans that the transition is difficult.

"It's horrendous in the beginning. I'm not going to kid you," she said. "It costs money, but then it costs money to stay with any plan."

It was a particularly complicated and costly transition for ETS because it designed and implemented its own plan administration software, "and it took us two years from the time we decided to do it to the time we had copyright enrollment forms," Ms. Klansky said.

The development of the original software cost ETS $250,000, and the total start-up costs came to $1.4 million, including the cost of benefits. However, ETS did not pay a consulting fee because the complete program was installed internally.

As for the proposed Internal Revenue Service regulations affecting flexible benefits, especially flexible spending accounts (*BI*, May 14), Ms. Klansky urged benefit managers that "if you have any clout with your senators or representatives, ask them to get in touch with Sen. Robert Packwood, R-Ore., to sign the letter he is sending" to the Senate Finance Committee that defends many provisions in FSAs that have been challenged by the IRS.

"That is very important," Ms. Klansky continued. "We have got to get the support for our flexible benefit plans and FSAs." ■

# PPOs not all the same, consultant says

By SALLIE J. DRURY

HERSHEY, Pa.—Although every preferred provider organization is unique, employers are wise to study the experiences of those companies and communities that have already dealt with PPOs.

"When you've seen one PPO...you've seen *one* PPO. Each one is different," said Gary F. Jenkins, account executive in the Englewood, Colo., office of consultant Martin E. Segal Co.

"But, I want to share with you the Denver experience, since we have been working with PPOs for seven years now," Mr. Jenkins told the annual symposium of the International Society of Certified Employee Benefit Specialists.

> 'If PPOs continue and are successful, it will be because they have a utilization review program that works. If they don't (have such a review program), they won't survive,' says Segal's Gary F. Jenkins.

**First, he said,** the structure and success of PPOs at containing costs varies widely. "How a PPO is structured depends on what attorney you talk to, and (measuring) success might be premature because PPOs in general have not been operating very long. The early PPOs were really an offshoot of some old hospital discount agreement, which you may be familiar with from the Blue Cross organizations."

But, the contemporary PPOs include free choice of health care providers for employees with incentives to seek care from preferred providers. They also include peer and utilization review procedures and the promise of improved cash flow to the providers, among other features, Mr. Jenkins said.

But, a PPO is not an insurance plan or a health maintenance organization, he continued. "It's a delivery system, not insurance."

Most PPOs give employees the freedom to choose providers at the point of service, but some companies, such as Stouffer Corp., lock employees into the preferred provider if they choose the PPO plan (*BI*, March 12).

**However,** freedom of choice is one of the key advantages to participants, Mr. Jenkins said, and that is how the Denver PPOs are structured. Freedom of choice is an advantage to providers because it protects the fee-for-service system, unlike an HMO, he said.

"However, some PPOs have a 'gatekeeper' concept (in which one family physician makes referrals to other specialists), but we in Denver haven't gotten into that.

"PPOs also continue to allow the physician to determine the appropriate level of care, which is cross-checked through the peer review system," he continued.

The advantages of PPOs to companies and associations that sponsor benefit plans include the reduction of costs because of the combined effect of utilization review and a negotiated fee schedule. Also, administration is easy and employees are more satisfied if they are given a choice of providers and incentives to use cost-effective providers.

In addition, introducing a PPO presents an opportunity to improve benefit communications. "Clear communication of the choice concept and incentives is mandatory," Mr. Jenkins said.

**However,** most companies think their only advantage in contracting with a PPO is to obtain a discount for services. "That totally misses the point," Mr. Jenkins said. "Utilization and claims review is where you really contain costs.

"If PPOs continue and are successful, it will be because they have a utilization review program that works. If they don't (have such a review program), they won't survive."

If employers want to set up a PPO or get involved in a hospital- or physician-established preferred provider organization, they should first look for or organize some kind of review panel that can exercise some control over member hospitals and physicians, Mr. Jenkins said. This is a quality-control measure to keep costs down while maintaining good medical care, he explained.

Then, employers and providers should work together to determine acceptable reimbursement levels, which can be guaranteed for a contract period.

"In the Denver area, the reimbursement levels negotiated with PPOs have not gone up the way usual, reasonable and customary levels have," he said.

**"PPOs in Denver** have renegotiated their fee schedules once a year for every year they have been in operation," Mr. Jenkins continued. "Negotiating a fee for a set service is better than negotiating a percentage (discount), because rates can be inflated (in the latter case)."

The next important step is to work with the PPO in establishing a peer review mechanism "that has some teeth to it," Mr. Jenkins said. If the peer review system doesn't work to make sure that hospitals and physicians are providing efficient, quality care, "the PPO won't work."

Next, draft and sign the documents that bind the company and PPO.

While the PPO will promise to accept certain reimbursement levels and to maintain the quality of care, the company will need to promise to turn around claims in an agreed-upon time and to provide incentives for employees, Mr. Jenkins said.

**The next step** for the PPO is to solicit provider members, which necessitates the development of a selection process and performance criteria.

While employers in the Denver area are pleased with the success PPOs have shown in keeping their rates below usual, reasonable and customary charges—as well as limited health care cost increases—Denver health care providers who participate in PPOs are also pleased.

"They are competing for business, and a lot of the doctors have really taken a hard line on the peer review system," Mr. Jenkins commented. ■

# CEBS official sees benefits, productivity linked

By SALLIE J. DRURY

HERSHEY, Pa.—"Lean and mean" are the words to describe the successful benefits program of the future, according to Jerry S. Rosenbloom, academic program director for the Certified Employee Benefit Specialist program.

Speaking at the annual symposium of the International Society of CEBS, Mr. Rosenbloom described trends affecting benefits.

"The emphasis on productivity will lead heavily to performance-related benefits and flexibility," Mr. Rosenbloom said. "And, firms are moving away from benefits competition in their industry toward benefits related to profit margins.

"They are asking themselves not, 'How will this benefit make us competitive?' but, 'How will it affect our bottom line?' "

Mr. Rosenbloom urged benefit managers to follow business and demographic trends to keep ahead of benefits changes.

"We as a country are moving away from manufacturing to services. There is more technical information available, with a greater demand for technical jobs, but unemployment will continue to be with us as more manufacturing companies cut their workforce," said Mr. Rosenbloom, who is also professor of insurance at The Wharton School at the University of Pennsylvania in Philadelphia.

"We will have to retrain them or they will continue on unemployment.

"But that is just one business trend," he continued. "The current benefit system still doesn't recognize the demographic situation.

"First, the 25- to 44-year-old baby boomers are the (income) 'savers group,' the fastest-expanding group by a wide margin, and increasing the demand on savings plans.

"Second, there is the so-called 'graying of America.' The number of individuals over 65, and over 75, is growing. The population that is 65 or over will increase by about 60% between 1984 and 2010, while we will experience a shortage of younger workers.

"This doesn't take into consideration any further life-extending measures," he added. "Gene transplants will be a considerable trend by the year 2000," he predicted.

Although industrial and demographic changes will continue to place a burden on public sector plans, they will present "a tremendous problem for private plans" as well, Mr. Rosenbloom said. "There will be increasing pressure on the active workforce to support your retirees since it takes two active employees to support one retiree."

Private plans will also feel the pinch because benefits are being scrutinized as sources of revenue, Mr. Rosenbloom noted.

"Regulators have to deal with the revenue situation, and $100 billion is what they estimate is lost in revenue from the non-taxability of benefits, $54 billion of it from pensions.

"Cost containment will continue to be the federal watchword," he continued, noting the use of diagnostic-related groups to cap Medicare costs, "and I think you will continue to see federal attempts to contain costs (on government-sponsored programs)."

Some of the cost-containment measures Mr. Rosenbloom predicted include higher Social Security taxes, a health care benefits tax cap, encouragement of Individual Retirement Accounts to decrease dependency on Social Security and pensions plans and greater restrictions placed on defined benefit pension plans.

"There is a growing feeling that we need some sort of national retirement policy," he noted.

Also, the government is concerned with benefits discrimination and benefit managers "will feel increasing pressure to decrease benefits for higher-paid employees," Mr. Rosenbloom explained.

The days of legislation that creates new opportunities for benefits are over, Mr. Rosenbloom said. "There are very few more government incentives for new employee benefit plans unless we see a general reworking of the tax system. It will be very difficult to provide additional incentives for employee benefit plans except perhaps in capital accumulation plans."

In general, benefit managers should expect legislation to be restrictive and aimed at generating tax revenue, he said.

Current government incentives favor defined contribution plans over defined benefit plans. "I don't predict the disappearance of defined benefit plans, but I don't see any increases on the horizon," Mr. Rosenbloom said.

"Another pension trend that is clearly here is less frequent updating of benefits for those already retired," he continued.

"Clearly, defined contribution plans are where the government is giving its attention. And there's no question 401(k) plans will expand, and perhaps additional tax credits will be granted for PAYSOPs in hopes this will support productivity."

However, he also said that continued inflation will intensify pressure from workers and retirees for cost-of-living increases.

Disputes over increases "are going to be back in the news. It's the one great weakness in the U.S. pension system. As you all know, it is costly and will involve debate."

Basing benefits heavily on performance is a strong trend for all types of benefit plans, Mr. Rosenbloom said.

"This is seen in some of the wage agreements; you will see a two-tiered wage system," he said. "People new to the labor force will be employed under a different wage scale and receive different benefits from those previously employed."

Similarly, flexibility in benefits will continue to be a trend. "I think we will see more of benefits suited to employees' needs," Mr. Rosenbloom said. Health care plans will be designed to reflect this need for flexibility, as well as the need for cost containment.

"We are going to see larger deductibles, larger coinsurance levels and larger stop-loss amounts," he said. "Deductibles based on pay scale will become more popular. I don't know if medical IRAs are going to go through, but this is the kind of thing being talked about. With our aging population, (health) costs can only rise."

Benefit plans of the future will also continue to provide incentives to use lower-cost health care services, such as ambulatory or outpatient care, he noted. Also, second surgical opinions and pre-certification for all kinds of non-emergency procedures will become more prevalent. And, health maintenance organizations and preferred provider

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organizations will continue to grow in use.

Some benefits popular now or in the past may decline in the future, such as corporate gymnasiums and other wellness programs, Mr. Rosenbloom speculated.

"Research has not shown much cost-containment effectiveness for wellness programs, except for smoking-cessation programs," he said. "As for gyms, people seem to think they are the right idea, but some research shows a tremendous increase in athletic-type injuries."

Other areas of change to look for in benefits, he said, are:

- Greater use of employee communications.
- Greater use of counseling programs.
- Greater use of employee assistance programs.

"We will especially see an increased demand for alcohol-abuse programs as more people retire and have more time on their hands," Mr. Rosenbloom said.

Life and disability insurance plans will not yield many changes in the future, he noted, "though you may see some changes from group life to individual coverage as the rates get very low."

Both business and demographic trends point to the need for benefit flexibility, but the same trends create an uncertain benefit environment that makes change difficult, he said.

"The era of confusion will continue, which means the role of the employee benefit profession will increase in importance to sort through the confusion.

"For the well-prepared employee benefit specialist, it is an extremely hopeful future," he continued. "There will be more pressure from the government and from employees and from your CEO to understand this area.

"If you can adapt to the changing environment, the future for you looks very, very hopeful." ■

# Medicare DRGs may hike employers' costs: Attorney

**By SALLIE J. DRURY**

HERSHEY, Pa.—The prospective payment system being introduced by the federal Medicare program—which is based on diagnostic related groups, or DRGs—could increase employers' health costs, an attorney said.

The system, now being phased in by hospitals for Medicare patients, is threatening benefit managers with additional health care cost-shifting from the government to private payers, he said, though DRGs offer employers a cost-containment opportunity if prospective pricing of medical procedures are applied to non-government payers, too.

The government introduced DRGs "to try to imitate the market environment (to the medical profession), where you don't normally have market forces," by rewarding the most efficient hospitals, explained John B. Reiss, an attorney with Dechert Price & Rhoads in Philadelphia.

Mr. Reiss addressed the annual symposium of the International Society of Certified Employee Benefit Specialists.

"It is very much the same as General Motors setting the price of cars. While the price may be negotiable, GM knows pretty much how much it costs to make a car and how much they need to get to cover costs.

"This puts the hospital in the position of thinking more seriously about efficient delivery because (what the government is saying it will pay) is all the hospital is going to get," he continued. "The incentive is for the hospital to think about putting in all those fancy gadgets" that drive up the hospital's costs.

The rate of payment is set by first classifying the primary reason for hospital admittance into one of 23 categories, known as major diagnostic classifications.

The diagnosis is then further classified into subgroups, based on length of stay and the complexity of the required treatment.

"There are (about) 400 DRGs in all, but most hospitals will deal with only about 80," which are the most common, Mr. Reiss said.

Each DRG is assigned a different price, he continued. "The prices were set by collecting a 20% sample of all medical cases, selected on the basis of the patient's Social Security number ending in a zero or a five. From the sample, the typical cost for certain procedures is set.

"However, the prices of DRGs also vary by the location of the hospital," he continued, "and whether it's urban or rural and the wage level in the area."

The cost-containment features of the DRG are to dissuade hospitals from adding unnecessary procedures, such as inappropriate X-rays or tests, which drive up the hospital's costs and add to the patient's bill, Mr. Reiss said.

"This has been done in the past because payment was made on a fee-for-service basis, and additional procedures mean additional revenue."

At present, the federal prospective payment system applies only to hospitals. But, if it is extended to included all providers, "the people who are really fee-for-service are the medical doctors, and they are the ones that are really affected by prospective payment," he said.

If a company wants to work toward payment based on the DRG system or negotiate preferred provider rates based on DRG data, a benefits manager can request information from the federal government on frequency of diagnosis, the range of rates that hospitals charge and how much will be paid by Medicare under the DRG program.

"It would also be helpful to get data from hospitals, with medical and financial records by patient and physician, but that is more difficult to get," Mr. Reiss said.

"Try to get an agreement in your benefits contract that you have a right to an employee's medical record, not by name of employee, but at least enough information to collect meaningful data and make a program run," he continued, though he added, "You may have some problems with unions on this."

Although prospective payment systems using DRGs have the potential to hold the line on health costs, some say they could also reduce the quality of health care.

"The issue of declining quality of care has been hotly debated," Mr. Reiss said. Employers looking for providers to work within a prospective payment system should make sure the provider has implemented quality controls, he said.

Such controls include, he said:

- A medical review entity, either on-staff or an outside reviewer.
- Pre-admission, concurrent and post-discharge utilization reviews.
- A hospital utilization review committee that reviews this data. ■

# New program protects defense contractors

**products & services**

Contractors still can get enough protection to bid on high-risk defense contracts, despite changes in federal regulations that limit the Defense Department's ability to indemnify contractors for liability judgments.

Alexander & Alexander Inc., the New York-based broker, recently announced a new insurance program for defense contractors that are no longer guaranteed protection by the government for substantial uninsured losses.

In the past, the federal government protected defense contractors against third-party liability claims, said Ernest Merklein Jr., senior vp in A&A's Shreveport, La., office. But under this change in law, which took effect April 1, the government's liability is limited to funds available at the time of an accident and there is no guarantee that Congress will appropriate more money at a later date, he said.

"We're the only one writing it now. We developed it with INSPRO. It was designed for this one client and we are working on selling it (to others)," Mr. Merklein said.

INSPRO Insurance Services, a broker in Walnut Creek, Calif., specializes in architects and engineers professional liability insurance.

"There is always the potential for a disaster resulting in massive personal and property damage. But now, unlike previously, there is no national policy to shield government contractors from catastrophic losses," Mr. Merklein said.

The program, which is renewable on an annual basis, includes the following coverages: contingency liability; research and development engineers professional errors and omissions liability; comprehensive general liability; products and completed operations; inclusion of government-owned property in contractor's care, custody and control; aviation and marine liability; environmental; punitive; and worldwide coverage.

When this product was developed early last year, the marketplace was different from the current market, said Horace Holcomb, director of IMPACT, the national marketing organization for A&A.

"At that time, it was softer and reinsurers were very supportive. Today the market is still competitive, but the reinsurers may want to support other things, so it may be harder to place," Mr. Holcomb said.

New product development may be inhibited by what's going on in the reinsurance market, which Mr. Holcomb labeled as "distressed" and contracting rapidly.

"(Reinsurers) will avoid newer coverages with no exposures," he said.

But A&A is going to continue to try to develop a market to respond to the need for this type of coverage, he said.

For more information on the coverage, contact Mr. Merklein at Alexander & Alexander Inc., 1700 Buckner Square, Shreveport, La. 71101; 318-221-1681.

## Electronic endorsement

Breakdown of electronic devices and equipment, including robots, is covered now under The Home Insurance Co.'s extended comprehensive coverage endorsement to its boiler and machinery policies.

This extension is designed for businesses or services that use climate control systems, electronic and computer-operated equipment and robots. Physical damage, business interruption and breakdown are covered.

The endorsement broadens the boiler and machinery accident definition to include electronic breakdown and reconstruction of data from duplicate material.

Limits can be written to policyholder specifications.

The endorsement does not cover electronic data processing equipment used for financial or management information reports.

*Continued on facing page*



# Pennsylvania Blues hope to cut costs

PHILADELPHIA—Pennsylvania's five Blue Cross plans, along with the state's Blue Shield plan, are engaging in a four-pronged program to control rising health costs.

The program focuses on four major areas: hospital utilization, excess health care capacity, negotiated hospital payment systems and competition among providers.

To control health care utilization, the program is encouraging that certain elective surgical procedures be performed on an outpatient basis and that home health care services be expanded. It also recommends that skilled nursing facilities be used after the acute phase of illnesses.

When hospitalization is necessary, the Pennsylvania Blues are recommending that pre-surgical laboratory and radiological tests be conducted on an outpatient basis before admission.

To eliminate excess capacity, BC/BS is recommending that state regulators limit the number of additional facilities and doctors that are approved.

Currently, more than 55% of Pennsylvania's hospitals have excess beds, and the number of in-state doctors has increased 30% in the last decade, according to David S. Markson, president of Blue Cross of Greater Philadelphia.

Negotiated hospital payment systems should be implemented, Blue Cross & Blue Shield officials say, because these systems are much more effective in containing costs than alternatives such as state-mandated rate setting programs.

In many instances, these other programs have resulted in unnecessary utilization and capacity increases, Mr. Markson said.

To increse competition among health care providers, the BC/BS program is encouraging development of alternative health care delivery systems, like health maintenance organizations. Also, it recommends that regulators require regular public disclosure of hospital financial statements and price schedules to further stimulate competition.

Pennsylvania hospital costs increased 78.1% from 1977 to 1981, compared to a 75.4% national increase during the same period, according to American Hospital Assn. figures. ■

*Continued from facing page*

The endorsement is available in all states, except Alaska and Hawaii. Filings are pending in Kentucky, Michigan and South Dakota.

For more information on the Home extended comprehensive coverage endorsement to boiler-machinery policies, contact any Home field office or A. Walters, Assistant Vp, The Home Insurance Co., 59 Maiden Lane, New York, N.Y. 10038; 212-530-7293.

## Hospital screening

Employers' hospital insurance costs can be reduced with a pre-admission approval program.

The Screen program from Mutual Medical Plans Inc., which administers self-funded health care plans, excludes payment for inpatient admissions if prior approval is not received before admission.

To get approval, physicians or patients can send a brief form or telephone in the information, such as diagnosis or complaint, procedures to be performed and hospital name. The pre-admission approvals are made within 24 hours; written notice is sent to the doctor, employee, employer and health insurer.

Employers may decide to have admissions denied based on medical necessity, alternate treatment available, like outpatient care, pricing consideration or all three factors.

If the admission is rejected because of cost, an alternate hospital will be recommended by Screen.

The screening cost is $16 per employee.

Pre-approval is not required for outpatient procedures or medical emergencies where the employee is admitted.

For more details, contact Ron Jones, Mutual Medical Plans Inc., First National Bank Building, Peoria, Ill. 61602; 309-674-0888.

## NAIC newsletter

Now there's a newsletter that helps risk managers stay up-to-date on insurance regulation.

The NAIC News is a monthly publication from the National Assn. of Insurance Commissioners that covers insurance regulation and special industry issues.

In addition to the eight-page newsletters, periodic NAIC bulletins on fast-breaking insurance developments are mailed to subscribers.

A one-year subscription costs $150. To order, write Information Service Office, NAIC, 1125 Grand Ave., Kansas City, Mo. 64106; 816-842-3600.

## Contractors coverage

A contractors liability program is now offered to small to medium-sized builders with total receipts of $3 million.

New Hampshire Insurance Group's contractors program features comprehensive general liability, products and completed operations, independent contractors and broad-form comprehensive general liability.

Liability limits available are $300,000, $500,000 and $1 million comprehensive single limit.

Extended broad-form property damage that modifies the care, custody and control exclusion, explosion collapse, underground operations coverage for landscapers and underground coverage for plumbers are coverage options.

The extended property damage option has a $10,000 limit.

Other options available, within the liability limits, cover heating and air conditioning, electrical, sheet metal, paving, masonry, painting and drywall contractors.

In addition to limits sought, experience and other factors, pricing is based on every $1,000 of payroll.

This coverage is offered in about 35 states, with new filings pending in other states.

For more information, contact your local New Hampshire Insurance Group branch office or Phil Kozyra, Product Line Manager, The New Hampshire Group, 1750 Elm St., Manchester, N.H. 03107; 603-669-6300.

New Hampshire Insurance Group is a subsidiary of American International Group Inc.

## California labor laws

The myriad of California's rules and regulations governing the complex relationships among employers, employees and labor unions, especially when dealing with workers compensation issues, is clearly explained in the "1984 Digest of California Labor Laws."

The 24th edition of the 129-page Digest, published by the California Chamber of Commerce, cuts through this maze by offering a lucid explanation and summary of the general principles and important rules developed under the statutes and decisions in the state.

The chapter on workers compensation goes into such areas as the employer's obligations and liabilities, benefits and the Workers' Compensation Appeals Board. It also explains the state's various special funds and accounts, like the Asbestos Workers' Account in the Uninsured Employer Fund.

Each section of the digest contains footnotes, citing the specific chapter and code in the law, or in some cases, the court decision. In the workers compensation chapter, for instance, there are 242 such reference citings.

The digest also explains the employers' role in other labor issues, including wages and hours, unemployment insurance, disability insurance, material data safety sheets, fair employment regulations, child labor laws, Cal/OSHA and collective bargaining.

The Digest costs $35 for California Chamber members and $45 for nonmembers. Copies may be obtained from the California Chamber of Commerce, Attention: Digest, P.O. Box 1736, Sacramento, Calif. 95808. ■

# Memphis transit workers get better benefits

Employees of the Memphis Area Transit Authority will receive improved pension and health benefits as a result of a three-year contract negotiated earlier this year.

The pact also includes several health coverage cost-saving provisions for Mid-South Transportation Management Inc., which operates the transit system.

The improved benefits cover 335 active members of Amalgamated Transit Union Local 713, as well as 250 retirees. Also receiving benefit increases are 80 office workers who are not union members.

The union contract expires June 30, 1986.

Weekly pension benefits for all employees will be set at 1.3% of their lifetime average salary. Previously, employees retiring before age 55 had received a weekly benefit equal to 1.15% of their salary, while those retiring later had received 1.3%.

**benefit beat**

The new plan also increases monthly pension benefits by $15 for employees who retired before July 1, 1974. This increase was retroactive to July 1, 1983, when the old contract expired. Similar increases will be made July 1, 1984 and July 1, 1985.

Employees retiring after July 1, 1974, will see $10 monthly pension increases on these dates.

The new contract also institutes a buy-back provision that allows former employees who return to the company after leaving or being laid off to re-establish pension benefits by contributing the amount of benefits they had withdrawn, plus interest.

Health benefit improvements include an increase in the maximum lifetime major medical payment per employee or dependent to $500,000 from $100,000.

Also, unmarried full-time student dependents will be covered to age 22, up from 19 under the old contract.

The new contract adds a conversion provision that will pay health costs for retirees and dependents not covered by other private and government insurance programs.

This coverage, effective July 1, will cost $10 per month per individual.

Among the cost-saving measures instituted is a requirement that employees and dependents undergo pre-admission testing to receive any coverage for non-emergency hospitalization costs.

To further save money, dependents who are covered by Medicare will be required to use it as primary coverage rather than relying on a company plan.

Also, ambulatory surgery, performed on an outpatient basis, will be covered at the same level as inpatient hospital services. Previously, these procedures had been covered at reduced levels, which discouraged their use.

## Plan management

City of Miami firefighters and police officers will take over management of their health and group insurance plans as a result of contracts negotiations.

Previously, the 650-member Local 587 of the Miami Assn. of Firefighters and the 1,050-member Fraternal Order of Police Lodge 20 had participated in the city's self-insured plans. Management of the plans will shift before July 1, according to the contract.

As with its own plan, the city will pay 80% of employees' coverage costs and 56% of dependents'.

The two unions requested the change to reduce management costs, said Richard W. Bender, a city assistant labor relations officer. Specific provisions of the new arrangement, such as administration and stop-loss insurance, have yet to be worked out, Mr. Bender said.

"It came to the point where we said, 'Fine. If you think you can do it more cheaply, go ahead with our blessing.' "

The contracts also provide for a revision in pension plans that could help settle lawsuits against the city totaling $45 million. The suits allege the city underfunded its pension plans and improperly used pension money.

The new agreements establish a new pension funding formula, although the city does not officially admit the pension plans were underpaid in the past. In turn, the firefighters' and police officers' pension boards have agreed to drop lawsuits filed more than five years ago.

A second city pension board, representing sanitation workers and general employees, is still negotiating a settlement. Mr. Bender said he is "cautiously optimistic" an agreement will be reached in the next few weeks that would permit the suits to be dropped.

## Benefit improvements

Dana Corp. employees who are members of the United Auto Workers will receive improved pension, life and other benefits, and will continue to receive first-dollar medical coverage as a result of a three-year contract negotiated late last year.

The contract, which covers more than 7,000 workers in five states, increases pension benefits to $20 per month per year of credited service for members retiring on or after Jan. 1, 1986.

Currently, retirees receive pensions of $18.45 to $18.75 per month per year of credited service, depending on length of employment. The single rate was instituted to reduce administrative costs.

Life insurance maximums will increase July 1, 1985, to $30,000 from $27,000. Workers earning $14.25 or more per hour will qualify for the new life insurance maximum.

Similar increases for accidental death and dismemberment coverage and disability benefits will go into effect on that date. The AD&D maximum will increase to $15,000 from $13,500, and the weekly disability maximum will increase to $300 from $270.

Dana pays the full cost of life and AD&D coverage.

The new contract also increases the special benefit to help disabled employees, retirees or surviving spouses pay premiums for Medicare Part B, which covers physicians' charges.

The benefit level rose to $14.60 Jan. 1 from $13.40 and will increase to $15.10 on Jan. 1, 1985, and $15.60 Jan. 1, 1986.

Other benefit improvements negotiated in the contract include wage increases, additional holidays, preferential hiring and cost of living adjustments. ■

# Chubb subrogates claims from mall fire

By JIM NORLAND

DENVER—Chubb & Son Inc. is suing a Denver heating and air-conditioning firm and the owner, the manager and one tenant of University Hills Mall, a shopping center in southeast Denver where a fire during the Christmas shopping season caused losses to Chubb policyholders.

In the suit filed in Denver District Court, Chubb is seeking $5 million from Climate Engineering Inc.; Hutchinson Sales Corp., manager of the mall; University Hills Inc., the mall owner; and Crandall Corp., doing business as Yarbro Drugs.

Chubb insured other mall tenants—Sid's Fine Foods & Gifts Inc., Fashion Bar Inc. and Dependable Cleaners Inc.—and already has paid "at least $25,000" to those three insureds, "and payments are continuing as evaluation and documentation of their losses continues," according to the suit, filed March 15.

**Chubb also** has paid "at least $1,000" for business interruption losses due to fire damage at the insured establishments and "payments are continuing," the court papers say.

In addition, Chubb and another insurer have formally notified the city of Denver that they believe the city and its fire department were negligent in allowing dangerous conditions and violations of city codes to exist. The formal notice was filed within the time required to preserve the insurers' right to sue the city.

In its subrogation suit, Chubb wants to recover all payments to its policyholders, claims adjustment expenses and legal costs, all subject to an interest rate adjustment. A plea for punitive damages, however, was recently dropped.

Chubb provided Dependable Cleaners with $15,000 of coverage for damage to personal property at that location, $160,000 for personal property of others at the same address and $15,000 in income insurance/extra expense coverage.

**Sid's Fine Foods** was insured for $550,000 for personal property, $500,000 for income insurance/gross earnings and $137,500 for peak season increase in personal property coverage, which was in effect at the time of the mall fire.

Chubb's policy issued to Fashion Bar provided $33.5 million of personal property coverage not specific to location; $15 million income/extra expense/gross earnings coverage, also not specific to location; and $50,000 in coverage for total personal property of others not specific to location. Specific to the mall location was $75,000 of personal property protection.

Chubb's suit charges that Climate Engineering was called Nov. 22, 1983, "to investigate complaints of smoke and possible fire at the mall only hours before the fire department was notified of the fire." The fire became apparent in the pre-dawn hours of Nov. 23.

**One of the Denver** heating and air-conditioning firm's employees allegedly "failed to exercise reasonable care to discover the dangerous condition of electrical wiring, light fixtures and connections within the mall," the suit contends.

Chubb claims that Hutchinson Sales Corp., manager of the mall, "failed to use reasonable care to see that the mall was kept in a reasonably safe condition. . .(and) to use reasonable care to discover existing building code violations. . .to discover fire hazards which existed in the mall, and failed to correct and eliminate such fire hazards," creating a hazard and unreasonable risk to people and property in the mall.

University Hills Inc., owner of the mall, "had a non-delegable duty to provide a safe place for the mall's tenants," the suit contends, and should have been aware of allegedly dangerous conditions that were there.

Crandall Corp., doing business as Yarbro Drugs, a tenant in the mall, "failed to use reasonable care to see that the mall location it occupied was kept in a reasonably safe condition," Chubb's suit contends, adding that it didn't correct and eliminate fire hazards that existed in its portion of the space and violated applicable building codes in that space.

**The suit charges** that Crandall did not correct dangerous wiring conditions, that it failed to correct a fire hazard caused by the proximity of light fixtures to combustible materials and that it allowed the excessive use of electrical extension cords.

Chubb's complaint alleges that the Nov. 23 fire originated in the portion of the mall occupied by Yarbro, but Yarbro specifically denies that in its answer to the suit.

Yarbro contends that the fire actually began Nov. 22, continuing until 5:53 a.m. Nov. 23. Yarbro is counter-claiming that the suit is "frivolous and groundless" and seeks not only dismissal but also recovery of its own legal fees.

Climate Engineering, through its attorneys, admits receiving a call involving a tenant's complaint at the University Hills Mall Nov. 22, but denies the specifics of Chubb's complaint about tenants reporting a smell of smoke and concern of the possibility of a fire at the mall.

**Climate Engineering** also asserts that negligence of the personnel of the three firms insured by Chubb—Sid's Fine Foods, Fashion Bar and Dependable Cleaners—"precludes or diminishes the claims of said insureds."

The company also asserts that the plaintiff and/or its insureds failed to mitigate their damages and that the damages were caused by "acts or omissions of. . .parties over which this defendant has no control."

Climate Engineering is also asking that the complaint be dismissed with prejudice to the plaintiff and that it be reimbursed for its costs in connection with the suit.

Climate is being defended by Aid Insurance Co., which provides the company with "ample coverage of seven figures," said Lou Bindner, president of Climate.

University Hills Mall is insured by Royal Insurance Co., which is participating in its defense, according to a University Hills Mall attorney. He declined to discuss the limits of insurance.

Crandall and Hutchinson Sales declined to comment on their insurance coverage. ■

# datebook

**JUNE 24-28. National Assn. of Insurance Women** 1984 national convention in Las Vegas, Nev.; $110 for members; $125 for non-members. National Assn. of Insurance Women, 1847 E. 15th St., P.O. Box 4410, Tulsa, Okla. 74159; 918-744-5195.

**JUNE 25. Controlling Corporate Health Care Costs Through Preferred Provider Organizations** conference in Arlington, Va., sponsored by the Health Costs Management Conference Center division of the Energy Bureau; $695. Jared Smith, Health Costs Management Conference Center, 41 E. 42nd St., New York, N.Y. 10017; 212-687-3177.

**JUNE 25-26. Targeting the Future of Performance Guarantees** conference in New York, sponsored by CMA Consulting Group; $695. Arlene Brower, CMA Consulting Group, 170 E. Hanover Ave., P.O. Box 2287R, Morristown, N.J. 07960; 800-526-0746 or 201-267-7171.

**JUNE 25-27. Advanced Employee Benefits** course in New York, sponsored by American Management Assns.; $695 for members; $800 for non-members. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-0065.

**JUNE 25-27. 4th Annual Insurance Fraud** seminar in Atlanta, sponsored by American Insurance Services Group; $100. Patrick Henry, American Insurance Services Group, Committee on Insurance Fraud Investigation, 85 John St., New York, N.Y. 10038; 212-669-0537.

**JUNE 26. Organizing and Operating Association Captives** workshop in the District of Columbia, sponsored by the Society of Chartered Property & Casualty Underwriters; $80 for members; $90 for non-members. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2735.

**JUNE 28-29. Reinsurance Security** seminar in London, sponsored by ReActions; $410 plus value added tax; 10% discounts for multiple registrants from the same company. ReActions, 39-41 North Road, London N7 9DP; 01-609-8661.

**JULY 11-13. Annual Arkansas Safety** conference in Little Rock, Ark., sponsored by the Arkansas Chapter of the American Society of Safety Engineers; $45; $30 before July 5. J.C. Smith, Arkansas Chapter of the American Society of Safety Engineers, P.O. Box 56311, Little Rock, Ark. 56311; 501-666-5560 or 501-661-8293.

**JULY 15-18. 1984 Corporate Benefits Management** conference in McAfee, N.J., sponsored by the International Foundation of Employee Benefit Plans; $500 for members, $575 for non-members. Jordan Fox, International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

**JULY 15-21. National Wellness** conference in Stevens Point, Wis., sponsored by the University of Wisconsin; $325. Institute for Lifestyle Improvement, Delzell Hall, University of Wisconsin —Stevens Point, Wis. 54481; 715-346-2172.

**JULY 16-18. Basic Safety Management** course in Houston, sponsored by the International Safety Academy; $425; group discounts available. Also **Sept. 24-26, Nov. 12-14** in Houston. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

**JULY 19. Fundamentals of Environmental Health** seminar in Houston, sponsored by the International Safety Academy; $175. Also **Sept. 27, Nov. 15** in Houston. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

**JULY 23-25. International Foundation of Employee Benefit Plans 1984 Trustees and Administrators** institute in Monterey, Calif.; $420. Also **Aug. 13-15** in McAfee, N.J. Public Relations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

**JULY 30-31. Dollars and Sense of Communicating Employee Benefits,** conference in New York City, sponsored by *Business Insurance*; $545; 10% discount for additional registrants from same company. Ann Vazquez, Registrar, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

**JULY 30-31. Risk Management for Indian Nations** seminar in Reno, Nev., sponsored by Risk Management Publishing Co.; $125. Nestor Roos, Risk Management Publishing Co., 2030 E. Broadway, #110, Tucson, Ariz. 85719; 602-622-5174.

**JULY 30-AUG. 3. Fundamentals of Modern Safety Management** seminar in Atlanta, sponsored by the International Loss Control Institute; $625. Also **Sept. 10-14** in Atlanta. Richard Jump, International Loss Control Institute, Highway 78, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001 or 404-466-2208.

**AUG. 2-3. Health Care Cost Containment and Self-Insurance of Medical Benefits** seminar in Atlanta, sponsored by Tillinghast, Nelson & Warren; $600; $500 for subsequent registrants from same company. Pat Kelley, Tillinghast, Nelson & Warren, 3340 Peachtree Road, Atlanta, Ga. 30026; 404-261-5420.

**AUG. 2-3. Governmental Insurance** conference in Austin, Texas, sponsored by the Professional Development Institute; $245. Joanne Paulman, Professional Development Institute, P.O. Box 13288 NTSU, Denton, Texas 76203-3388;817-565-3344.

**AUG. 20-23. Inspector Training** seminar in Houston, sponsored by the International Safety Academy; $490; group discounts available. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa 19101; 800-231-3147 or 215-241-5800.

**AUG. 20-24. Accredited Safety Auditors** seminar in Atlanta, sponsored by the International Loss Control Institute; $625. Richard Jump, International Loss Control Institute, Highway 78, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001 or 404-466-2208.

**AUG. 27-29. 1984 Benefits for Public Employees** conference in San Francisco sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. Jordan Fox, IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005 414-786-6700

**SEPT. 5-7. Industrial Hygiene Sampling Strategies** course in Los Angeles, sponsored by the University of Southern California; $625. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90007; 213-743-6523/6524.

**SEPT. 10-12. Computerized Programs for Occupational Health Systems** course in Los Angeles, sponsored by the University of Southern California; $400. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90007; 213-743-6523/6524.

**SEPT. 10-14. Total Loss Control Management** seminar in Houston, sponsored by the International Safety Academy; $625; group discounts are available. Also **Dec. 3-7** in Houston. Roseanne Kornicki, International Safety Academy P.O. Box 8527, 1600 Arch St., Philadelphia, Pa 19101; 800-231-3147 or 215-241-5800.

**SEPT. 10-21. 51st Insurance Management** course in Long Grove, Ill., sponsored by Kemper Group; $900. Carol Ruhter, Kemper Group, Long Grove, Ill. 60049; 312-540-2321.

**SEPT. 13-14. Ergonomics** course in Los Angeles, sponsored by the University of Southern California; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90007; 213-743-6523/6524.

**SEPT. 17-19. Fundamentals of Industrial Exhaust Ventilation** course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $400; group discounts available. John Garis, National Loss Control Service Corp., Long Grove, Ill. 60049; 312-540-2026.

**SEPT. 17-20. American Society for Industrial Security 30th Annual** seminar and exhibition in Chicago; $295 for members; $395 for non-members. Pat Rivers, American Society for Industrial Security, Suite 1200, 1655 N. Fort Myer Drive, Arlington, Va. 22209 703-522-5800.

**SEPT. 17-20. Employee Benefits** seminar in Lincolnshire, Ill., sponsored by Hewitt Associates; $1,150. Also **Nov. 12-15** in Lincolnshire. Jamie Ebner, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

**SEPT. 18-20. Fundamentals of Reinsurance** seminar in Irving, Texas, sponsored by the University of Dallas; $475. Bruce Evans, Reinsurance Management Institute, University of Dallas, Irving, Texas 75061; 214-721-5360/5299.

**SEPT. 24-26. Radiation Safety Officers'** workshop and refresher course in Ottawa, for graduates of five-day RSO training program, sponsored by Applied Health Physics; $550. Also **Oct. 16-18** in Pittsburgh. Robert Gallaghar, Applied Health Physics, 2986 Industrial Blvd., Box 197, Bethel Park, Pa. 15102; 412-563-2242.

**SEPT. 24-26. Highly Protected Risk Valuation** seminar in Long Grove, Ill., sponsored by Kemper Group; $300. W.P. Thomas Jr., Engineering Research and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

**SEPT. 24-28. Advanced Instruction in Retirement Plans for Bank Trust Personnel** seminar in Winston-Salem, N.C., sponsored by Booke & Co.; $775. Booke & Co., P.O. Box 66, Winston-Salem, N.C. 27102; 919-748-1120.

**OCT. 1-3. Safety for the Oil Field** seminar in Houston, sponsored by the International Safety Academy; $425. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147.

**OCT. 9. Accident Investigation and Analysis** seminar in Houston, sponsored by the International Safety Academy; $175; group discounts available. Also **Dec. 10** in Los Angeles. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

**OCT. 10. Effective Safety Committees** seminar in Houston, sponsored by the International Safety Academy; $175; group discounts available. Also **Dec. 11** in Los Angeles. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147.

**OCT. 14-17. 1984 Society of Chartered Property & Casualty Underwriters** annual meeting in Seattle; $225. Margaret Kalalian, Society of CPCU, Kahler Hall, Providence Rd., Malvern, Pa. 19355; 215-251-2739.

**OCT. 21-24. Fourth International Benefits** seminar in Chicago, sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

**OCT. 22-24. Controlling Manual Material Handling Injuries** seminar in Philadelphia, sponsored by the International Safety Academy; $425. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

**OCT. 22-26. Social Responsibilities of the Insurance Industry** program in Bangkok, Thailand, sponsored by the East Asian Insurance Congress; $200 for members; $400 for associate members; $600 for non-members. M.C. Douglas, Thai Reinsurance Co. Ltd., General Insurance Assn. Building, 3rd Floor, 223 Soi Ruamrudee, Wireless Road, Bangkok 10500; 2514811, 2514826-9.

**OCT. 23-25. What Financial Managers Need to Know About Employee Benefits** seminar in Lincolnshire, Ill., sponsored by Hewitt Associates; $900. Jamie Ebner, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

**OCT. 24-27. 1984 National Education** conference in Boston, sponsored by the Self-Insurance Institute of America; $345 for members; $395 for non-members. Marcia Vaughan, Self-Insurance Institute of America, P.O. Box 15466, Santa Ana, Calif. 92705; 714-979-6318.

**OCT. 29. Back Injury Prevention Using NIOSH Guidelines** seminar in Los Angeles, sponsored by the International Safety Academy; $175. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

**OCT. 29-NOV. 2. Advanced Property Conservation** course in Long Grove, Ill., sponsored by Kemper Group; $400. W.P. Thomas Jr., Engineering Research and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

**NOV. 7-9. Risk/Loss Control Management** seminar in Philadelphia, sponsored by the International Safety Academy; $450. Registrar, International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

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*The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.*

# Lloyd's wants rules for 'umbrella' brokers

By STACY SHAPIRO

LONDON—Lloyd's of London wants to ban at least 34 non-Lloyd's brokers from having so-called "umbrella" arrangements with Lloyd's brokers.

An umbrella arrangement allows non-Lloyd's brokers to place risks on the floor of the Lloyd's market under the auspices of a Lloyd's broker.

Through such an arrangement, a non-Lloyd's company places its clients' risks directly with Lloyd's underwriters.

There are 125 such arrangements generating an annual premium income in excess of 155 million pounds ($215 million), according to Lloyd's.

However, some of the non-Lloyd's brokers have engaged in "slipshod" and "improper" practices, says Lloyd's Chief Executive and Deputy Chairman Ian Hay Davison.

Such practices, he says, include some non-Lloyd's brokers misrepresenting themselves to policyholders and Lloyd's underwriters as if they were bona fide Lloyd's brokers.

These charges are contained in a consultative document Lloyd's drew up earlier this month and sent to Lloyd's brokers, managing agents and associations, as well as to the British Insurance Brokers' Registration Council and the British Insurance Brokers Assn.

After these groups comment on the document, the Council of Lloyd's will draft a bylaw on umbrella arrangements that probably will take effect by early next year, a Lloyd's spokesman said.

## london line

Although Lloyd's has never before issued such regulations on the umbrella arrangements, the report notes that recently some non-Lloyd's brokers have abused these arrangements and thereby "caused damage to the good name of Lloyd's."

Often, the report adds, Lloyd's underwriters have been unaware that they are being offered business by a non-Lloyd's broker.

Lloyd's is currently investigating at least one allegation that a non-Lloyd's broker abused an umbrella arrangement, according to Mr. Davison.

Lloyd's announced last year that extended warranty policies marketed and managed by Multi-Guarantee Ltd. had been altered. The business was placed with Lloyd's underwriters by non-Lloyd's broker Campbell Roberts (Insurance Brokers) Ltd., which had an umbrella arrangement with Lloyd's broker Robert Morris Bray Ltd. (*BI*, March 21, 1983).

However, there are legitimate and valid reasons for the existence of the umbrella arrangements, the report notes.

For example, sometimes former employees of Lloyd's brokers who want to form their own Lloyd's company set up an umbrella arrangement with a Lloyd's broker during the two years a brokerage must operate before it can be approved by Lloyd's.

In the report, Lloyd's recommends that in the future:

- All umbrella arrangements must be approved by the Lloyd's Council, and that the Lloyd's broker must take complete responsibility for the actions of the non-Lloyd's brokers.
- Only non-Lloyd's brokers that plan on becoming Lloyd's brokers in at least three years or those that are non-Lloyd's subsidiaries of Lloyd's brokers should be allowed to have such arrangements. There are 91 umbrellas in these categories.
- There should be a 12-month grace period to allow any unacceptable arrangements to be dissolved. Lloyd's reckons that there are around 34 of these arrangements.

## Sedgwick defections

The deputy chairman of Lloyd's of London broker Sedgwick North America Ltd. and three of his colleagues will join rival broker Alexander Howden Group P.L.C.

And, three Howden officials in its North American division have resigned.

Recently, a Howden spokesman confirmed that Sedgwick Deputy Chairman Dennis Mahoney and Directors Brian Ainsworth, Paul Chilton and Ian Waite are joining Howden's North American division, known as Alexander Howden Ltd.

The spokesman said that the four men had handled many accounts for Howden parent Alexander & Alexander Services Inc. while they were at Sedgwick.

However, the spokesman also noted that Mr. Mahoney approached Howden first. Mr. Mahoney was unavailable for comment.

Also, the spokesman reported that Howden Managing Director Colin Bird and Directors Richard Goward and Steve Row have resigned.

## Underwriters' stock

Lloyd's of London will have to decide whether to approve the recent private stock issue by Sturge Holdings P.L.C. under the new bylaw on the ownership of underwriting agencies.

And, Lloyd's will have to review and decide whether to approve the similar offering made two years ago by underwriting agency Merrett Holdings P.L.C.

But, neither agency should run into problems, said Lloyd's Chairman Peter Miller.

"Sturge and Merrett will have to abide the bylaw and be reviewed," he said.

"I have not studied the articles of association. . .but if something falls outside the bylaw, we will have to take that on board and it will have to be changed," he added.

Recently, Sturge followed Merrett's lead and issued more than 4.2 million shares to its Lloyd's underwriting members to raise more than 3.5 million pounds ($4.9 million) in extra funds.

The extra capital will allow the underwriting agency "to take advantage of any opportunities arising from the divestment by Lloyd's brokers of their interests in managing agencies as required by Lloyd's Act of 1982," according to the company.

Sturge is one of Lloyd's largest underwriting agencies and may be showing the way for broker-owned agencies to cope with Lloyd's new divestment rules.

In 1983, the group managed 11 syndicates with a premium income capacity of 246 million pounds ($341.9 million), or 8% of Lloyd's total capacity.

## Storm losses

Damage from storms that hit Britain near the end of last year may cost the British insurance industry up to 200 million pounds ($278 million), the British Insurance Assn. confirmed.

Earlier, the BIA had said the losses from the storm damage would total only 70 million pounds ($97.3 million).

However, a BIA spokesman said that, unofficially, the association now believes the figure is much larger. It bases this new estimate on the first-quarter results of the major British insurance companies.

## Lawyers malpractice

Malpractice coverage rates for 24,000 British lawyers will rise by only 6% this year. This is the smallest increase in more than four years.

The mandatory coverage for all members of the British Law Society is provided by a consortium in which Guardian Royal Exchange of London has a 50% stake. Lloyd's of London underwriters have a 45% stake, while General Accident Fire & Life Assurance Co. P.L.C. has a 5% stake. ■

# California company's programs aimed at reducing back injuries

By STEVE TARAVELLA

TUSTIN, Calif.—Some employers, trying to control employee back injuries and the resulting workers compensation costs, are finding solace with American Network Services Inc.

ANS is a Tustin-based management, consulting and training firm that specializes in the treatment and prevention of back injuries.

Several clients—ranging from a group of nursing homes to a soft drink bottler—say they expect ANS programs to help reduce the number of back-related injuries at their workplaces.

ANS provides a number of services to help employers prevent back injuries and combat work comp costs, including:

- A "train-the-trainers" program, in which ANS instructs supervisory employees in a tailored-to-the-company back care and injury prevention program. These supervisors then instruct other employees.
- Training programs aimed directly at the employees.
- Developing pre-employment screening programs, designed to red-flag those employees whose physical condition may make them likely candidates for an on-the-job back injury.
- Designing disability case management programs, in which the health of injured employees is carefully monitored, stressing as quick a return to work as possible.
- The Back School, a comprehensive audiovisual teaching product—including cassette tapes, slides and manuals—that employers can use to train employees or physicians can use with groups of patients.

About 25% to 30% of all workers compensation claims and 40% to 60% of all work comp costs are attributed to back-related injuries, estimates Dr. Ray C. Mulry, ANS executive director. He also estimates that there is a 90% chance of a back problem reoccurring.

The company's services would most help those employers that spend at least $50,000 to $100,000 annually on back care, says Dr. Mulry.

**The cost of** AMS' services varies. For instance, the cost of the "train-the-trainer" program depends on many different factors, but Dr. Mulry says fees have ranged from $5,000 to $50,000, though the cost is usually around $10,000.

The company's philosophy, he explains, dictates that back problems are a "lifestyle" problem. Thus, AMS tailors its training programs to the lifestyle of the individuals being trained, whether they are warehousemen or corporate executives.

Successful back treatment must consider all of the different factors currently blamed for back pain, Dr. Mulry says.

"There's no silver bullet. You just can't have some company come in, do a production or program and solve your problem. It's that simplistic thinking that people have to get out of," he explains.

"The back problem is a big problem that involves many different things. Chiropractors are right. Orthopedists are right. Osteopaths are right. Safety directors are right. And the exercise physiologists are right," Mr. Mulry says.

"But everybody looks at this problem from a specific point of view. We look at all of it."

**He says** the best results are produced when the concerned individuals at a company work together—not separately—to solve the problem. These individuals, he says, include the risk manager, safety director and benefits manager.

About 50% of the training in ANS programs is physical, involving body mechanics, stretching and exercise. The other 50% is psychological, involving stress management, deep breathing and relaxation exercises, "bringing you into a twilight zone," explains Dr. Mulry, who is a psychologist.

"This deals with your feelings, your attitudes, your willingness to take responsibility and the recognition that you're really the only one who can deal with the problem. That's very important," he says.

"I think they (ANS) have the most thorough approach," notes Donald Wilderoter, coordinator of technical services for Frank B. Hall's international loss-control division in Briarcliff Manor, N.Y.

"There are other (back training programs), but they seem either to take a pure physical therapy approach or a pure ergonomic approach. Ray seems to have the ability to bundle all this together in a way that works well. Other companies are only doing pieces of what he's doing."

Over the past year, Hall has referred four corporate clients with a high incidence rate of employee back injuries to ANS' train-the-trainer program, and Mr. Wilderoter predicts that the company will refer another eight or nine more to the program by the end of this year.

There are no monetary transactions between Hall and ANS. "We just consider it our duty to our clients to find the best services for their needs," Mr. Wilderoter says.

He says he refers clients to ANS because "other programs didn't have as complete an approach as I was looking for."

**Mr. Wilderoter** reports that his clients are seeing reduction in their workers compensation claims, but that the program hasn't been in place long enough at any company to represent savings in accurate figures.

Health Care Group Inc., an association of 130 long-term health care facilities throughout Minnesota, reports substantial savings using the Back School program in conjuction with its Bermuda-based captive, Health Care Insurance Co. Ltd. The captive is managed by nine of the nursing home administrators, and its workers compensation policies are fronted through New York-based Ideal Mutual Insurance Co.

The nursing homes have cut their work comp costs an average of 30% to 40% since Health Care Group began working with ANS two years ago, and some have saved more than 50%, reports Harry J. Lemieux, president of the nursing home group in West St. Paul, Minn.

Nursing homes traditionally face a high risk of on-the-job back injuries because of frequent and heavy lifting, he points out.

Part of the savings the nursing homes are receiving through the captive program can be attributed to other, simultaneous cost-contain-

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ment efforts, like safety contests, but Mr. Lemieux estimates that at least 60% of the money saved can be attributed to ANS.

"The Back School was very instrumental in helping us do this," he says. "And, if we followed the direction of the Back School program 100%, we'd drop costs even further."

More than 300 Health Care Group employees have received instruction through the two-day "train-the-trainer" programs, and Mr. Lemieux notes that virtually all of the homes' employees have now been trained. He says the employers were "very receptive" to the instruction.

So were employees at Chicago-based Pepsi-Cola General Bottlers Inc., an independent bottler serving eight Midwestern states that is owned by IC Industries Inc.

Paul W. Murray, corporate director of safety and health, quips that some employees responded to the training by remarking, "It's been a long time coming, we're glad to see it, and what took you so long?"

He adds that most workers have been pleased that the company would expend the time and money to provide the training.

About 40 safety, sales or human resource managers for each of the bottler's 10 operating divisions and three canning facilities attended the two-day "train-the-trainers" program in November 1983. These "disciples" then returned to their operations to instruct about 1,500 employees, Mr. Murray explains.

"We have to teach them very correct concepts to follow because there's nobody there to correct them if they do it wrong," Mr. Murray says of the route salesman. "Every time he (a salesman) lifts a case of pop, he exposes himself to injury."

Pepsi won't have any concrete results until August, but Mr. Murray says the company is so pleased that it is trying to establish a network of clinics that will use the Back School program in treating employees with back injuries.

Pepsi has spent between $15,000 and $22,000 on training, but Mr. Murray says the expense is definitely worth it. With non-major back injuries costing upward of $7,000, the program will pay for itself if it prevents three injuries, he notes.

The bottler began using the ANS program in June 1983. By the end of this year, the company hopes to reduce its on-the-job back injuries to 3.1 per million cases of soda sold from today's 3.95 per million cases sold, a 20% reduction in claims, explains Paul W. Murray, corporate director of safety and health.

The company paid out about $600,000 for work-related accidents last year, 90% of which was from back claims, Mr. Murray estimates.

Mr. Murray worked with ANS to conduct a job analysis of the bottler's route salesmen to determine what their high-risk activities were and where their back injury exposures lie. The close observation of route salesmen on their daily routine included taking slides of the workers performing their duties.

Using that information, ANS developed a training program for the salesmen. Part of the program included exercises that employees could perform while simultaneously doing their job.

"You should be decreasing the likelihood of a back problem through work-related activities, as opposed to increasing one," Dr. Mulry explains.

He says that virtually all of the major life and health insurance companies reimburse employers for the costs of administering the Back School program if it's administered by a physician or physical therapist. The treatment is generally billed under rehabilitative medicine.

While employers say they're pleased with ANS' training programs, one insurer says it is happy with the results of the company's disability case management program, which helps return injured employees to their jobs as quickly as possible.

Warren R. Bloomquist, reinsurance medical claims specialist for Northwestern National Life Insurance Co. in Minneapolis, reports the program was "imminently successful" in rehabilitating three of four injured employees of a corporate policyholder.

The cases were difficult to treat because all the employees were middle-aged women with a history of back problems, he explains.

Mr. Bloomquist, who worked as Northwestern National's rehabilitation coordinator until January, says, "The purpose (of ANS case management) is, in the best possible state-of-the-art sense, to find out what's wrong. Had we not intervened, these ladies might never have gone back to work."

The fourth case, he explains, presented "certain psycho-social difficulties we simply couldn't deal with." That individual was unable to return to work.

Savings through prevention is what the city of Santa Ana, Calif., is working toward. Santa Ana, which projects it will pay an estimated $1.5 million in comp claims in fiscal 1983-84, is considering contracting with ANS to train 825 of the city's 1,300 employees in proper back care, says Jeff Stevens, risk manager. The training would be conducted in weekly sessions over a one-year period and would cost the city $55,000 to $60,000. The proposal is being reviewed by the city manager.

Other employers that reported success with ANS services include ARA Services Inc. in Philadelphia; Coors Distributing Co. in Tustin, Calif.; Boise Cascade Trucking Division in Boise, Idaho; Princeton University Plasma Physics Laboratory in Princeton, N.J.; The May Co. in Los Angeles; Minneapolis-based North Star Casualty Services Inc.; and the city of Costa Mesa, Calif. ■

# Doctors alerted to litigation-prone patients

By STEVE TARAVELLA

DETROIT—If a local attorney has his way, doctors nationwide may soon be able to reduce their medical malpractice claims and insurance premiums by subscribing to a service that red-flags litigation-prone patients.

Physican's Alert Inc. operates under the premise that people who have been plaintiffs in civil lawsuits in the past are more likely to file a malpractice claim against their physician than are people who never have initiated litigation.

For a fee, the 7-month-old Detriot-based company will provide physicians with a legal history of potential patients, calling attention to any suits that have been filed in the three-county metro Detroit area within the past 48 years,


explains Paul H. Huth, the company's legal counsel and co-founder.

Mr. Huth explains that, having this information, a physician may:

- Deny the patient treatment.
- Treat the patient, but charge a higher fee.
- Treat the patient more conservatively and with more caution than he or she would otherwise.
- Just take the information into consideration without acting on it.

The legal screenings do not tell the doctor if the patient was successful in prior legal action. Mr. Huth says searching for that information would be particularly time-consuming, since the majority of medical malpractice suits are settled out of court.

Because of a proliferation of health maintenance organizations and preferred provider organizations, many doctors are now seeing patients who are referred to them not by friends or fellow physicians, but by an employer's health care plan, he points out. Thus, doctors have no real way of knowing about their patients' legal histories.

> 'We were shocked and astounded by the high number of people filing repeat lawsuits. We believe, based on those figures, we can truly provide service to doctors,' Paul Huth explains.

For an annual charge of $300, the family-owned company will conduct legal screenings on 50 patients. For each legal history after 50, doctors are charged an additional $2, Mr. Huth says.

He estimates that arriving at a jury verdict in a medical malpractice case in the United States costs an average of $100,000 in both public and private monies.

"If you have a screening that pinpoints a 'professional plaintiff,' then $300 a year is peanuts to save that one lawsuit," he says.

By the end of this year, Physician's Alert expects to have enrolled 5% of the estimated 13,700 physicians in the Detroit metropolitan area, where about 96 new medical malpractice suits are filed weekly.

And, and the service is in the process of expanding nationwide. Mr. Huth says the business has received 80 requests for franchises in 26 states.

And, he says that the company currently is negotiating with a Detroit-area doctor-owned insurance company, which he declined to identify, that is interested in providing the service to its physician policyholders.

"People in the high-risk categories and in private practice who pay for their own insurance are the ones who'd benefit the most from this," he explains.

High-risk medical malpractice policyholders, who most frequently see rate increases, include obstetricians, gynecologists, neurosurgeons and neurologists (*BI*, Sept. 26, 1983).

Mr. Huth says the company's current clients are not doctors who work in hospitals, where physicians' malpractice insurance costs are sometimes paid by the institutions, but private physicians, high-risk specialists and doctors who are seeing new patients. The latter category includes those doctors who are just starting their practice, or who have relocated an existing practice.

Doctors who subscribe to the service are given a red sticker to place in their office window, presumably to ward off litigious patients.

"The doctors have been very, very pleased with our service," he reports. He says the company receives about 120 screening requests daily. Screening requests generally do not come in one at a time. More frequently, a physician or the physician's receptionist will call with five or six names from the upcoming week's appointment calendar.

Doctors look at the service as a way to combat increasing malpractice insurance rates, but also to avoid unnecessary "adversarial relationships" with a patient, he says.

He explains that when someone a doctor thinks is a risky patient turns out never to have filed a suit, the doctor is relieved and can trust that patient without anxiety.

When asked about the medical or ethical issues involved in denying a sick individual care simply because he or she has filed one or several lawsuits, Mr. Huth responds, "That's an interesting issue, and one we've certainly thought of. But I don't know any doctor who would ever turn down a patient in an emergency situation."

Physician's Alert's seven staff researchers work five days a week, keeping abreast of local court dockets much like a newspaper reporter. The work involves driving to different courthouses in the three-county area, and much cross-checking of records.

Courthouse records are computerized five years back; the company manually digs through re-

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maining records, which date back an additional 43 years.

With information obtained from court records and legal documents, Mr. Huth says Physician's Alert is slowly developing its own computer data base.

"We're just making public information more readily available," Mr. Huth says of his service, pointing out that none of the information given to physicians is either private or classified.

Some records are "awkward and hard to get," he says, "but once you understand how the courthouse works, (obtaining the appropriate) information doesn't take too long."

The company usually responds to a screening request within one day, but in emergency situations it can provide a legal history in only half an hour, Mr. Huth explains.

The idea for Physician's Alert began in November 1983 during a dinner conversation among Mr. Huth, a corporate attorney in private practice; his wife, a nurse anesthesist; his father-in-law, an obstetrician-gynecologist; and his mother-in-law, Yolanda I. Mascarin, now owner of the company.

**That conversation** spurred Mr. Huth to study the incidence rate of medical malpractice suits in three Detroit-area counties—Oakland, Wayne and Macomb—in a three-month period in 1982 and again in 1983. In both instances, he reports, 35% to 40% of the plaintiffs had initiated some sort of civil litigation in the past: other than divorce or child custody cases.

"We were shocked and astounded by the high number of people filing repeat lawsuits," he says. "We believe, based on those figures, we can truly provide service to doctors."

But he insists the company aims only to red-flag the "professional plaintiffs.

"Certainly, some lawsuits have merit. We're trying to weed out those (people) who live from one lawsuit to another."

Recent examples of the what he calls the kind of "frivolous and ridiculous" litigation he hopes to help doctors avoid include: a woman who sued her doctor for failing to have a box of facial tissues next to her hospital bed, and a woman who sued a hospital for alleged racial discrimination in the treatment of her newborn child.

A recent legal search turned up one individual who filed 22 separate lawsuits in January, he adds.

"It's clear to me and to insurance companies that it's prudent to settle (malpractice claims)," he says. "That's wrong. The general public is beginning to realize that by filing, they're sure to get $5,000-$3,000 in a nuisance settlement."

Mr. Huth says that since word of the company has spread, he has received requests to conduct similar legal screenings from:

- Beauticians who fear customers may sue over unattractive results from hair dyes.
- Stockbrokers who want a history of clients who have filed malpractice suits.
- Fellow attorneys who want to know about prior suits brought against individuals they are suing.
- Businesses that want the information for pre-employment screening purposes.
- A chain of auto brake-repair shops that wants the information to evaluate new customers' chances of filing suits.

"The market has just mushroomed and we haven't had the time or the money to pursue these other areas," Mr. Huth explains. ■

## April storm cost insurers $68 million

RAHWAY, N.J.—A weather system affecting 10 states from April 3-7 caused an estimated $68 million in insured property damage, says C. Edward Hermanson, vp of American Insurance Services Group Inc.'s Property Claims Services.

Included in the total damage figure is an estimated $25 million in insured damage in New Jersey and New York, which experienced severe flooding caused by record rainfall.

Damage from wind, hail, tornadoes and flooding was also sustained in Missouri, Arkansas, Illinois, Kentucky, North Carolina, Virginia, Maryland, Delaware and possibly other areas.

The PCS estimate does not include damage that is insured under the National Flood Insurance Program.

The storm system was assigned Catastrophe Number 33 by the Insurance Services Office. ■

# Survey details components of typical Midwest health plan

By SALLIE J. DRURY

The typical Midwest employee health care plan in 1983 was self-funded and included a 20% copayment on comprehensive medical coverage after a $100 deductible for individuals, a new survey reveals.

The usual maximum copayment was $1,000 for an individual and $2,000 for a family. Employees typically did not contribute to the premium for their own coverage, but paid 15% of the cost of the premium for dependent coverage.

This profile is derived from a benefit plan survey conducted by the Midwest Business Group on Health. The 86 respondents to a survey of 100 member and nonmember companies in the Midwest region employ more than 1 million workers.

Fifty-six percent of the respondents said they self-insured their health benefits in 1983. An additional 28% had a minimum premium arrangement with an insurer, while 14% were fully insured.

The survey did not quiz the employers on their benefit practices prior to 1983, so year-to-year comparisons cannot be made.

More companies said their claims were administered by third-party administrators rather than by insurers. Some 51% tapped a TPA, while 38% of the respondents hired an insurer to administer claims.

Ten percent administered claims in-house.

Most responding companies asked employees to share the cost of coverage. Although most companies—60%—did not ask employees to contribute to their own premium, 58% asked employees to contribute to the premium for dependent coverage. The most common contributions toward dependent premium were 11% to 20% of the cost.

Further cost-sharings through deductibles and copayments were popular features.

Some 58% of the respondents required employee deductibles; about 51% of these companies priced the deductible from $51 to $100 per person. Whether the deductible was an annual or a one-time cost was not specified.

Some 37% of the companies have increased the amount of the deductible during the past several years, and 20% of the respondents plan to increase the deductible within the year. And, 29% are interested in increasing the deductible, although no implementation is planned.

Eighteen of those companies that increased the employee deductible rated the effects as positive; one said it was negative.

Other deductible features respondents noted include:

- Special deductibles for emergency room (15 respondents).
- Deductibles indexed to salary (three respondents).
- Deductibles indexed to the cost of living (one respondent).
- Deductibles based on first-day room and board (three respondents).
- Deductibles waived in case of auto accident if a seat belt were buckled (one respondent).

Also, 63% of the surveyed companies required employee copayments for medical coverage, with a 20% copayment the most common share required. Of the companies requiring copayments, 78% also require deductibles.

Some companies had special copayment features. For example, the copayment for mental health benefits differed from the medical coverage deductible at 60% of the companies surveyed. It also varied for prescription drugs at 55% of the companies, while the deductible for emergency room costs differed from the medical plan deductible at 34% of the respondents.

Also, two companies offered reduced copayments to employees if they used certain preferred providers.

However, the responding companies tempered their employee cost-sharing with a stop-loss arrangement. Some 72% of the respondents provided a stop-loss limit for employees. The most common out-of-pocket limit, excluding deductibles, was $1,000 per person, the survey reports.

The MBGH also asked companies about specific plan design features that have been implemented in the last several years, are planned within the year or are being considered but not yet implemented.

The survey further asked the companies to evaluate these plan design features as generally positive, generally negative or neutral.

Benefit managers had been most active in implementing changes in the outpatient benefits area. More than three-quarters of the companies—76%—had implemented or plan to implement coverage for pre-admission testing, and more than half—62%—now cover diagnostic X-ray and lab features.

Most employers that had evaluated these features rated them as generally positive, although some were neutral on the changes.

Seventy-two percent of the respondents either have added or plan to add coverage for outpatient surgery, while 57% have implemented or plan to implement home health care coverage.

Of 22 companies that evaluated the outpatient surgery benefit, 21 rated it positive; one was neutral. For home care, six companies rated it positive; four were neutral.

Benefits for outpatient treatment of chemical dependency were implemented or planned by 65% of the companies. Coverage for extended care facilities was also popular, with 69% of the respondents reporting that their plans featured or would feature this coverage.

Of these, 80% provided coverage after a hospital stay; 20% did not require the employee to be first hospitalized. The majority of companies rated these benefits as generally positive.

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Less-common outpatient benefits that were either implemented or will soon be implemented include hospice care (noted by 49% of the respondents), post-admission testing (noted by 22% of the companies), urgent care centers (mentioned by 21%), birthing centers (mentioned by 19%) and home births (cited by 9%).

The majority of the evaluations for all of these benefits were positive, except for birthing centers and home births. Of the four companies evaluating these features, one company gave each feature a positive rating, while three companies gave each a neutral rating.

**Another extremely** popular feature of the respondents' plan design was coordination of benefits. Sixty-four companies, or 75%, now screen or plan to screen claims of duplicate coverage.

Of the 49 companies that provided an evaluation of the feature, 48 said it was generally positive; one company was neutral.

Other cost-cutting features in the form of exclusions or incentives were adopted or planned by employers. An exclusion from coverage or reduction of benefits for non-emergency admissions on a Friday or Saturday has either been implemented or will be implemented by 21% of the respondents, while another 58% were interested in the feature, though they had no plans for implementation.

Incentives for second surgical opinions also were popular features. Those already mandating the second opinion (16% of the respondents) rated the feature as positive, while those that had only a voluntary second opinion provision (35%) gave the feature mixed reviews: four companies were positive, five were neutral and seven were negative. Nine companies said the provision was too young to evaluate.

**Incentives in the form** of greater coverage for outpatient care were also part, or were scheduled to be a part, of some companies' benefit plans. Twelve percent either used or would use such incentives for mental health coverage; 38% either had such incentives for specific surgical procedures or plan to implement them; and 33% either encourage or plan to encourage outpatient lab and X-ray procedures. Few companies evaluated these procedures, but the evaluations that were made were positive.

Five companies offered or planned to offer financial incentives for no or few claims; three offered or would offer an early discharge bonus; eight provided or would provide a medical expense account; 11 offered or planned to offer a higher benefit level for preadmission certification; and 17 companies offered or planned to offer shared savings for patient audit of hospital bills.

The survey also showed that large numbers of employers are interested in—although they have not yet implemented—certain nontraditional benefit designs. These are flexible benefits, high/low coverage alternatives and preferred provider organizations.

Fifteen percent of the employers said they already had or would install within the year a flexible benefits plan. Another 53% expressed an interested in flexible benefits plans.

**A feature frequently** a part of flexible benefit plans—high/low-coverage options—also was not yet widely installed: Only 7% had this option or said they would adopt it within a year. However, another 44% said they were interested in the concept.

Also, few employers—13%—had already lined up preferred provider organizations, but 66% of the respondents were interested in offering this feature.

Most changes in benefit plans were for the better, employers reported. Of those that had modified their plans in the last several years, 66% said they were generally satisfied; only 4% said they were not satisfied.

Employees were generally amenable to change as well, employers said. Forty-nine percent said they had little reaction to change from employees, while 15% said they had received a mixed reaction.

More than half the respondents did not say they would do anything differently if they had to change their benefit plans again. However, 12 companies said they would "make more cutbacks," and 10 said they would have "better and earlier communications" if they were starting over. Also, more than half the employers— 52%—said it is best to make many changes at one time.

Respondents also were asked to name the three implemented changes they felt are or would be most significant to the plans. Respondents named:

- Introducing or increasing employee deductibles (cited by 37%).
- Introducing or increasing employee copayments (cited by 33%).
- Incentives in the form of greater coverage for outpatient services (cited by 27%).

More changes are on the way for 56% of the respondents, and the MBGH intends to survey and report those changes.

"This is the first step in tracking benefit trends," said Iris P. Masotti, project director for the survey at the MBGH. "We hope to have these surveys out about every six months."

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*Companies interested in more information on the MBGH 1983 Innovative Plan Design survey results may contact Ms. Masotti at the Midwest Business Group on Health, 417 S. Dearborn St., Suite 410, Chicago, Ill. 60605; 312-922-1383.*

## Florida OKs health cost law

TALLAHASSEE, Fla.—Florida hospitals will face stiff penalties if their revenues exceed state-mandated limits as a result of a law signed in mid-May by Gov. Robert Graham.

The Health Care Access Act of 1984 sets a ceiling on the budgets of the state's 260 public and private hospitals.

If a hospital exceeds the ceiling for any year, the state's hospital cost-containment board, established in 1979, can reduce the hospital's budget for the next year.

The state also is now empowered to close any hospital whose budget exceeds its ceilings three times within five years.

Revenue growth will be measured by a "hospital index," which measures the inflation rate of hospital supplies. During the program's first year, hospital budgets can rise no more than the hospital index plus 5%. During the second year, this limit will drop to the index plus 4%. Thereafter, it will be the index plus 3%.

The law also establishes a $150 fund to pay for health care for the indigent. About $70 million of this amount will come from a 1% tax on hospital revenues. In 1986, the tax will climb to 1.5% of revenues, and the total fund will reach almost $300 million. The rest of the funding will come from a $20 million state contribution and federal funds.

To encourage competition among hospitals, the law requires hospitals to publish their rates for services.

# Take the offensive against toxic torts: Lawyers

By STACY SHAPIRO

LONDON—A good offense is also a good defense for companies facing injury claims arising from exposure to hazardous products or substances, attorneys say.

Companies that handle toxic substances should begin preparing for possible lawsuits or workers compensation claims before accidents or injuries are reported, advise attorneys with the Boston law firm of Morrison, Mahoney & Miller.

Likewise, a defendant should take the offensive throughout the legal process, the attorneys said at a seminar on toxic tort litigation held in London earlier this month.

First of all, companies should have a thorough knowledge of their products, said Philip M. Davis, one of the attorneys.

"Your knowledge of major risks is an important defense. It behooves you to learn everything you can about your risks, plus the types of records that are kept, the chemicals that are used, the employees who deal with them, etc.," he said.

Next, companies that deal with hazardous substances should hire attorneys and experts as soon as they have an inkling that they could face a claim. A good attorney acting quickly can help reduce whatever judgments the company may face, Mr. Davis said.

He cited the example of a firm that used hexane in its manufacturing process. Just one hour after hexane from the company's plant leaked into the city's main sewage system, causing an explosion that damaged two miles of sewer lines, the company contacted an attorney.

The attorney immediately interviewed 39 employees who handled the hexane, thus protecting their statements through the client-attorney privilege. He also informed the employees that any information that they gave to the plaintiffs may be held against them.

As a result, the only evidence available to the plaintiffs were company records, and the lack of available evidence reduced the amount the company ultimately had to pay, Mr. Davis said.

Once a case goes to court, there still are ways to convince juries that awards should be denied or reduced, Mr. Davis noted.

Of these, the medical defense—through which defendants are able to prove that the substance or product handled by the company could not have caused the plaintiff's injury—works the best, he said.

For example, a company could try to show that the product couldn't have caused the injury because the product was not sold or manufactured in the area at the time the injury occurred.

"If you can show that your product was not there at the time, you can walk away from the case," Mr. Davis said.

Or, a defendant may try to prove that other dangerous products to which the plaintiff was exposed, like cigarettes, could have caused the injury.

Once a lawsuit is filed and/or a trial begins, however, it may be less expensive—both in time and legal costs—to settle the claims out of court, another attorney said.

Mark S. Granger, another member of the law firm, said, "One of the most perplexing problems is whether to settle cases and when and how. If the timing or terms are wrong, a settlement can be an absolute disaster."

To decide whether it is in a defendant's best interest to settle a claim, Mr. Granger said, the defendant should:

- Know exactly with whom you are settling. For example, if the defendant is dealing with the federal Environmental Protection Agency, a settlement would not include other government agencies. Other agencies still could file lawsuits.
- Make sure the settlement will be approved by the judge if you are named in a class action.
- Make sure the documentation is clear and concise, and include a good-faith release that precludes all later action by the plaintiffs.
- Determine how many future claimants remain following the settlement and what effect the settlement will have on future litigation.
- Decide where and when to settle the first case if the company is facing many claims.
- Attempt to seal the terms of the settlement and the court documents, and also attempt to have each party sign a non-disclosure agreement so that the amount of the settlement is not released. Otherwise, the settlement will be "broadcast all over the place," said Mr. Granger, causing unwanted adverse publicity. ■

# Toxic waste costs could outstrip insurers' funds

LONDON—Pollution insurers don't have enough funds to cover cleanup costs and liability claims arising from U.S. hazardous-waste sites, said Stephen J. Paris, an attorney with the law firm of Morrison, Mahoney & Miller in Boston.

"It is estimated that there are 6,000 to 12,000 hazardous-waste sites in the United States. Multiply that by $6 million for each site (for cleanup costs) and you come out with a 36 with nine zeros after it," Mr. Paris said at a seminar on hazardous-substance claims held recently in London.

"There is not enough money in the insurance industry to cover that type of exposure. As Sen. (Everett M.) Dirksen once said, 'A billion here and a billion there and you are talking about a lot of money.'"

Comprehensive general liability and environmental impairment liability insurers will cover some of these costs, Mr. Paris pointed out.

But, he noted, the wording of some of the policies, especially older CGL policies, probably will trigger a court battle between the insurer and the policyholder over the definition of an "occurrence."

To date, no legislation or court ruling clearly defines when bodily injury and property damage is caused by hazardous wastes or toxic products and what insurance policy covers what accident, Mr. Paris pointed out.

Instead, courts have issued a "quartet" of decisions that explain what coverage should apply to a long-latent injury claim, the attorney said.

They are:

- The exposure theory, which says that injury occurs at or shortly after the time the victim is exposed to the product. The principal case expounding this theory is *INA vs. 48 Insulations Inc.*
- The manifestation theory, which says that coverage is triggered at the time an injury manifests itself. This theory is supported by *Eagle-Picher Industries Inc. vs. Liberty Mutual Insurance Co.*
- The tripple-trigger theory, which says that a policyholder should be covered from the time of exposure through the time the injury manifests itself. This theory was handed down in *Keene vs. INA Corp.*
- Most recently, a U.S. District Court in New York in *American Home Products vs. Liberty Mutual Insurance Co.* determined that coverage is triggered by the date that a victim's medical injuries actually occurred, not when the victim was exposed to the product or when the injury manifested itself.

Medical science supposedly now can target the date when the injury actually begins, Mr. Paris explained (*BI*, July 4, 1983). ■

# Survey shows states spend relatively little on regulation

COLUMBUS, Ohio—A recent survey by the Insurance Industry Committee of Ohio shows that state insurance regulators spend a fraction of the premium taxes and other fees that states collect from insurers.

The survey examines state insurance departments for the year ending Dec. 31, 1981, although some of the individual figures are for other years.

According to William H. Fletcher of the Ohio Insurance Institute in Columbus, which compiled the survey, the statistics were gathered from questionnaires sent to the insurance departments in each state.

*Businss Insurance* was unable to independently confirm the data.

According to the survey, the New York Insurance Department spent the highest percentage—12.2%—of the money the state collected from insurers.

New York collected $184.97 million in premium and other taxes and $27.8 million in fees for a total of $212.8 million in revenue. The department spent $25.99 million, or 12.2% of the revenue.

Florida spent the next-highest percentage of its revenue, the survey shows. That state took in $112.98 million in premium and other taxes and $12.28 million in fees for a total of $125.27 million. Of that, the department spent $14.95 million, or 12%, on Insurance Department operations.

Nevada took in a total of $15.96 million and spent $1.51 million, or 9.5%. Texas took in $213.83 million and spent $19.87 million, or 9.3%. (The figures for Texas are for the year ended Aug. 31, 1982.)

Ranking fifth was South Carolina, which took in $45.41 million and spent $3.82 million, or 8.4% of revenues.

Missouri spent the lowest percentage—1.8%—of what it earned from insurers.

According to the survey, Missouri took in $67.74 million in premium and other taxes and $4.37 million in fees, for a total of $72.11 million in revenue. But, it only spent $1.29 million, or 1.8%, on operation of the department.

Ohio, Connecticut and Hawaii each spent 2% of revenues, the survey shows. Ohio collected $154.06 million and spent $3.13 million; Connecticut took in $75.53 million and spent $1.47 million; and Hawaii collected $31.96 million and spent $608,252.

South Dakota collected $16.19 million and spent $332,615, or 2.1% of its revenue, according to the survey.

The other states listed in the survey and their state insurance regulators spent include:

Alabama, 2.5%; Alaska, 6.2%; Arizona, 3.9%; Arkansas, 4.4%; California, 4%; Colorado, 3.2%; Delaware, 5.1%; the District of Columbia, 4.5%; Georgia, 3.1%; Idaho, 4.4%.

Also, Illinois, 6.4%; Indiana, 3.4%; Iowa, 3%; Kansas, 6.4%; Kentucky, 6.3%; Louisiana, 2.9%; Maine, 4.8%; Maryland, 4.5%; Massachusetts, 2.6%; Michigan, 3.6%; Minnesota, 2.4%; Montana, 3.2%; Nebraska, 6.3%; New Hampshire, 5.6%; and New Jersey, 4.7%.

And, North Carolina, 6.2%; North Dakota, 3.7%; Oklahoma, 2.4%; Oregon, 5.5%; Pennsylvania, 3.5%; Rhode Island, 4.1%; Tennessee, 3.2%; Utah, 6%; Virginia, 4.1%; Washington, 5.9%; West Virginia, 2.5%; Wisconsin, 5.4%; and Wyoming, 7.8%.

The survey did not provide statistics for Mississippi, New Mexico and Vermont.

According to the survey, insurers in the state of California generated the highest total premium volume for 1981, with $23.53 billion in premiums. New York followed closely, with $23.52 billion in total premium volume.

Rounding out the survey's top five in premium volume were Texas with $18.26 billion; Illinois with $11.86 billion; and Pennsylvania with $11.85 billion.

Of the states that reported figures to the survey, Alaska reported the lowest total premium volume, with $578,457.

Arkansas reported $339.29 million, followed by Wyoming with $423.18 million; Delaware with $484.68 million; and Montana with $527.45 million. The survey reports that Texas had the highest number of licensed insurance companies in 1981 with 2,022. Texas was followed by Arizona with 1,795; Illinois, with 1,583; Colorado, with 1,431; and Indiana, with 1,410.

Of the states in the survey, Hawaii had the fewest licensed insurance companies—640. It was followed by Maine with 686; New Hampshire with 694; Massachusetts with 735; and Rhode Island with 739.

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*Copies of the survey results may be obtained by writing to the Insurance Industry Committee of Ohio, P.O. Box 632, Columbus, Ohio 43216.*

# Hawaii plan gets final OSHA approval

WASHINGTON—Hawaii's job safety and health program has become the first state plan to receive final approval from the federal Occupational Safety and Health Administration.

OSHA will now relinquish its standards and enforcement authority in areas covered by the Hawaii program.

These areas include safety and health in private industry, except maritime firms, and the public sector.

OSHA will continue to cover maritime operations, to investigate complaints of discrimination against workers for exercising their safety and health rights under the Occupational Safety and Health Act of 1970, and to evaluate the state program.

The Hawaii program began operation in 1974. ■

## comings & goings: buyers

# Wickes promotes Fisher to risk management vp

**M. Douglas Fisher**, 37, is now vp of risk management, a new position, at Wickes Cos. Inc. in Santa Monica, Calif. He heads the worldwide property and casualty insurance programs for the company. He joined Wickes in 1980 as supervisor of insurance and became director of risk management in 1982. Before he joined Wickes, Mr. Fisher worked in risk management for Sambo's Restaurants. He earned his bachelor degree in general studies from Ohio University in Lancaster in 1977. He reports to Wilhelm A. Mallory, executive vp of finance and chief financial officer at Wickes.


Mr. Fisher

* * *

**Laura Hinckley**, 33, was appointed director of risk management for Avery International in Pasadena, Calif. Ms. Hinckley joined Avery in 1981 as corporate risk manager. She is now responsible for the company's worldwide risk management program. She also negotiates policies, claims and new product development and formulates risk funding strategies. Ms. Hinckley received her bachelor of science from North Central College in Naperville, Ill., in 1972. She earned a master of business administration degree in 1975 from Northern Illinois University in De Kalb. She has also received the Associate in Risk Management and Chartered Property & Casualty Underwriter designations. She reports to Wayne H. Smith, vp and treasurer.

Also at Avery International, **Mary E. Steele**, 31, has been promoted to risk analyst, a new position. She will administer the U.S. workers compensation and fleet insurance programs, the risk management information system and publication of the company's risk management manual. She also will assist in compiling competitive bid specifications, insurance coverage reviews and assume a greater role in safety and claims management. Ms. Steele was most recently risk information coordinator, a post she was named to in 1981. Before that, she was a senior secretary in the treasury department at Avery, which she joined in 1979. She is currently working on her degree. She reports to Ms. Hinckley.

* * *

**Thomas R. Coles**, 33, is now corporate claims manager at Revco D.S. Inc. in Twinsburg, Ohio. Mr. Coles handles all casualty lines claims for Revco. He joined the drugstore company in 1982 and previously was claims supervisor. He received his bachelor of arts in business administration at Westminster College in New Wellington, Pa., in 1973. Mr. Coles reports to Lawrence J. Bell, assistant vp of risk management.

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*We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Write to Claudette Dampier, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5282. Please send a photograph, too.*

# Asbestos producers mulling agreement

Continued from page 1
vs. INA in 1981. In that case, the court said all insurers on an asbestos risk from the time of exposure through manifestation, including the latency period, are liable.

"I wouldn't say it is any broader than Keene," says Aetna's Mr. Shea. "It triggers all years of coverage and each insurer pays a proportionate share."

But, from an insurer's perspective, it is a better arrangement because the agreement does not allow insureds to select the particular policy that will apply, as the Keene decision allows, and then force those insurers to seek contribution from other insurers, he adds.

The agreement also deals with more coverage issues than the Keene decision, like insurers' duty to defend and how to handle policies that have no aggregate limits.

For some policyholders, signing the agreement would mean more coverage than under court decisions to date, and for others it would mean less coverage.

James Ralston, general counsel of asbestos producer Eagle-Picher Industries Inc., says the agreement will give his company more coverage than was afforded under a decision by the 1st U.S. Circuit Court of Appeals in 1982 in *Eagle-Picher Industries Inc. vs. Liberty Mutual Insurance Co.*

That decision, which espoused the manifestation theory, said Eagle-Picher's insurers would have to respond if they were on the risk during the time an asbestos disease was reasonably capable of diagnosis in a victim, not if they were on the risk during exposure or the latency period.

## Punitive claims won't be paid

The claims handling facility proposed by the agreement between insurers and asbestos producers will administer, evaluate, settle, pay or defend all asbestos-related claims against producers and insurers.

However, it will only settle claims on behalf of all the producers and insurers and will not pay any punitive damages to claimants, the agreement notes.

The agreement emphasizes that valid evidence will be required to support all claims and the facility will hire legal counsel and medical personnel to defend asbestos claims.

Claimants will be asked to provide certain standard information, including job, medical and compensation history, to determine if the claimant is eligible for further compensation.

To be eligible, the claimant would have to have been exposed to an asbestos product produced by a facility member and have an asbestos-related condition.

The facility would have the power to allow claimants whose claims have not matured an opportunity to resubmit them to the facilty if additional medical evidence becomes available. The statute of limitations may also be extended for particular cases.

There won't be a predetermined schedule of benefits, but detailed claims guidelines will be used to evaluate and settle the claims, the agreement says.

The facility will be a non-profit organization governed by a board of directors with at least 12 members containing an equal number of subcribing insurer and producer members.

All start-up costs will be paid by subscribing primary insurers and all operating expenses will be paid by subscribing primary and excess insurers. ■

Eagle-Picher claims not covered under that court decision now would be indemnified under the agreement.

However, AC&S Inc. of Lancaster, Pa., which won coverage even broader than Keene's in a decision late last year in a U.S. District Court in Philadelphia, would not fare as well under the proposed agreement.

According to James Hipolit, general counsel for AC&S, the negotiated agreement is "somewhat less favorable than our decision," but he adds that this must be weighed against the advantages of the agreement.

In *AC&S Inc. vs. Aetna Casualty & Surety Co.*, handed down by the U.S. District Court in Philadelphia, the court followed the triple-trigger approach handed down in Keene but also ruled that under pre-1966 policy forms, primary insurers have an unlimited duty to defend.

In accepting the agreement, asbestos producers will have to weigh their chances of winning in court coverage as broad as Keene or AC&S, Mr. Hipolit says.

It's not a foregone conclusion that every policyholder will be granted the broadest coverage available by the courts, he warns.

Some asbestos producers and their attorneys are also concerned that the "lifetime" defense coverage provision in the agreement will not provide as much coverage as afforded under some pre-1966 policies.

At least two courts have agreed with policyholders that, under pre-1966 policy forms, insurers must provide an unlimited defense even if policy limits are exhausted.

Under the agreement, the duty to defend under pre-1966 policies ends upon exhaustion of the policy limits.

But if a producer exhausts all of its other defense coverage, including excess insurance, coverage would be revived. Rather than any individual policy providing defense coverage, though, all the insurers that signed the agreement would set up a defense fund that would guarantee the lifetime payment of defense coverage due under a pre-1966 policy form.

However, according to Raymark Corp. outside counsel Frank Heap of the Chicago firm of Bell Boyd & Lloyd, this defense coverage plan could mean less indemnity coverage from excess insurers for some producers.

Excess policies, unlike primary policies, usually include defense costs within the policy limits. Therefore, if excess insurers are tapped for defense costs instead of a primary insurer providing unlimited defense, excess coverage that would normally be used to pay claims will be spent on defense.

"It is a big, big dollar concession from the policyholder's point of view," Mr. Heap says.

James Restivo, outside counsel for Pittsburgh-Corning Corp. with the firm of Reed, Smith, Shaw & McClay, agrees the defense cost provision is a "substantial concession of the policyholders.

"Instead of a continuing duty to defend at the front end, it's being deferred until a later point in time. The immediate liability and immediate expenditure is now made conditional and may or may not ever come into play."

Another concern among some asbestos producers is how much coverage they will lose by agreeing to a cap on coverage provided by policies that have no aggregate limits.

Policies without aggregates include some early policies written by Lloyd's of London underwriters and a predecessor of Commercial Union Insurance Co., sources say.

While policyholders have contended in the court that the insurers are on the risk for their per-occurrence limit for every claim filed, under the agreement the asbestos producers would agree to a cap on the policies' coverage.

By agreeing to such a cap on their policy coverage, "If in three or four years they run through those caps, those firms will be without insurance for those years," warns Eugene Anderson, an attorney for Keene Corp. with the firm of Anderson Russell Kill & Olick in Washington, D.C.

Under the agreement, for policies with a $100,000 per-occurrence limit, the cap is 10 times that or $1 million. At that point, the next layer of insurance is triggered.

If per-occurrence limits are higher than $100,000, the multiplier in the formula is less than 10.

In the case of a per-occurrence limit of $300,000, for example, the insurer's liability is initially capped at $2 million.

This includes the $1 million for the first $100,000 of the $300,000 per occurrence limit based on the multiplier of 10 and $1 million for the next $200,000 per occurrence, based on a multiplier of 5.

However, if all applicable insurance policies for a particular year are exhausted but claims remain, the primary policy with no aggregate is tapped again.

At that point, the primary policy without an aggregate will pay 10 times the per-occurrence limit. Thus on a $300,000 per occurrence policy, the aggregate limit would be $3 million. But since the insurer has already paid $2 million, it would owe only another $1 million.

After that $1 million is paid, the asbestos producer is without any more coverage for that year. The producer then taps the next policy year, but conceivably it could run through all the coverage.

A similar formula caps policyholders' deductibles.

If a policyholder had to pay a $5,000 deductible under an older policy, a multiplier of 10 is used so once the policyholder pays $50,000 —or 10 times the $5,000 deductible —he owes nothing more in deductibles.

Some of the asbestos producers are also not sure they like the agreement provision that forces them to give up punitive damages claims against their insurers.

Under the agreement, all of the litigation between policyholders and insurers would be dismissed, including punitive damage claims sought by producers like GAF Corp., Nicolet Industries Inc. and Manville Corp. in coverage litigation in California.

"We believe forcefully in the merits and substance of our bad-faith case against our carrier," says David Steuber, an attorney with the law firm of Paul, Hastings Janofsky & Walker, which represents asbestos defendants GAF and Nicolet Industries in California coverage litigation. "It would be a major concern if bad-faith claims were abandoned and waived.

"I'm not sure that major concessions of the insurance industry are contained in the agreement," he adds.

"We are skeptical," Mr. Steuber continues. "It assumes a considerable amount of faith and trust between the parties. That requires a big step in and of itself."

"There are a lot of unknowns," says Mr. Ralston of Eagle-Picher. "It's an untried situation. There are risks, but there are also rewards."

"There's probably something in this for everybody," adds Edward Tanenhaus, an attorney with Munves, Tanenhaus & Storch and a consultant to GAF. "The problem is, are the give-ups greater than the benefits."

"This involves a compromise on both sides," says Scott D. Gilbert, an attorney for Armstrong World Industries Inc. with the Washington firm of Covington & Burling, who helped negotiate the agreement. "In our view, it is a good deal for all concerned." ■

# How producers' liability will be set

Each asbestos producer who signs the settlement agreement will be allocated a percentage of liability for each claim paid by the facility.

Based on the proposed formula, those producers that have been sued the most and have paid out the most will continue to bear the larger share of liability.

The percentage of liability for each producer will be determined by a formula that takes into account for each producer the number of claims paid or owing, the amount of indemnity paid or owing and the number of open claims as of Sept. 30, 1983, plus any new claims reported to the producer or the asbestos facility for the period from Oct. 1, 1983, until one year after the opening of the facility.

In addition, the formula takes into account that in some states claims have been paid at a consistently higher amount.

All these claims will be divided into groups by whether they were filed in so-called "major states" or not.

The major states have been determined to be Pennsylvania, California, Texas, Washington, Massachusetts, Maryland, Virginia, New Jersey, Mississippi and Connecticut.

Looking at the claims filed in each major state, the formula calls for:

- Determining the number of closed claims for each company as of Sept. 30, 1983.
- Determining the amount of indemnity dollars, including any punitive damages, paid or owing for each company as of Sept. 30, 1983.
- Dividing each company's number of closed claims into its amount of indemnity paid or owing to arrive at an average cost per claim for each company.
- Determining the number of open claims for each company as of Sept. 30, 1983.
- Multiplying each company's number of open claims by each company's average cost per claim for a product.

Looking at the claims filed in all the remaining states not considered a major state, the formula calls for:

- Adding together the number of closed claims in all remaining states as of Sept. 30, 1983.
- Adding together the amount of indemnity paid or owing including any punitive damages as of Sept. 30, 1983.
- Dividing each company's total number of closed claims into each company's total amount of indemnity paid or owing to arrive at each company's average cost per claim for states other than the major ones.
- Adding together the number of open claims in the remaining states as of Sept. 30, 1983.
- Multiplying each company's number of open claims by its average cost per claim for a product.

The formula then calls for combining the information from each of the major states and the remaining states.

Each company's average cost times open claims for each major state is added to the average cost times open claims for the remaining states.

Each company's share of liability for asbestos claims is then determined by dividing each company's average cost times open claims into the aggregate of all participating companies' average costs times open claims.

An adjustment will be made for each company that had 20 or less closed claims in a state. For that company, its simple arithmetic nationwide average cost per claim (total closed claims in all states divided into the total amount of indemnity paid or owing in all states) is used as that state's average cost per closed claim.

Each company's allocated expense percentage will be calculated by dividing its number of open claims as of Sept. 30, 1983, by the aggregate of all open claims against participating companies as of Sept. 30, 1983.

The data submitted by the asbestos producers for use in calculating their share of liability "will be reviewed for accuracy, consistency, reasonableness and completeness," the agreement says.

If it is discovered that a company submitted incomplete or inaccurate data, the company will be bound to accept any necessary adjustment in its allocated percentage of liability. Otherwise, a company will not be bound by its allocated percentage of liability if audit adjustments increase the company's allocation percentage by more than 10%.

Several producers are believed to have already agreed to their allocated percentage of liability, but the percentages are closely guarded secrets. The producers who have accepted their liability shares do not even know how much other producers have agreed to pay, sources say. ■

# Stress claims more costly

NEW YORK—Stress claims are becoming more expensive relative to other occupational disease claims, a recent study reports.

They also are less likely to involve permanent disability, and claimants are younger and twice as likely to be female as are non-stress claimants, says a survey by the Economic and Social Research Division of the National Council on Compensation Insurance.

The average stress claim cost exceeded that for all other occupational diseases for the first time in 1982, the NCCI survey found.

Females represented 48% of stress cases, compared with 23% of non-stress occupational diseases, according to the study.

Fifty-nine percent of all stress claims were filed by workers under 40. This age group accounted for 40% of all non-stress claims.

Almost three-quarters of workers filing stress claims are able to return to work, compared with less than 60% of non-stress occupational disease claimants.

The NCCI study is based on a random sampling of claims data from 13 states that were selected to provide a geographic sample of the entire country.

NCCI, headquartered in New York City, is a voluntary, non-profit, statistical, research and ratemaking organization. ■

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## AGENDA

**Sunday, July 29**
**REGISTRATION** **5:00 - 7:00 p.m.**
Advance conference check-in. Meet speakers and attendees during a cocktail reception. Browse the EBC Gallery; collect material available in the Literature Gallery.

**Monday, July 30**
**REGISTRATION** **8:00 a.m.**
A continental breakfast will be served. Chat informally with speakers and attendees. The EBC Gallery and Literature Gallery will be open.

### GENERAL SESSIONS

**Opening Remarks**
*Kathryn J. McIntyre, Editor, BUSINESS INSURANCE*

**Washington vs. Employee Benefits**
*Jerry Geisel, Washington Editor, BUSINESS INSURANCE*
Recent legislative and regulatory developments affect the type of employee benefits programs you offer and how you fund them. Mr. Geisel will explain the reasons behind — and the latest news about — the attacks on employee benefit plans waged by Congress and the Internal Revenue Service. He will also alert you to what you can expect out of Washington in the future.

**Strategic Planning**
*Richard M. Coffin, VP, TOWERS, PERRIN, FORSTER & CROSBY*
Developing your plan, setting objectives, analyzing your audience, and being alert to emerging trends, are the keys to every successful communication effort. Mr. Coffin will define 'strategic planning' and explain why it's especially needed in benefits communication. He'll focus on the principles and components needed as well as the specific steps to be followed in developing your own strategic plan.

**Budgeting**
*Julio Estaban, VP, Manager of Creative Services, BENEFACTS INC.*
Effective budgeting requires organized thinking, logic and an intense business sense. Mr. Estaban's unique approach provides insight in the common elements used in budgeting for benefits communication. He positions these principles as the 'heart' of the proposed presentation.

**Media Selection**
*Polly Carpenter, President, CARPENTER GRAPHIC DESIGN, INC.*
*Mary Anne Pakosta, Sales & Client Services, FRAME ONE, Inc.*
Two experts offer innovative ideas for print and state-of-the-art audio-visual communication approaches. In this two part session, they'll look at when, where, why and how to select the right medium for your communication needs.

**Luncheon/EBC Awards Presentation**
***Alfred Malecki, Publisher, BUSINESS INSURANCE***
**Business Insurance honors the winners of the 12th annual EBC Competition. One of the winning audio-visuals selected for excellence in communicating an employee benefits program will be shown.**

**Media Selection**
Part two.

### CONCURRENT SESSIONS

Concurrents afford you the opportunity to zero in on specific communication programs. Sessions will be repeated in the afternoon and again on Tuesday morning so that you may attend all three sessions. These smaller work-groups are presented as 'Case Studies' dealing with:

**Flexible Benefits**
*Robert E. Mathieu, Asst. VP - Benefits, MELLON NATIONAL CORPORATION*
*David M. Kieffer, Sr. VP, WILLIAM M. MERCER-MEIDINGER, INC.*
In 1983, the judges of the EBC Competition called Mellon National Corporation's award winning program "one of the most effective descriptions of flexible benefits ever seen." Mr. Mathieu and Mr. Kieffer will walk you through the communication concepts used to provide a clear understanding of flexible benefits so that employees can make well educated choices.

**Communicating On Your Own**
*Russ Ringl, Personnel Director, PLAYBOY ENTERPRISES*
Their objectives seemed simple ... to effectively communicate a high standard of benefits to serve as a motivating factor to employees; to keep employees informed, updated and clear about the company's benefits. Focusing on their booklet component, Mr. Ringl tells how his firm did it on its own - providing benefits in a serious yet personal manner.

**Flexible Spending Accounts & The IRS**
*Ed Dewees, Director, Department of Human Resources,*
*THOMAS JEFFERSON UNIVERSITY*
FSA's - everyone came up with a different way to design and communicate their plan. If you are confronted with a program in the works or on the drawing board, you won't want to miss Mr. Dewees' program. He went ahead with a program and anticipated restrictive IRS regulations.

**Tuesday, July 31**
### CONCURRENT SESSIONS
Repeated this morning

**A Look At This Year's Winners**
*Herb Zeltner, HERBERT ZELTNER INC., Marketing & Communications Consultant*
Mr. Zeltner, invited for a return engagement at the Conference, takes an in-depth look at what makes a winning program. This two part session is lively, entertaining and informative. It has been the highest rated by past attendees.

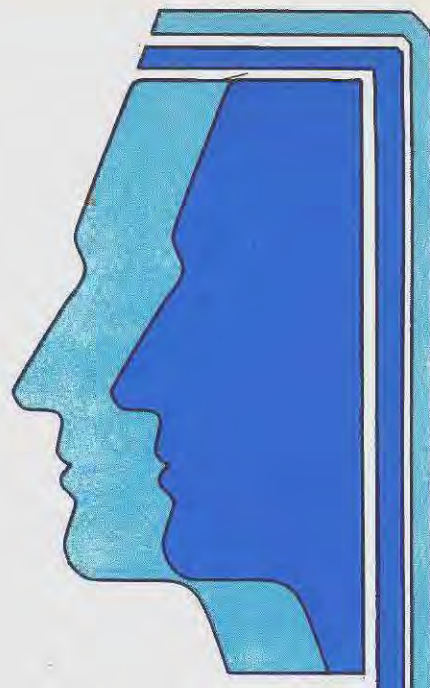
**Luncheon**
Exchange ideas with speakers and attendees. Spend some additional time in the Galleries.

**A Look At This Year's Winners**
Part two. This is your best opportunity to see what other professionals are doing.

**Management Training**
*David M. Kieffer, Sr. VP, WILLIAM M. MERCER-MEIDINGER, INC.*
You've planned, budgeted, and selected your media ... but your program can still fall flat without properly trained managers, meeting leaders, counselors, human resource personnel and, sometimes even employees to carry the communications program through. Mr. Kieffer will focus on inter-personal communication and the important issues essential in such training.

**Closing Remarks**
*Kathryn J. McIntyre, Editor, BUSINESS INSURANCE*

**The Conference adjourns at 3:30 p.m.**



In today's economic climate, corporations are particularly sensitive to the rising cost of benefits and are concerned about more efficient and effective ways to communicate the value of benefits to employees.

The *BI Employee Benefits Communication Conference* is a valuable investment of your time and dollars that makes sense for your company and for you as a benefits professional.

While exploring issues that are critical to your professional responsibilities, the *BI Conference* will focus on the foundation of effective communication. A clearer understanding of the methods used by the experts in your field will help you achieve better targeting of communication and more efficient utilization of your company's benefits programs.

You'll leave this Conference with a new perspective that's bound to have a positive effect on your company's bottom line!

**Sessions and speakers have been selected to help you meet the challenges of your profession. General sessions focus on the planning and implementation of communication efforts. Concurrent sessions afford you the opportunity to zero in on specific communication programs. You can attend all three of these work-groups, presented as 'Case Studies.'**

**Highlighting this year's conference is the 12th annual EBC Competition Awards Presentation. Competition programs will be available for review in the EBC Gallery. The Benefits Literature Gallery makes it possible for you to collect some of the latest information available from consultants, insurance companies and service organizations.**

### REGISTRATION

The cost is **$545**. A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook and educational materials, breakfast, coffee breaks, luncheons and cocktail reception.

Payment required with registration.
(Check or credit card accepted, see registration form.)

All cancellations must be received in writing. A full refund will be made on cancellations received prior to July 1. A $100 service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than five business days prior to the Conference.

However, if your plans change at any time, you may substitute the name of another person from your company without penalty.

All registrations will be confirmed in writing.

To register, simply complete the form and send it along with your payment to:

**Business Insurance, Communication Services Department**
**220 East 42nd Street, New York, NY 10017**

For additional information call:
Ann Vazquez at 212/210-0137

### HOTEL ACCOMMODATIONS

We have set aside a block of rooms at a special rate at the Grand Hyatt Hotel in New York. These rates are available to Conference registrants only: $95 single room; $120 double room.

You must mention the Business Insurance Benefits Conference when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call The Grand Hyatt Hotel at (212)883-1234; or toll-free at (800)228-9000. These rates will be honored only until July 15.

### TRAVEL ACCOMMODATIONS

We are pleased to announce that Travel Headquarters Ltd. has been selected to help you coordinate money-saving flights to New York for the BI Conference. Travel Headquarters will provide travel arrangements for registrants, from every major city in the U.S. and Canada, at substantial discounts without sacrificing your comfort or convenience. Space is limited and reservations will be accepted on a first come-first serve basis.

For special airfares and reservations call:
In Illinois and Canada, (312)641-3088;
or toll-free from anywhere in the U.S., (800)621-1676.

You must mention the Business Insurance Benefits Conference when making your reservations. Airfares and reservation cards will be included with your Conference Registration Confirmation.

**It's all there at the BI Benefits Communication Conference.**
**"The Dollars & Sense of Communicating Employee Benefits," July 30 and 31 at The Grand Hyatt Hotel in New York City.**
**This Conference makes good sense for you and your company.**
**Register NOW and save on your hotel and airfare too.**

## REGISTRATION FORM

Please register me for the
**1984 Business Insurance Conference**
**"The Dollars & Sense of Communicating Employee Benefits"**
**July 30 and 31 at The Grand Hyatt Hotel in New York City**

Name _____

Title _____

Organization _____

Address _____

City _____ State _____ Zip _____

Business Phone (area code) (____) _____

**Mail To:**
**Business Insurance *Communication Services Department***
**220 East 42nd Street, New York, NY 10017**
For additional information call:
Ann Vazquez at (212)210-0137

Additional Registrants From My Organization:

Name _____

Title _____

Credit Card _____

Account # _____

Expiration Date _____

Signature _____

I am enclosing my check # _____ in the amount of _____

$ _____ for _____ registrants.

# A&P to terminate pension plan, get excess funds

*Continued from page 2*
ample, A&P lost $231.6 million.

To help reduce those deficits, A&P turned to its pension plan for help. For instance, at the beginning of 1981, the plan had $345 million in assets with which to pay $178 million in vested benefits, according to Schedule B of its Form 5500 filed with the federal government.

The large surplus in the A&P plan, like similar surpluses in other corporate pension programs, is partly the result of the recent recession, during which many workers were laid off before they were vested in pension benefits.

At the beginning of 1979, for instance, the A&P pension plan had 12,870 employee-participants. As of Feb. 29, the number of employee-participants had shrunk to 7,355.

In addition, A&P conservatively figured during the 1970s that assets in its pension plan would increase between 6% and 6.5% each year, a spokesman said.

However, plan assets actually increased by more than 15% during the early 1980s as the value of plan assets, like common stocks, soared.

A&P's attempt to recapture the excess pension plan assets was thwarted just two weeks after the planned termination was announced when William J. Walsh, a retired A&P executive, filed a class-action suit in U.S. District Court to block the termination.

**Mr. Walsh asked** the court to declare null and void a provision added to the plan that said A&P was entitled to surplus assets if the plan was terminated. Mr. Walsh charged that the amendment was a breach of A&P's duty as a plan fiduciary.

In April 1982, A&P and attorneys representing Mr. Walsh settled the suit. A&P agreed to amend its plan so that $50 million in excess funds would be used to sweeten the retirement benefits of participants in the plan.

The remainder of the excess funds—then estimated at $200 million and now calculated by A&P to be $275 million because of favorable market rates—will revert to A&P.

Despite the settlement, however, litigation challenging the plan termination continued until early this year, when the 3rd U.S. Circuit Court of Appeals upheld the settlement, thus giving A&P the go-ahead to terminate the plan (*BI*, Jan. 9).

A&P decided to terminate the plan even though it has since returned to profitability.

# classified advertising

## RATES AND CLOSING TIME:

*Rates: Display classified is $65.70 per column inch, minimum of one inch. Straight classified is $6.00 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional $12.00 charge for blind box ads. Responses to blind box ads must fit into business size envelope. Responses are forwarded daily.*

*Closing: Published every Monday. Copy must be in written form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required. Mail ads to Beverly Kluxdal, Classified Advertising, 740 N. Rush St., Chicago, IL 60611. For more information call 312-649-5340.*

**SITUATION WANTED**

**SURETY U/W or PRODUCER.** 12 years experience with major writer and/or agency. Agency mgt. experience. Pursuing ARM designation. Will relocate for the right opportunity.
**Box 1273, Business Insurance**
**740 Rush St., Chicago, IL 60611**

**HELP WANTED**

**BOND SPECIALIST**
Leading Northwest agency seeks experienced surety bond specialist. Qualified candidates will have solid policy coverage knowledge and may come from an underwriting or marketing/producer type environment at the agency/brokerage level. Starting salary, DOE, will fall into the $35,000 to $50,000 range. Contact immediately: INSURANCE RECRUITERS, INC. 6060 N. Central Exp. #470, Dallas, Tx. 75206. AC214/361-9323.

**HELP WANTED**

**ACCOUNT EXECUTIVE**
This position calls for a person whose primary duties will be that servicing medium-to-large commercial accounts. Must have large agency or brokerage experience. Starting salary in the area of $45/$50,000. Contact INSURANCE RECRUITERS, INC. 6060 N. Central Exp. #470, Dallas, Tx. 75206. AC214/361-9323.

**DIRECTOR OF MARKETING/ NATIONAL BROKER**
Exceptional opportunity to participate as deputy team leader in leading Sunbelt city with high quality of life.

Medical Malpractice and Stop Loss Reinsurance company and broker experience preferable.

Submit resume, including accomplishments and earnings history to:

**Box 1261, Business Insurance**
**740 Rush St., Chicago, Ill. 60611**

**DO—IT—YOURSELF PHONES FOR BUSINESS**
ITT multi-line systems are prewired and connectorized for easy self installation and substantial savings. Complete info kit. **1-800-328-5369**

**ALASKA OPPORTUNITY**
National ins. broker seeks P&C agent for Anchorage. Experience should include servicing and production of commercial accounts. Excellent compensation package. Send resume to:
**Box 1255, Business Insurance**
**740 Rush Street, Chicago, IL 60611**

## BANK INSURANCE SPECIALIST

Progressive national insurance brokerage is looking for aggressive individual with commercial account sales background. Our organization specializes in the sale of insurance products and services to financial institutions. Limited travel involved. Salary plus bonus, auto and excellent fringe benefits package. Please provide resume including references to:

**Financial Insurance Service, Inc.**
**2603 West 22nd. Street, Suite #22**
**Oak Brook, Illinois 60521**

## PRODUCT DIRECTOR

Our solid growth and dynamic plans for future expansion have created an excellent opportunity. We are a recognized leader in business service programs and specialty insurance, seeking a marketing professional to develop and communicate corporate marketing strategies.

The person selected for this position will design and test marketing techniques to continue our excellent growth. He or she will develop new marketing networks and product guidelines, as well as enhance our current products. We seek a person with strong communication abilities, dynamic presentation skills, creativity, and organization. The right candidate should have 3-5 years of experience in product direction and placement.

The value of this position is recognized for its importance to corporate growth and offers an attractive compensation, benefits, and relocation package. If you're a motivated professional and enjoy the role of product champion, apply in confidence to:

**RLI CORP.**
**ATTN: HUMAN RESOURCES**
**9025 N. LINDBERGH DRIVE**
**PEORIA, IL 61615**

Equal Opportunity Employer M/F

**Business Insurance**

**Circulation Breakdown***

| | |
|---|---|
| **Commercial Consumers** | |
| **Administrative Management:** owners, presidents, vps, etc. | 5,638 |
| **Financial Management:** chief financial officers, vps of finance, secretaries, treasurers, etc. | 10,202 |
| **Insurance Management:** vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc. | 6,604 |
| **Associations** | 1,133 |
| **Government, Unions, Educational Institutions** | 799 |
| **Commercial Consumers Sub-total** | **24,376** |
| Insurance Agents & Brokers | 9,655 |
| Insurance Cos. | 5,461 |
| Financial Institutions | 441 |
| Actuaries, Attorneys, Adjusters, Appraisers & Consultants | 2,977 |
| Others allied to the field | 1,083 |
| **TOTAL** | **43,993** |

*Source: Business/Occupational breakdown of qualified circulation, November 7, 1983 issue, as submitted to BPA for December 1983, BPA Publisher's Statement.

**BI Classifieds assure top quality results!**

## MARINE CLAIMS SUPERVISOR

**Zapata Corporation,** an international energy related company has an opening in its Risk Management department for a **Marine Claims Supervisor.**

The person selected for this position will be degreed with 3-5 years experience as a Maritime Personal Injury Adjuster (including USL&H experience), 3-5 years adjusting H&M claims and some supervisory experience a plus. For consideration, please send your confidential resume along with salary history to:

**Manager Employment**
**Zapata Corporation**
**P.O. Box 4240**
**Houston, Texas 77210-4240**

ZAPATA CORPORATION

An Equal Opportunity Employer M/F

## DIRECTOR OF SALES
### GROUP HEALTH INSURANCE

Humana Inc. is a rapidly growing multi-hospital company with 89 hospitals nationwide. The continued success of our Group Health Division has created an exceptional opportunity for an experienced professional to direct our field sales operation for Group Health Programs.

The qualified individual we select will direct the marketing effort for "Humana Care Plus," an innovative solution to rising health care costs. This position implements sales programs and systems to enroll employers in Group Health plans, selects and assists a sales staff, and develops tracking systems to monitor sales activity and target accounts. The Director of Sales will interact with marketing managers, marketing researchers, and hospital administrators to maintain data on competition and potential markets. This responsibility involves approximately 40% travel.

Qualified candidates will have a Bachelor's degree in Marketing or Business Administration and 5-8 years in HMO, PPO, and health insurance sales management. A thorough understanding of field sales operations is required, along with outstanding communication skills.

Headquartered in Louisville, a city of cultural sophistication and steady economic growth, Humana offers an outstanding salary plus incentive compensation plan, comprehensive benefits program, and excellent opportunities for career growth. **For consideration, submit a resume with salary history, in confidence, to Mr. Robert A. Horrar, Humana Inc., P.O. Box 1438, Louisville, KY 40201.** *Equal Opportunity Employer M/F.*

Humana
The Hospital Company

## RISK MANAGEMENT

We are an established leader in the field of real estate investment experiencing a phemonemal growth rate, and are currently seeking a Risk Administrator to manage our insurance division. We require an individual with min. 3 yrs. exp. in underwriting and technical administration and proven capabilities in negotiation and departmental administration.

A background in property/casualty insurance and exposure to general ledger is mandatory; experience with financial insurance products would be preferred.

Responsibilities will include: Investigating insurance and financial products, analysis of various practices, interaction with engineering and portfolio management depts., and various specific projects. This position requires detailed attention to ensure both long and short term goals be reached.

Interested candidates please submit resume and salary requirement to:

**CONSOLIDATED CAPITAL**
1900 Powell St., Suite 1000
Emeryville, CA 94608
Attn: Margaret Johnson

Principal applications only. Non-smoker preferred.

## Baldwin plan

*Continued from page 2*

itan's senior vp and chief actuary.

A plan previously approved by courts and insurance regulators in Indiana and Arkansas, where the Baldwin life insurance units that wrote the annuities are in rehabilitation, is to be mailed to annuity holders on June 1, but that plan could still be replaced by the Metropolitan proposal.

The Metropolitan proposal would guarantee holders of Baldwin annuities a 7.5% return, while the earlier plan would "assure, but not guarantee" a 5.5% return, according to Mr. Poortvliet.

Although the specific details of the plan will probably take months to work out, Mr. Poortvliet says, its outline should be completed by June 1 to forestall mailing the previous plan.

**Metropolitan is** leading the plan at the request of the National Assn. of Insurance Commissioners.

Under the Metropolitan proposal, a fund initially estimated at about $250 million would be created to supplement the $4 billion in assets still held by the Baldwin life insurers.

Stockbrokers would provide 80% of the fund, while participating life insurers would pay the remaining 20%. This division is based on the fact that 80% of the Baldwin annuities were sold by stockbrokers.

Metropolitan could possibly issue new annuities to replace the Baldwin policies, and these annuities would be guaranteed by Metropolitan and the participating insurers and brokers, according to Mr. Poortvliet.

For the plan to work, 75% of Baldwin-United's annuity holders would have to agree not to sue Baldwin and the participating life insurers and stockbrokers.

The plan's basic concept has received a favorable reception from E.F. Hutton & Co. Inc. and Prudential-Bache Securities Inc., two firms that sold large amounts of Baldwin annuities, as well as the Indiana Insurance Commissioner Don H. Miller.

Linda N. Garner, the Arkansas insurance commissioner, could not be reached for comment.

To meet final approval, however, the plan's details must also be approved by Baldwin-United creditors and enough life insurers and and stockbrokers to make it workable.

"I don't think you can overestimate the difficulties involved," Mr. Poortvliet says.

While "all kinds of proposals" have been suggested, "if a good, reputable company" took over the contracts, E.F. Hutton would support it, says Thomas Rae, Hutton's general counsel.

More than 30 members of the American Council of Life Insurers have said they are willing to consider participating in the plan, according to Met Life. None of them, including Met Life, sold any Baldwin-United annuities, although some of their agents may have.

**Mr. Poortvliet** notes there are some serious obstacles to formation of a viable plan. Despite a prime interest rate of about 12.5%, the $4 billion asset base may not be sufficient to pay a 7.5% interest rate on the securities, he says.

In addition, Mr. Seifer of First Boston adds, "My concern is that a lot of marginal types will say, 'We can design a program where we can grab the money and run away and leave the industry with the bill two years later.' That's a negative consideration."

A spokeswoman for Baldwin-United says the company is pleased that the life insurance industry will be a "key participant in efforts to negotiate a global settlement that will treat all policyholders fairly and equitably."

In a related matter, MGIC Investment Corp. management last week proposed to form a new company that would purchase MGIC.

The proposal was presented before a Special Masters commission appointed by courts in Arkansas and Indiana that is charged with selling MGIC.

MGIC officials, including Chairman Max H. Karl, were given 60 days to come up with a more detailed proposal, says Mr. Miller, the Indiana insurance commissioner and a member of the masters' panel.

No price was mentioned, he says, explaining "They hadn't got that far with it."

An MGIC spokesman refused to comment on the meeting.

Baldwin purchased MGIC for $1.2 billion in 1982 from a company headed by Mr. Karl, who later became Baldwin's chairman.

The commission also told its financial adviser, investment banker Goldman Sachs & Co., to continue to pursue discussions with others concerning the sale of MGIC Investment as well as American Municipal Bond Assurance Corp., its wholly owned municipal bond guarantee subsidiary.

He referred a questions regarding other bids to buy MGIC to Goldman Sachs. A spokesman for the firm would not comment on the matter.

A spokeswoman for the Ford Motor Credit Co. would not discuss a report that the firm had made a $900 million bid for MGIC.

"It's a rumor, and it's a company policy not to comment on a rumor," she said. "In other words, we're neither confirming nor denying." ■

## DC-10 crash settlement negotiated

CHICAGO—American Airlines Inc. and McDonnell-Douglas Corp. have agreed to pay an undisclosed amount to the relatives of four persons killed in the May 1979 crash of an American Airlines DC-10 jetliner near Chicago.

The settlement, which provided that the amount and terms not be made public, came three days short of the fifth anniversary of the crash.

Some 273 people, including two people on the ground, were killed in the crash, which was the worst aviation disaster in American history.

The settlement will be paid to the heirs and next-of-kin of Stephen and Carolyn Sutton, who were killed in the crash along with their two children.

**Plaintiffs'** attorney Robert Glenn said the case involved claims that the family suffered "pre-impact flight terror, mental anguish and emotional distress resulting in physical manifestation prior to the moment of death."

It would have been the first case tried in Illinois on that theory, Mr. Glenn said.

The settlement was reached in U.S. District Court one day after trial had begun and prior to jury selection.

The trial was to only consider the amount of damages, American and McDonnell-Douglas having admitted liability.

The defendants reportedly had asked the trial to be delayed because of the proximity of the anniversary date of the crash to the start of the trial.

At the time of the accident, McDonnell-Douglas had $450 million in product liability insurance, about 80% of which was placed in the London market. Under an agreement among American, McDonnell-Douglas and their insurers, American is paying 75% of the passenger claims and the aircraft manufacturer is paying 25%. ■

# Airline coverage

*Continued from page 1*

There is no effort to negotiate anymore."

The last straw for the airlines came last month when leading London aviation underwriters—who dominate the world aviation market—met informally and agreed unilaterally that as of July 1. deductibles for all partial hull losses will be higher.

According to Barry Coleman, a leading Lloyd's of London aviation underwriter, deductibles for all partial losses on hulls will be:

- $1 million for wide-bodied aircraft.
- $500,000 for narrow-bodied aircraft.
- $750,000 for hybrid aircraft, which fall between wide bodies and narrow bodies, such as the Boeing 737.

However, there still will be no deductibles for total losses.

These new imposed retentions replace a complicated scale of partial loss deductibles that were imposed by underwriters in 1980.

This scale included ground deductibles of $20,000 for wide-bodied aircraft, taxiing deductibles of up to $500,000 for jumbo jets and ingestion deductibles of $600,000, or 1% of the value of the aircraft, for wide bodies.

The new deductibles serve several purposes for underwriters, Mr. Coleman pointed out. They help to improve the disastrous losses aviation underwriters have suffered over the past three years and they simplify the system.

Last year, aviation underwriters paid more than $700 million in hull and liability losses, while the aviation reinsurance market has also tightened.

"We have tried to simplify the system," Mr. Coleman explained.

"The present deductibles, because of inflation, became less effective for the small attritional losses and it has become expensive for underwriters and for clients who pay higher premiums because of the losses."

And, by increasing deductibles, aviation underwriters will now offer just catastrophe coverage, which is what airlines want, Mr. Coleman said.

Eddie Simms, leading Lloyd's aviation underwriter for the Ariel Syndicate, also defends the need to increase deductibles now.

"We amended the deductibles about 3½ years ago and put brokers on notice that deductibles would be reviewed, but we have not during this period," he said.

"What prompted us to review them now are the troubles we have had with the losses in the past three years plus the anomalies of the deductibles. . .different policies had different wordings, and we felt that we had to revise this, plus cater to the hybrid (planes that are neither wide-bodied nor narrow-bodied).

"Also, there was a general need and desire to increase the level of deductibles.

"I believe that the whole market will support this move," he said.

Because of antitrust laws, U.S. aviation underwriters will not say if they will follow the new deductibles led by London, but they do approve of the London move. (In 1980, they did follow the London lead and raise deductibles).

"It is something that everyone would like to see happen," said John Leigh, vp of the Aviation Office of America Inc. in Dallas, "but whether or not it does happen, we will have to wait and see. But no renewals have been presented to us yet for July 1 so it is too early to tell."

"I would suspect for the most part that U.S. aviation underwriters will follow what London underwriters are doing on the airlines," said Wayne Gregory, vp and underwriting manager of American Aviation Underwriters in Houston.

"We used to, but our reinsurance treaty does not allow us to underwrite airlines anymore, just general light aviation."

The increased deductibles will not help hold down rates, Pacific Southwest Airlines found out recently.

PSA reluctantly accepted the new deductibles from its leading London underwriter, Aviation & General Insurance Co. Ltd., reports Paul Rasmussen, PSA vp and treasurer.

"The market appears to be unified in its position and we believed that there was not an alternative," he said.

PSA's hull rate increased 31.8% and its liability rate was up 30.8%. Its total premium is expected to increase 55% to $5.38 million, a London underwriter on the program told *Business Insurance*.

Mr. Rasmussen would not comment on the accuracy of these figures, but he did confirm that rates had increased.

Although PSA's insurance usually is placed 100% in London, the airline has until July 1 to shop around to find other markets that are less expensive and will take the risk, Mr. Rasmussen pointed out.

But, airlines may have a difficult time reducing the percentage of business placed in the London market, Mr. Kelly of IATA pointed out.

"U.S. airlines will have to give a minimum order to London underwriters of at least 20% of their risk," he said.

That means that if U.S. airlines do not like London's terms, they may have to pull out of London altogether rather than reduce their order, and that gap in capacity may be hard to fill.

While Mr. Simms points out that required minimum orders are not new in the London market, the fact that the London underwriters apparently are not willing to negotiate on this point or any others is making the requirement another thorn in the sides of buyers; the IATA says.

Mr. Simms said the average American airline now places 25% to 30% of its coverage in the London market and any smaller share would not be feasible since 40 or 50 London underwriters often take a piece of the risk following the lead underwriter. ■

# Pension bill amendments propose new liabilities

*Continued from page 1*

10 years of service but without reaching the early retirement age, the former employee would have to be notified that he has the right to select a survivor's benefit option.

In addition, the amendment says the new rules on survivors' benefits will be communicated to the public by the Labor Department.

The original House bill also proposed:

- Lowering the minimum age for vesting purposes to 18 from 22.
- Lowering the minimum participation age in pension plans to 21 from 25.
- Giving courts the authority to distribute, if they so chose, a portion of the participant's pension to the spouse as part of a divorce settlement.

A bill, S. 2769, passed last year by the Senate, also lowers pension plan vesting and participation ages (*BI*, Nov. 7, 1983).

The provisions of the original House bill aren't of great concern to benefits consultants, but the last-minute changes made by the Ways and Means Committee are.

Since there was no public debate on these amendments and the language in the committee report is ambiguous, experts aren't sure just how far the amendments go.

Employers late last week were lobbying to convince Senate leaders that a conference committee should be formed to iron out differences between the House and Senate bills. Lobbyists feared that the Senate might simply accept the House bill.

One of the amendments suggests that employers cannot eliminate optional forms of distributing previously accrued benefits, including lump-sum distribution options, explains a "Special Alert" published by the Assn. of Private Pension & Welfare Plans, a Washington-based lobbying group.

For example, instead of receiving a pension benefit of $200 a month, many employers now give employees the option of taking several thousand dollars in a lump sum.

Some employers, though, have begun to eliminate lump-sum distribution options because it is difficult to calculate the cash value of a benefit that would have been paid out over many years because of volatile interest rates.

But, if the pension bill passes, employers with lump-sum distribution options would be stuck with them.

"It is the right to change that is at issue," said TPF&C's Mr. Alden.

In addition, some experts worry that the amendment in the bill that apparently bars employers from eliminating benefit improvements made to pension plans would prevent employers from canceling temporary early retirement incentives from their plans.

Some companies, particularly during the recession of the early 1980s, added temporary early retirement sweeteners. If a company can't eliminate such incentives, as the bill suggests, employees in future years would be entitled to the same special early retirement bonuses.

And, if that happens, employers would be very reluctant to offer such sweeteners in the first place.

The APPWP warns that an employer stuck with provisions in its pension plan that it cannot change may have no choice but to terminate the plan.

"If the plan sponsor terminates its plan, a participant who has not satisfied all the conditions for entitlement to the subsidy at the time of terminaton will not be eligible for the subsidy," the APPWP special alert said.

"Thus, an employer could cut off its liability by terminating a plan, thereby creating an obvious incentive to abandon a plan."

Both the House and Senate bills provide for better survivors' benefits, but the amendment to the House bill proposes a radical change.

Under the Senate bill, survivors' benefits would have to be offered after a participant reaches age 45 and has 10 years of service. By contrast, the House bill stipulates that survivors' benefits must be offered as soon as a participant vests.

Pension activists, such as Karen Ferguson, director of the Washington-based Pension Rights Center, are particularly enthusiastic about automatic survivors' benefits after a participant vests.

Ms. Ferguson says women can be left with nothing if their vested husbands die before reaching a pension plan's early retirement age.

For example, Pat Tice, a Maryland homemaker whose husband died after 22 years of service with IBM Corp., testified before a House committee that she was not eligible for a survivor's benefit because her husband died before reaching 55—IBM's early retirement age.

"It is difficult to be middle-aged" and lose the right to a survivors' benefit, Ms. Tice said. Had IBM been required to offer survivor's benefits to spouses of all vested participants, Ms. Tice said, she would have been entitled to an annual benefit of between $12,000 and $15,000.

But others say Ms. Tice's example is exceptional. They say that many survivors whose spouses died in their early 30s would have received only small benefits.

"You are talking about, in many cases, $15 to $25 a month in benefits," said Dallas Salisbury, president of the Washington-based Employee Benefit Research Institute. "There are horror stories about employees who die a week before they reach a plan's early retirement age," said Fredrick Rumack, director of tax and legal services for Buck Consultants Inc. in New York. "That is why companies provide group life insurance programs."

A tax-free life insurance benefit that may equal twice an employee's salary is worth a lot more than a small survivor's benefit that is taxed as ordinary income, consultants say.

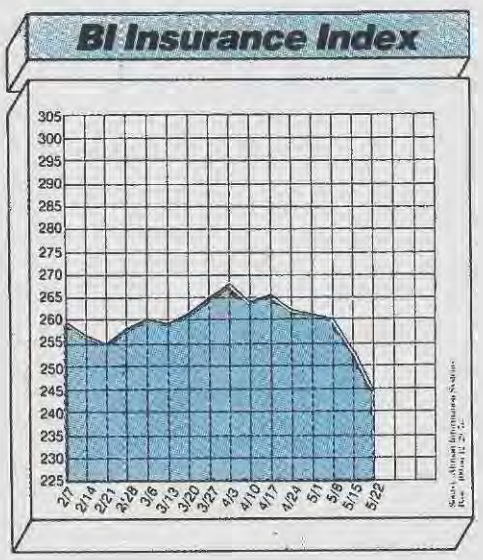
But Rep. Geraldine Ferraro, D-N.Y., a key backer of the House legislation, said she will not accept the Senate bill that sets age 45 as the earliest age at which a survivors' benefit can be offered.

Instead, she says once a worker is vested, neither the worker nor a spouse should be deprived of that benefit.

In addition to the new amendments, both House and Senate bills would lower the minimum pension plan participation age to 21 from 25, while credit toward vesting would begin at age 18, compared with the current age 22.

These lower participation and vesting ages, though, would not significantly increase the number of women collecting pensions, experts say. That's because few young women stay at one job long enough to vest.

On the other hand, employers now would have to pay termination insurance premiums to the Pension Benefit Guaranty Corp. for employees who most likely would never vest, said Theresa Stuchiner, a partner with Kwasha Lipton in Fort Lee, N.J. ■




**The *Business Insurance* stock index plummeted even further during the recent trading period ending May 22. The index of insurance industry stocks dropped 8.3 points to 244.8 from 253.1 reported on May 15, hitting a new low for the year. Forty-four issues closed down, 11 were unchanged and only five reported gains. The largest losses were reported by Bitco Corp., 15.4%; Integrated Resources Inc., 15.2%; CNA Financial Corp., 10.9%; Combined International Corp., 10.4%; and Old Republic International Corp., 10.3%. The only five issues that gained during the period were: Emett & Chandler Cos. Inc., 5.7%; Zenith National Insurance Corp., 4.1%; Northwestern National Life Insurance Co., 2.6%; Orion Capital Corp., 1.2%; and Equifax Inc., 0.5%. The *BI* index posted a 3.3% drop for the trading period, while the New York Stock Exchange composite reported a 2.7% loss for the same week. The *BI* index has lost 16.1 points since May 8.**

## British Issues

| 22 May Companies | Price pence | P/E | Div. pence | Yield % | 1 Week High—Low pence | pence |
|---|---|---|---|---|---|---|
| Comml Union | 209 | 10.4 | 16.86 | 8.1 | 217— | 209 |
| Genl Accident | 450 | 9.0 | 30.00 | 6.7 | 472— | 435 |
| Phoenix | 446 | 12.7 | 31.43 | 7.0 | 456— | 446 |
| Royal | 553 | 9.2 | 42.86 | 7.7 | 566— | 553 |
| Sun Alliance | 1475 | 10.8 | 91.43 | 6.2 | 1500— | 1475 |
| **Brokers** | | | | | | |
| CE Heath | 435 | 7.9 | 28.57 | 6.6 | 435— | 393 |
| Hogg Robinson | 192 | 12.8 | 10.43 | 5.4 | 196— | 192 |
| JH Minet | 162 | 10.8 | 9.00 | 5.6 | 166— | 162 |
| Sedg Grp | 240 | 13.9 | 12.86 | 5.4 | 253— | 240 |
| Stew Wrightson | 367 | 10.9 | 24.00 | 6.5 | 370— | 367 |
| Willis Faber | 837 | 14.9 | 35.00 | 4.2 | 837— | 820 |

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# Catastrophes not to blame for bad first-quarter results

**By MYRON M. PICOULT**

*Special to Business Insurance*

THERE ARE NOT many words that can describe the property/casualty insurance industry's first-quarter underwriting and operating results. "Plain lousy" seems to be quite appropriate.

Mr. Picoult

With very few exceptions, results were well below what had been expected, both by company managements and external industry observers. The quarter's results seem to have highlighted all of the industry's shortcomings.

In some circles, the abysmal underwriting and profit performances were ascribed to catastrophe losses, which were noted as being unusually large. The average first-quarter catastrophe loss for the 10 years from 1974 through 1983 was $145.6 million.

Although this year's first-quarter wind, hail and tornado losses of $325.5 million were well above the 10-year average, we do not believe this was the primary cause of the poor underwriting results.

It is to be remembered that winter comes every year. Sometimes the wind blows, and sometimes it does not. This is all part and parcel of the risk-taking process. The first-quarter combined ratios reflect inadequate pricing decisions made in 1983 and earlier years together with erosion of underwriting standards.

Our data base includes 17 of the major stock underwriters and accounts for about 42% of the stock industry's premium volume. Hence, it is and has been a fairly good indicator of trends.

For the three months ended March 31, 1984, our screen showed the following:

- Net premiums written, on average, expanded 5.5%. Only three insurers—Continental Corp., Home Insurance Group and Kemper Group—recorded declines in written premiums. Increases ranged from 2% to 19.5%, with GEICO Corp., CNA Insurance Cos. and Crum & Forster posting the only double-digit increments.

Earned premium trends were relatively comparable, and an average increase of 7% was posted. There was scant evidence that the industry cheering squads, designed to get commercial prices moving up, ever made it out of the executive suites.

- Pretax net investment income expanded 10.4%. However, this figure is distorted by a 37.1% gain at USF&G Corp. Adjusting for this, the average increase fell to 8.7%. Nonetheless, a wide variance of increments was evident, with increases ranging from 0.7% to 37.1%. Only CIGNA Corp. recorded a decline in this area.

In all instances, there is a race on to generate more taxable income as an offset for the underwriting losses as the deferred tax figure disappears.

- The combined ratio after policyholders' dividends jumped to 118.9% from 107.5% in the corresponding period of 1983. The bulk of the deterioration, as expected, was in the loss ratio, which increased to 87.1% from 76%. The expense ratio edged up to 31.8% from 31.5%, reflecting intensified expense-control measures.

Only one company, GEICO, posted a combined ratio of less than 100%. The results for everyone else ranged from a low of 104.3% (SAFECO Corp.) to a high of 137.2% (CIGNA).

Interestingly enough, if one were to consider only those underwriters owned by a diversified entity (e.g., Fireman's Fund Insurance Cos., CNA, The Home and Crum & Forster), the combined ratios on average were below our overall group average. For these four companies, the combined ratio was 116.5%, up from 105.4% last year. What happened to the tax-loss shelter game feared so by the independent insurers? Perhaps there is a message in this for the independents.

- There is increasing evidence that the reserve noose is beginning to choke some underwriters. While the movement is not uniform, there was clear evidence that a few companies began to recognize some reserve deficiencies during the quarter. Reserves rose 9.5% above the comparable March 31, 1983 levels. In many instances, reserve increments from year-end 1983 levels exceeded 100%.

- Cash flow, defined as written premiums less expenses and paid claims, continued to deteriorate. With data available for 15 companies, nine showed negative cash flow while two barely showed positive cash flow.

- Property/casualty operating earnings plunged almost 33%, while consolidated earnings slipped a little more than 21%.

It should be quite clear by now to all concerned that 1984 will not be a good year for the industry. The few optimists who are left should be aware of the fact that second-quarter catastrophe losses through May 9 have already exceeded the 1984 first-quarter figure and the 1983 second-quarter level.

The obvious question is, What about 1985?

There are still many who believe that a strong recovery will take place in 1985 and beyond. It remains to be seen just how aggressive the price-cheering squads will be as they slowly exit from the executive suites. To be sure, commercial pricing has bottomed, but the level of increases may prove to be painfully slow.

It took six years to create this mess, and it is not going to disappear overnight.

*Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column appears the fourth Monday of every month.*

## Aneco Re

Bermuda-based Aneco Reinsurance Co. Ltd. may restate its 1983 earnings, depending upon the outcome of an actuarial study of the adequacy of loss reserves established by the company's underwriting subsidiary, Aneco Reinsurance Underwriting Ltd., the company says.

Actuarial consultants Tillinghast, Nelson & Warren were engaged to review Aneco's loss reserves after longstanding Aneco auditor Peat, Marwick, Mitchell & Co. expressed concerns about the adequacy of the company's reserves.

Peat, Marwick in Bermuda had approved Aneco's 1983 annual statement, said Aneco Underwriting President Jonathan Crawley. But, subsequent to the approval, Peat, Marwick in New York informed Aneco that there had been a breakdown in communication between the New York and Bermuda offices and that the New York office wanted to reaudit Aneco.

A second team of auditors, reviewing the same data, said their review "indicates that an acceleration of adverse claims experience may require an increase in the company's reserves for losses incurred but not reported," according to a prepared statement issued by Aneco.

As a result of the differing findings, Aneco and Peat, Marwick agreed to submit the loss reserves to a third expert for analysis. Whether Aneco will increase its IBNR reserves, thereby decreasing its reported 1983 earnings, will depend upon the findings by Tillinghast. The Tillinghast report is expected in a few weeks, Mr. Crawley said.

In the meantime, Peat, Marwick's initial approval of Aneco's 1983 statement stands. Although the approval has been neither withdrawn nor qualified, Aneco has not mailed its annual report to shareholders.

The Tillinghast study of the company's loss reserves also has delayed the company's previously announced public offering of convertible shares and the filing of the company's first-quarter 10-Q report.

If Aneco does increase its IBNR reserves, Mr. Crawley said, "it will not affect the strength of the company.

"If we do restate 1983, we can certainly tell the world that we are excludable from the generalization that most insurance and reinsurance companies are substantially underreserved," he said.

In March, Aneco had reported net income in 1983 of $746,018. Aneco Underwriting reported underwriting income of $427,605, on a combined ratio of 97.1%.

Mr. Crawley declined to elaborate on the nature of the IBNR reserves and the amount at issue with the auditors until the Tillinghast study is completed. ■

# BI Industry Stock Report

MAY 22, 1984 — 5/16/84 THRU 5/22/84

| Insurance Cos. | | Price | % Chg. | P/E | $ Div. | % Yld. | High | Low | Vol. (000) |
|---|---|---|---|---|---|---|---|---|---|
| Aetna Life & Cas Co | NYSE | 32.13 | -3.4 | 15.7 | 2.64 | 8.2 | 33.00 | 32.13* | 1,517.1 |
| American Bankers Ins Group | OTC | 11.38 | -5.2 | 8.1 | 0.50 | 4.4 | 12.00 | 11.38* | 147.3 |
| American General Corp | NYSE | 20.75 | -2.9 | 7.0 | 0.90 | 4.3 | 21.38 | 20.75 | 572.8 |
| American Indty Finl Corp | OTC | 16.25 | -8.5 | 116.1 | 1.12 | 6.9 | 17.75 | 16.25* | 14.4 |
| American Intl Group Inc | OTC | 58.00 | -4.1 | 10.2 | 0.44 | 0.8 | 60.00 | 58.00 | 763.4 |
| American Natl Ins Co | OTC | 25.25 | -7.3 | 7.4 | 0.96 | 3.8 | 26.25 | 25.25 | 271.7 |
| Aneco Reins Ltd | OTC | 2.25 | -5.3 | 6.6 | 0.00 | 0.0 | 2.25 | 2.13* | 103.4 |
| Avemco Corp | AMEX | 18.00 | -2.0 | 11.5 | 0.58 | 3.2 | 18.38 | 18.00 | 3.2 |
| Banks Iowa Inc | OTC | 51.50 | 0.0 | 20.4 | 1.56 | 3.0 | 51.50 | 51.50 | 6.6 |
| Bitco Corp | OTC | 11.00 | -15.4 | 0.0 | 1.33 | 12.1 | 12.00 | 11.00* | 19.0 |
| Carolina Cas Ins Co | OTC | 3.50 | 0.0 | 0.0 | 0.00 | 0.0 | 4.00 | 3.50 | 0.4 |
| Chubb Corp | OTC | 65.38 | -3.3 | 11.9 | 3.12 | 4.8 | 69.50 | 65.38 | 231.1 |
| Combined Intl Corp | NYSE | 30.00 | -10.4 | 7.7 | 2.08 | 6.9 | 33.00 | 30.00* | 309.4 |
| Continental Corp | NYSE | 27.13 | -5.2 | 0.0 | 2.60 | 9.6 | 28.00 | 27.13 | 186.7 |
| Crawford & Co | OTC | 15.25 | 0.0 | 10.4 | 0.66 | 4.3 | 15.25 | 15.25 | 2.3 |
| Crown Life Ins Co | OTC | 120.00 | -0.8 | 7.8 | 3.20 | 2.7 | 121.00 | 120.00 | 0.0 |
| Employers Cas Co | OTC | 30.50 | -0.8 | 7.2 | 1.20 | 3.9 | 30.75 | 30.50 | 15.8 |
| Equifax Inc | NYSE | 26.25 | 0.5 | 11.6 | 1.60 | 6.1 | 26.38 | 26.00 | 6.3 |
| Farmers Group Inc | OTC | 38.75 | -3.1 | 9.2 | 1.52 | 3.9 | 40.13 | 38.75 | 451.1 |
| Foremost Corp Amer | OTC | 24.25 | -4.0 | 13.3 | 0.96 | 4.0 | 24.50 | 24.25 | 54.9 |
| Fremont Gen Corp | OTC | 13.63 | -0.9 | 0.0 | 0.48 | 3.5 | 13.63 | 13.13 | 156.6 |
| Great West Life Assurn Co | OTC | 300.00 | 0.0 | 9.6 | 12.00 | 4.0 | 300.00 | 300.00 | 0.0 |
| Hanover Ins Co | OTC | 23.75 | -5.0 | 7.9 | 0.44 | 1.9 | 24.50 | 23.75* | 46.7 |
| Hartford Steam Boiler Insptn | OTC | 50.00 | -2.9 | 12.6 | 3.00 | 6.0 | 51.50 | 50.00 | 14.9 |
| Jefferson Natl Life Ins Co | OTC | 40.75 | -0.6 | 18.5 | 0.76 | 1.9 | 41.00 | 40.75 | 0.7 |
| Kemper Corp | OTC | 34.88 | -2.1 | 11.4 | 1.80 | 5.2 | 35.75 | 34.88 | 169.8 |
| Lincoln Natl Corp Ind | NYSE | 30.25 | -3.2 | 7.4 | 1.68 | 5.6 | 31.50 | 30.25 | 118.0 |
| Mission Ins Group Inc | NYSE | 13.38 | -7.8 | 0.0 | 0.50 | 3.7 | 15.00 | 13.38* | 162.3 |
| Northwestern Natl Life Ins | OTC | 39.00 | 2.6 | 8.7 | 1.50 | 3.8 | 39.13 | 38.75 | 102.4 |
| Ohio Cas Corp | OTC | 40.75 | -6.9 | 11.3 | 2.68 | 6.6 | 43.50 | 40.75* | 57.2 |
| Old Rep Intl Corp | OTC | 31.63 | -10.3 | 6.9 | 0.88 | 2.8 | 35.00 | 31.63 | 27.2 |
| Orion Cap Corp | NYSE | 21.25 | 1.2 | 12.4 | 0.76 | 3.6 | 21.75 | 20.63* | 199.7 |
| Preferred Risk Life Ins Co | OTC | 22.63 | 0.0 | 7.8 | 0.74 | 3.3 | 22.63 | 22.63 | 5.0 |
| Provident Life & Acc Ins Co | OTC | 70.00 | -1.4 | 6.9 | 2.88 | 4.1 | 71.00 | 70.00 | 23.5 |
| St Paul Cos Inc | OTC | 53.13 | -7.6 | 12.1 | 3.00 | 5.6 | 56.13 | 52.75* | 422.6 |
| SAFECO Corp | OTC | 63.00 | -4.7 | 8.8 | 2.60 | 4.1 | 66.00 | 63.00 | 146.5 |
| Sri Corp | OTC | 15.75 | -3.1 | 9.3 | 0.68 | 4.3 | 16.63 | 15.75 | 545.9 |
| Seibels Bruce Group Inc | OTC | 21.75 | 0.6 | 14.1 | 0.80 | 3.7 | 21.75 | 21.63 | 47.6 |
| Statesman Group Inc | OTC | 6.88 | -3.5 | 8.0 | 0.15 | 2.2 | 7.00 | 6.75* | 112.6 |
| Tokio Marine & Fire Ins Co | OTC | 120.25 | -6.2 | 24.3 | 0.96 | 0.8 | 125.25 | 120.00 | 3.3 |
| Travelers Corp | NYSE | 30.50 | -0.8 | 7.6 | 1.92 | 6.3 | 31.00 | 30.50 | 838.5 |
| United Fire & Cas Co | OTC | 28.75 | 0.0 | 16.4 | 1.60 | 5.6 | 28.75 | 28.75 | 0.2 |
| United States Fid & Gty Co | NYSE | 48.00 | -6.6 | 7.3 | 4.16 | 8.7 | 51.50 | 47.88* | 230.2 |
| United Svcs Life Ins Co | OTC | 26.63 | -4.5 | 7.8 | 1.00 | 3.8 | 27.88 | 26.63 | 54.9 |
| Uslife Corp | NYSE | 24.75 | -3.4 | 6.6 | 0.96 | 3.9 | 25.63 | 24.75 | 171.1 |
| Washington Natl Corp | NYSE | 18.75 | -0.7 | 10.9 | 1.08 | 5.8 | 19.38 | 18.75 | 66.0 |
| Zenith Natl Ins Corp | OTC | 12.75 | 4.1 | 8.5 | 0.60 | 4.7 | 12.75 | 12.25 | 8.0 |
| INSURANCE COMPANIES | AVERAGE | | | 11.1 | | 4.2 | | | |
| **Agents/Brokers** | | | | | | | | | |
| Alexander & Alexander Svcs | NYSE | 19.88 | -0.6 | 0.0 | 1.00 | 5.0 | 19.88 | 19.00* | 179.1 |
| Baldwin & Lyons Inc | OTC | 37.00 | 0.0 | 616.7 | 0.80 | 2.2 | 37.00 | 37.00 | 0.4 |
| Corroon & Black Corp | NYSE | 23.00 | -0.5 | 14.5 | 1.00 | 4.3 | 23.13 | 23.00 | 75.2 |
| Crump E H Cos Inc | OTC | 12.25 | 0.0 | 15.3 | 0.40 | 3.3 | 12.63 | 12.25 | 46.6 |
| Emett & Chandler Cos Inc | OTC | 9.25 | 5.7 | 20.1 | 0.00 | 0.0 | 9.25 | 8.75 | 1.5 |
| Hall Frank B & Co Inc | NYSE | 20.63 | -5.2 | 27.9 | 1.18 | 5.7 | 21.63 | 20.63 | 162.1 |
| Integrated Res Inc | AMEX | 20.25 | -15.2 | 4.7 | 0.00 | 0.0 | 23.88 | 20.25* | 125.8 |
| Marsh & Mclennan Cos Inc | NYSE | 38.75 | -3.1 | 11.1 | 2.20 | 5.7 | 40.13 | 38.75* | 304.9 |
| Poe & Assoc Inc | OTC | 5.00 | 0.0 | 0.0 | 0.00 | 0.0 | 5.00 | 5.00 | 0.8 |
| Reed Stenhouse Cos Ltd | OTC | 11.75 | -9.6 | 15.3 | 0.60 | 5.1 | 13.00 | 11.75* | 433.5 |
| AGENTS/BROKERS | AVERAGE | | | 18.2 | | 3.6 | | | |
| **Conglomerates Holding Cos.** | | | | | | | | | |
| American Express(Fireman's Fd) | NYSE | 29.75 | -6.3 | 13.1 | 1.28 | 4.3 | 31.50 | 29.50 | 1,916.8 |
| Anderson Clayton(Ranger/PanAm) | NYSE | 26.25 | -2.8 | 11.9 | 1.32 | 5.0 | 27.38 | 26.25* | 26.7 |
| Armco Inc | NYSE | 17.88 | -3.4 | 0.0 | 0.40 | 2.2 | 18.75 | 17.88* | 341.0 |
| Baldwin Utd Corp | NYSE | 1.38 | 0.0 | 0.0 | 0.00 | 0.0 | 1.50 | 1.38 | 176.4 |
| CIGNA Corp | NYSE | 35.75 | -2.7 | 8.8 | 2.60 | 7.3 | 36.00 | 35.13* | 804.9 |
| City Investing Co. (Home Ins.) | NYSE | 41.38 | -1.2 | 9.9 | 2.00 | 4.8 | 42.63 | 41.38 | 1,831.3 |
| CNA Finl Corp (CNA) | NYSE | 22.38 | -10.9 | 8.3 | 0.00 | 0.0 | 25.13 | 22.38 | 54.2 |
| Control Data (Comml. Credit) | NYSE | 30.38 | -4.7 | 7.3 | 0.66 | 2.2 | 31.88 | 30.00 | 645.6 |
| General Re Corp | NYSE | 53.13 | -3.4 | 14.2 | 1.44 | 2.7 | 54.50 | 52.50* | 264.1 |
| ITT (Hartford Group) | NYSE | 34.50 | -4.8 | 7.7 | 2.76 | 8.0 | 36.50 | 34.50* | 1,044.9 |
| Optimum Hldg Corp | OTC | 4.00 | 0.0 | 0.0 | 0.00 | 0.0 | 4.00 | 4.00 | 13.4 |
| Sears Roebuck & Co. (Allstate) | NYSE | 31.38 | 0.4 | 7.9 | 1.76 | 5.6 | 31.38 | 30.50 | 1,956.6 |
| Teledyne Inc (Argonaut) | NYSE | 192.63 | -0.1 | 14.6 | 0.00 | 0.0 | 193.13 | 191.88 | 1,327.9 |
| Transamerica Corp (Occidental & Fred S. James) | NYSE | 22.00 | -4.3 | 7.6 | 1.56 | 7.1 | 22.88 | 22.00* | 397.7 |
| CONGLOMERATES/HOLDING COS. | AVERAGE | | | 79.3 | | 2.9 | | | |

*Record high/low since Jan. 1, 1983

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