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Update

Court strikes down Texas tax on self-funded benefit plans

NEW ORLEANS—A federal appellate court has struck down a tax Texas imposed on self-funded employee benefit plans and has ordered the state to refund millions of dollars to employers.

The 5th U.S. Circuit Court of Appeals found that the tax violates the Employee Retirement Income Security Act of 1974, which pre-empts state regulation of self-funded benefit plans.

But it is also not clear whether the 5th Circuit decision requires the state to re-

Continued on next page

States rethinking health cover laws

Hawaii considers altering universal program

By LOUISE KERTESZ

HONOLULU—More than 15 years after Hawaii implemented its unique universal health care law, employers, government officials and labor representatives are still trying to smooth out its rough edges.

Consider that:

- With improved access to health care leading to a generally healthier population, health care costs in the state are climbing at a slower clip than on the mainland.

But, costs are indeed climbing and employers have few options to rein them in under the state's Prepaid Health Care Act of 1974.

- Nearly all residents of Hawaii have broad health care coverage.

But, employers and health care experts complain that the PHCA is so restrictive that employers—especially small firms—cannot afford to offer benefits that go beyond what is required by the law.

And, larger companies that are based on the U.S. mainland that have opened offices in Hawaii have difficulty obtaining approval under the universal health care law to offer the generous health care plans they offer to workers in other states.

Those concerns, coupled with hospitals' complaints about low reimbursement from government health care programs and the growing population of elderly residents covered by those

Continued on page 81

Massachusetts plan appears doomed

By JERRY GEISEL

BOSTON—The so-called "play or pay" centerpiece of Massachusetts' landmark universal health care law—often hailed as a model of bold state action to achieve universal health care coverage—is on the road to repeal.

And, the expected demise of Massachusetts' approach could influence other state as well as federal lawmakers as they grapple with how to improve Americans' access to health care coverage, health care experts say.

But, the search for a solution will continue, they add.

Under the 1988 Massachusetts statute, most employers, starting next January, face a new "medical security contribution" tax that could total as much as $1,680 per employee.

However, an employer with a health care plan can offset the security contribution tax by each dollar spent on its health care plan. Employers whose annual health care expenses exceed $1,680 will be exempt (see story, page 80).

In addition, the law, among other things, imposes a small tax on employers to fund state coverage for poor unemployed residents. But, state legislators and others are not seeking repeal of these provisions.

At the time of enactment, then-Gov. Michael Dukakis hailed Massachusetts' so-called "play or pay" approach as a model other states could use to achieve universal health care coverage.

The exception would have been Hawaii, where—as a result of a special exemption from the Employee Retirement Income Security

Continued on page 79



Who you gonna call?

The 29th annual RIMS conference kicked off last week with a combination of traditional New Orleans jazz and a high tech video presentation. The conference attracted more than 8,300 registrants and exhibitors. Reports on employee benefit and workers compensation sessions begin on page 3. Reports on risk management sessions will appear in the May 13 issue.

Only fear will turn market: Buffett

By DOUGLAS McLEOD

OMAHA, Neb.—Widespread fear of uncontrollable losses is the only thing that will force property/casualty insurers to abandon rate-cutting and—absent a major catastrophe—that point is still a year or two away, says insurance holding company executive and investment guru Warren E. Buffett.

While considered by some to be unduly pessimistic when he predicted a prolonged soft market two years ago, the forecast by Mr. Buffett, chairman and chief executive of Berkshire Hathaway Inc., has so far been borne out.

He is also sticking with that forecast, telling shareholders that it will be 1992 or 1993 before eroding premium volume and rising combined ratios instill enough fear to turn the market.

With the exception of assumed reinsurance business, premium volume at Berkshire's own insurance units has dwindled over the last three years as they have turned away underpriced business, according to Berkshire's annual report.



Berkshire is a large writer of super catastrophe cover, 'so when a major quake occurs in an urban area or a winter storm rages across Europe, light a candle for us.'

—Warren Buffett

"Results will improve only when most insurance managements become so fearful that they run from business, even though it can be done at much higher prices than now exist," Mr. Buffett says in the annual report.

"The most important thing to do when you find yourself in a hole is to stop digging," he adds. "But so far that point hasn't gotten across: Insurance managers continue to dig—sullenly but vigorously."

When prices finally do increase, he added, "Berkshire will be ready—both financially and psychologically—to write huge amounts of business."

"We are upbeat long-term about insurance. We are not upbeat short-term about it," Mr. Buffett told the 1,500 or so shareholders who packed Omaha's ornate old Orpheum Theater last week for Berkshire's annual meeting.

Seated onstage beside Vice Chairman Charles T. Munger, Mr. Buffett also echoed calls for better regulation in the wake of continuing huge insolvencies.

Citing "a great many deficiencies" in current regulation, he said improvement is needed. "Whether it comes about through a state system or a federal system" makes lit-

Continued on page 74

President-elect of III outlines goals to expand group's role
Page 2

Members' suit alleges loophole in Lloyd's immunity from liability
Page 65

Risk managers at midsize firms taking on more duties: Survey
Page 50

NEWSPAPER

Update

Texas tax violates ERISA: Court

Continued from previous page
fund all of the estimated $200 million the state has collected under this tax or only the $2.7 million it collected from the several hundred companies that filed this lawsuit, attorneys say.

The tax was approved in 1987. As part of a larger revenue package, the Texas Legislature levied a 2.5% administrative services tax on claims and administrative fees paid by self-insured employee benefit plans (*BI*, March 6, 1939; May 2, 1988; July 27, 1987).

Had the 5th Circuit upheld the tax, other states would have passed similar measures, speculated attorney Stephen J. Sacher of Johnson & Gibbs in Washington, D.C., who represented employers in the case.

Texas has not decided whether it will seek to appeal the decision to the U.S. Supreme Court, said William Story, assistant state attorney general and chief of the office's insurance tax section.

Federal oversight proposal

NEW YORK—A coalition of insurance brokers, insurers and policyholders is developing a proposal calling for optional federal regulation of large commercial insurers.

The Insurance Solvency Coalition is working on a proposal that would allow optional federal chartering of large insurers, which would be free to operate nationally without state rate and policy form regulation, confirmed Philip F. Petronis, a managing director of Marsh & McLennan Inc. in New York. But, federally chartered insurers would still be subject to "rigorous federal solvency regulation" by either a newly created or existing federal regulatory body, he said.

The draft proposal does not envision any guaranty fund protection for federally chartered insurers' commercial policyholders, though insurers that opted to remain state-chartered would still be subject to guaranty fund laws, he said.

"We are still working on putting the ideas into a form that we think will work and that we think would find a positive reception in Washington," Mr. Petronis said. "We want to be part of" discussions begun by the House Oversight & Investigations Subcommittee over a possible federal role in regulation, he added.

The coalition includes M&M and Alexander & Alexander Services Inc. Mr. Petronis declined to identify other group members.

Cleanup costs insured: Court

PHILADELPHIA—The costs of cleaning polluted property are covered "damages" as that term is used in the comprehensive general liability policy, a federal appeals court has ruled.

The 3rd U.S. Circuit Court of Appeals, reversing a lower court decision, on April 10 ruled: "The common, everyday meaning of the word 'damages' encompasses liabilities arising from. . .the cost of repairing the property damage caused by pollution" at a landfill owned by the City of New Castle, Del.

The court also ruled the pollution exclusion—which bars coverage for pollution that is not "sudden and accidental"—applies only when the policyholder expected the pollution. Insurers say the clause bars coverage for pollution that does not occur abruptly.

The case has been remanded to the U.S. District Court in Delaware for a factual determination of whether the city expected or intended to discharge pollution at the landfill.

If the city wins at trial, it will be able to tap its CGL insurance to pay for the costs of cleaning the landfill—estimated at $8 million. The city settled with all of its insurers except Continental Casualty Co. of Chicago, a unit of CNA Financial Corp. that wrote its primary CGL coverage from 1973 to 1975.

The 3rd Circuit ruling "is a continuation of favorable policyholder decisions on the pollution exclusion," said Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York, who represented the city.

Insurer attorney Arthur Makadon of Ballard, Spahr, Andrews & Ingersoll in Philadelphia said Continental Casualty was "gratified" that the appellate court held that the exclusion focuses on the discharge of pollution rather the damage it caused.

The 2nd U.S. Circuit Court of Appeals also has held that cleanup costs are insured damages under the CGL policy (*BI*, Oct. 23, 1989).

A&A, others settle fraud suits

WASHINGTON—Alexander & Alexander Inc. is one of several firms and individuals contributing to the $47 million settlement of Federal Trade Commission lawsuits over a massive telemarketing fraud scheme.

According to the FTC, three south Florida companies—U.S. Oil & Gas Corp., Eagle Oil & Gas Corp. and The Stratford Co.—bilked thousands of investors out of more than $51 million in a telemarketing scheme related to a federal lottery of oil and gas leases in the early 1980s. Among other things, the agency charged that the companies falsely promised investors would recoup their money after seven years whether or not they won a federal lease. To provide refunds, the companies used a portion of each investor's fee to buy an annuity, though the investors were never made beneficiaries, according to the FTC.

Once the individual and corporate assets of those involved were frozen, the agency pursued civil suits against several other parties, including actions against:

- A&A, which acted as a broker for the annuities, and is paying $8.5 million.
- Belvedere Insurance Co. Ltd. and Pinnacle Reinsurance Co. Ltd. of Bermuda, which underwrote annuities and are paying $500,000 each.

In all, the FTC says it has collected $47 million, which will allow 8,230 consumers who lost between $5,000 and $10,000 each to recoup 90% of their losses.

Officials of A&A, Belvedere and Pinnacle denied any wrongdoing.

Updates continued on page 82

New III president sees a wider role for group

By MARK A. HOFMANN

NEW YORK—Gordon C. Stewart wants to emphasize the "institute" in Insurance Information Institute after he takes over as president of the property/casualty insurance industry's public relations arm next month.

"The third word is 'Institute' and we're going to try to be one," said Mr. Stewart, who is currently executive vp and chief operating officer.

As part of this effort, the New York-based organization is considering launching an "Insurance Information Institute Press" in conjunction with the University Press of America in Lanham, Md., a publisher of academic works. The III Press would be overseen by an independent editorial board consisting of academics as well as III representatives, he said.

But despite this and other goals, Mr. Stewart makes no attempt to conceal the fact that the III he is inheriting from current President Mechlin Moore will be a leaner organization than in the past. He predicted that the III's 1992 budget will be closer to that of 1988 or 1989—$10.8 million and $11.3 million, respectively—than to this year's record $13.3 million.


Mr. Stewart

The reduction in funds is due in part to the withdrawal of five major insurers during the past year or so. Allstate Insurance Co. of Northbrook, Ill., a unit of Sears, Roebuck & Co., was the most recent to withdraw, announcing its intentions late last month.

Over the next several months "we'll be examining what we're about and what the purpose of the organization is," Mr. Stewart said.

He said he wants the organization to determine at the outset of his presidency what its core activities will be, what "dedicated" programs dealing with specific areas of the property/casualty industry should be undertaken and what joint programs with individual insurers—regardless of their III membership—should be offered.

However, the institute will not engage in large-scale public advocacy advertising campaigns, like the program that was announced with considerable fanfare in early 1989 and that has since died quietly (*BI*, April 1; Jan. 15, 1990; Jan. 2, 1989).

The projected three-to-five year industry image-building program, which experts estimated might cost as much as $90 million, never drew significant insurance company support.

Instead, the III will focus on a three-tier strategy of dealing with the public on a one-to-one basis, disseminating information to the media and public, and spurring thought among policymakers about the insurance industry and how it

Continued on page 77

Brokerage listings due soon

Business Insurance will publish its 20th annual directory of agents and brokers in the July 1 issue.

That issue will also contain a spotlight report on the commercial retail insurance brokerage business and profiles on the 20 largest brokerages in the world.

The directory is published as an editorial service; there is no charge to be listed. However, brokers must return a questionnaire supplied by *Business Insurance* to be listed in the directory.

If your company generated at least $500,000 of its 1990 gross revenues from commercial retail brokerage and you have not yet received a questionnaire, please request one by writing Karen Armaganian, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or call 312-280-3195.

The extended deadline for returning completed questionnaires to *Business Insurance* is May 20.

Offshore insurer writes U.S. risks

Bank disputing trust's existence

By DOUGLAS McLEOD

JOHNSTOWN, Pa.—A Pennsylvania bank denies it holds a $2.5 million trust account purportedly set up by Northern Commercial Fire & General Insurance Co. Ltd., an offshore insurer that has written extensively in the United States.

Northern Commercial, based in the Turks & Caicos Islands, has claimed to have a trust deposit securing U.S. policyholders with Cenwest National Bank in Johnstown, Pa.

But when a California insurance agent earlier this year attempted to confirm the trust's existence, a lawyer for Cenwest said it had no relationship with Northern Commercial.

A 1989 letter on Cenwest letterhead that appears to confirm the existence of the $2.5 million trust was not written by a bank employee, Cenwest's lawyer said.

A spokesman for the FBI in Pittsburgh confirmed that the agency has been "made aware" of the situation but declined to comment whether it is investigating.

Northern Commercial is a subsidiary of American Financial Co., a Lexington, Ky.-based firm that is unrelated to American Financial Corp. of Cincinnati.

Robert R. Campbell, a principal of American Financial Co., and Keith A. Straton, Northern Commercial's president, did not return several phone calls.

American Financial Co. is also the parent of two insurers—Wilmington Marine & General Insurance Co. Ltd. and Wilmington National Insurance Co. Ltd., both of the Turks & Caicos—that assumed reinsurance business through London-based intermediary Consortium of 89 Ltd. (*BI*, Dec. 11, 1989).

Colin Youell, a Consortium of 89 official, was at the center of a series of disputes over allegedly phony binding authorities, and was arrested with two other Consortium of 89 employees last year on fraud charges in the United Kingdom. The charges were later

Continued on page 82

Inside

- The Massachusetts approach to universal health care fails to address the soaring cost of medical services, says this week's editorial. **PAGE 8**
- Risk managers at midsized companies are assuming more direct, hands-on responsibility for certain tasks in response to recessionary pressures, a new survey shows. **PAGE 50**
- Executive Life Insurance Co.'s problems, the survival of book value accounting and pension plan sponsors' fiduciary liability are among the major issues viewed at a recent GIC conference. Coverage begins on **PAGE 54**
- A lawsuit filed by members of troubled Oakeley Vaughan syndicates charges there may be a loophole in the Lloyd's Act, 1982 that would allow Lloyd's members to hold the Corporation of Lloyd's liable for their losses. **PAGE 65**
- Stock analyst Myron Picoult of Oppenheimer & Co. says signs point to tougher times for primary insurers should bode well for the U.S. reinsurance industry. **PAGE 83**

Departments

Advertiser index....64
Around the states....44
Ask a casualty actuary....47
Bermuda....65
Classifieds....78
Datebook....75
Info....63
Insider trading....53
Insurance services guide....79
International....65
International issues....48
Letters....8
London....65
Markets....41
Opinions....8
Perspectives....49
Washington....79

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Susan Nelson, Elizabeth Hoy, Gregery Riedi and Gaylen Young trumpet managed care, despite Dr. Donald K. Crandall's opposition at last week's RIMS conference.

Benefits, comp in RIMS spotlight

Managed care savings could cause a delay in needed care, warns panelist

By JERRY GEISEL

NEW ORLEANS—Efforts to better control health costs through managed care and utilization review programs may backfire because they cause employees to postpone needed medical services, a representative of the American Medical Assn. warns.

The trouble with managed care is that savings from a reduction in health care spending are only measured over a short period of time, according to Dr. Donald K. Crandall, a member of the AMA's Council on Medical Service.

"If the managed care system is designed to postpone services, in the short run you can demonstrate significant savings," Dr. Crandall allowed.

But such a delay may not be cost-effective in the long term if services that should be performed today are delayed, he said during a spirited panel discussion at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

"We don't know the cost of delaying services. That issue has yet to be addressed," said Dr. Crandall, who is a general surgeon in Muskegon, Mich.

"You assume lower levels of utilization (in managed care programs) are appropriate and that may not be correct. To artificially lower utilization doesn't make sense" when it has not been determined what is the appropriate level of care, Dr. Crandall said.

The first step toward improving the health care delivery system is to determine appropriate levels of care and then decide "if we can afford that level of care," he said.

Physicians can be trained in cost-effective treatment, Dr. Crandall said. But, first, there must be agreement on the costs and benefits of treatment, he said.

But, other panelists challenged Dr. Crandall's interpretation of the goals of managed care and utilization review.

Taking strong exception to Dr. Crandall's remarks, Gregery Riedi, senior vp at Intracorp, a health care cost management firm in Berwyn, Pa., denied that the goals of managed care and UR are to postpone needed services.

"That is not a correct characterization of the UR industry," Mr. Riedi said.

Much of the evidence on the cost effectiveness of managed care programs is anecdotal, acknowledged Elizabeth Hoy, a policy analyst and consultant with the Health Insurance Assn. of America in Washington, D.C.

But, Ms. Hoy noted that the HIAA is studying how effective those programs are at controlling costs. The group's study is not expected to be ready for another year and a half.

Dr. Crandall's skepticism on how successful managed care will be in the long run comes amid enormous investment by insurers in managed care programs.

The insurance industry has invested more than $1 billion in managed care over the last three years, according to Ms. Hoy.

Ms. Hoy defined managed care as a system in which there are contractual agreements between providers and employers with financial arrangements that encourage their employees to use those providers. There also is a strong emphasis on utilization review and quality assurance, according to Ms. Hoy.

Big employers, like Allied-Signal Inc. of Morristown, N.J.; American Telephone & Telegraph Co. in New York; Southwestern Bell Corp. in St. Louis; and Pacific Telesis Group in San Francisco are among the pioneering firms to join managed care networks organized by insurers.

Under those network agreements, employees have strong financial incentives to take health care services from network providers.

Allied-Signal already has reported that it projects savings—compared with projections of costs if it had made no changes in its health care plan—of $200 million over three years through its CIGNA Corp.-administered managed health network (*BI*, April 8).

And, managed care networks are not just for big, national employers, Ms. Hoy said. Insurers that have organized networks also want small employers to participate in these programs to give insurers more leverage in negotiating with providers, she explained.

Dr. Crandall said he is skeptical whether the core of managed care networks—employers and insurers negotiating agreements with

Continued on page 37

Cost concerns voiced

Rising comp, health expenses top worry for many

By JERRY GEISEL

NEW ORLEANS—Rising workers compensation and health care costs are a major concern of senior corporate management, according to risk management and benefit professionals attending the 29th annual Risk & Insurance Management Society conference last week.

Of the 217 people who responded to a *Business Insurance* survey conducted at the conference, 32.3% said rising workers compensation costs are the top concern of their companies' senior management, and 35.9% said rising workers comp costs were one of the top five corporate concerns. Another 27.6% said workers comp costs were only a moderate concern to their companies, while 4.1% said top management was not at all concerned about rising workers comp costs.

One risk manager, who was attending his 13th RIMS conference, summed up the concern about skyrocketing workers compensation costs when he said "This is the biggest challenge I have faced since I got into this line of work."

Of the 215 professionals who responded to a similar question about the cost of health care, 34.4% said rising health care costs are the top priority item for their companies' top management. Some 39.4% of the respondents said health care costs were one of the top five corporate concerns, while 25.6% said top management was moderately concerned about rising costs and less than 1% said top management was not concerned.

These findings are based on the responses of 227 risk and benefit managers—as well as insurers, agents, brokers, consultants, third-party claims administrators and other employee benefit and risk management professionals—who responded to the *Business Insurance* "One-minute Opinion Poll" while touring the Exhibit Hall at the conference last week.

Survey respondents pointed the finger at a number of sources for rising workers compensation costs (see chart).

Of the 223 people who responded to the question, "Whom do you blame for rising workers comp costs?" 74% blamed lawyers, 52% cited state workers comp administrators and 48.9% blamed doctors.

Other parties that were held responsible for the increase in workers comp costs included malingering or fraudulent claimants, cited by 40.3% of respondents, state legislators, cited by 36.3% of respondents, and insurance companies, named by 18.4%. Respondents were allowed to name more than one category.

Surveyed risk management and benefit professionals, by a slight margin, favor combining workers comp and group health coverage into a 24-hour program funded by employers. Of the 208 respondents, 52.4% favored a 24-hour program, while 47.5% were opposed.

There is currently no agreed-upon definition of 24-hour coverage, but definitions in use generally range from consolidated administration of claims for separate workers comp and group health insurance policies to a single insurance product that pays medical and/or disability benefits (*BI*, March 18).

More than 60% of respondents said they were opposed to a Canadian-type national health insurance program in the United States, while about 40% were in favor of a national health plan.

The opposition to a Canadian-style national health insurance system, comes at a time of growing congressional interest in Canada's program. For example, the House Ways and Means Committee has been closely examining the Canadian program.

Under the Canadian plan, which is funded by federal and provincial taxes and administered by the provinces, all Canadians are assured of comprehensive health care coverage.

But one consultant worries that a

Continued on page 83



GRAPHIC BY CYNTHIA WATSON

Employee needs drive Volvo flex plan

By JERRY GEISEL

NEW ORLEANS—Volvo North America Corp. takes the same approach to providing employee benefits that it does to selling cars: provide a basic package, then give customers many options to meet individual needs.

Four years ago, Volvo put that philosophy into action when it replaced a traditional employee benefits plan with a new flexible benefits package (*BI*, May 21, 1990).

"Our main goal at Volvo is consumer satisfaction. To those of us who are employed in the benefits field, the employees are our customers. Therefore, I look at Volvo's benefits program as a consumer satisfaction program," said Keld Alstrup, vp-human resources with Volvo in Rockleigh, N.J.

Speaking last week at the 29th annual Risk & Insurance Management Society conference in New Orleans, Mr. Alstrup said Volvo recognized several years ago that its traditional benefits plan no longer met the needs of a changed workforce.

The auto company's old program was designed for an employee with a non-working spouse and several children.

However, in two-thirds of families today both spouses work outside the home resulting in duplication of coverage without much value, Mr. Alstrup said.

Just as Volvo provides a basic car and then allows customers to choose from an array of options, its flexible benefits plan offers workers a core package of medical, life, disability and pension benefits with many additional options.

Under the basic medical plan, designed to protect employees against catastrophic expenses, the annual deductible is 5% of salary with 75% coinsurance.

"We wanted our employees to have a safety net and then provide various choices," Mr. Alstrup said.

Above that core package, the Volvo flex plan, known as "Volvo Options," provides "Flex Bucks" to employees. Employees use Flex Bucks to purchase benefit options, resulting in a custom-designed benefit package.

Each employee receives 870 Flex Bucks. In addition, employees receive 15 Flex Bucks for each year of service and Flex Bucks equal to 1% of base salary.

Those Flex Bucks then can be used to purchase a richer medical plan with lower deductibles and coinsurance levels; dental benefits; additional life, disability and accidental death coverage; and extra vacation days.

Employees who don't need the additional benefits can roll unused Flex Bucks into the company's 401(k) savings plans, Mr. Alstrup said.

They can also contribute pretax dollars in spending accounts to cover dependent care expenses as well as out-of-pocket health care expenses.

In setting up a flexible benefits plan, Volvo wanted "to make the benefit plan a positive experience for employees," Mr. Alstrup said. And, according to a recent survey, the company has met that objective: 90% of the more than 1,100 employees covered by the flexible benefits plan said they were satisfied with it.

"The plan is flexible, it provides employees with what they want," he said.

And, now in its fourth year, the flexible benefits plan is being kept up-to-date. Volvo recently, for example, established a personal computer-based system to handle record keeping.

"Administration is not a major problem," Mr. Alstrup said. Buck Consultants Inc. assisted Volvo in designing and explaining the plan to workers.

Mr. Alstrup stressed that the benefits plan was not adopted to cut medical costs. "The plan may have saved some money, but that was not the driving force," he said, noting that Volvo's health care costs now average about $3,250 per employee.

"We did not make this change to cut costs. Employees are our customers. We wanted to provide the best possible value for the company and employees for the dollars expended," he said.

Another speaker at the RIMS session said there are steps employers can take—without slashing benefits—to hold down the rate of health care plan cost increases.

"Costs are increasing dramatically. Employers say: 'The only way to limit costs is to limit benefits.' I'm not a believer in that theory," said Edward Pouzar, a consultant with Betterley Risk Consultants Inc. in Worcester, Mass., who coordinated the session.

According to Mr. Pouzar, strategies that employers can deploy to hold down costs include:

- Directly contract with hospitals so that fees are set ahead of time based on procedures, such as through diagnostic related groups, or DRGs.
- Find the most efficient health care providers and then contract with those providers through a preferred provider organization.

"You can't contract with every hospital to join the PPO. That will not solve your problem. You need to contract with a few select providers. That way you weed out the inefficient doctors and hospitals," he said.

- Use case management on jumbo-size claims to be sure that the medical care is appropriate.

"You need to zero in on these cases because 5% of cases can represent 50% of claims dollars," Mr. Pouzar said, noting that case management can save $6 for each $1 invested.

In addition, employers need to aggressively negotiate premiums with health maintenance organizations, advised Charles Humphrey, a consultant in the Boston office of KPMG Peat Marwick.

Mr. Humphrey said some HMOs "shadow price," which is essentially raising premiums to match cost increases incurred by employers' indemnity plans.

In the case of one of his clients, Mr. Humphrey said an HMO was matching indemnity plan increases even though it was attracting younger employees with fewer health care claims.

To eliminate this shadow pricing, the employer convinced the HMO that premiums would be based on the actual experience of its employees enrolled in the HMO, Mr. Humphrey said.

The session was moderated by Carol Brocci, risk manager at SPX Corp. in Muskegon, Mich. ■

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Coping with cost of long-term care

Two novel ways to fund coverage proposed

By JOANNE WOJCIK

NEW ORLEANS—Innovative financing of long-term care is needed to help workers cope with its devastating costs, a Medicaid administrator says.

One way to solve the financing dilemma is to create a private-public partnership in which insurers underwrite the first three years of care and state Medicaid programs pay the rest, the administrator suggests.

Another possibility is to modify group life insurance plans to allow employees to tap part, or perhaps all, of the benefit to pay for long-term care, an insurance company executive says.

These two new approaches to financing long-term care costs were presented during a session at the annual Risk & Insurance Management Society Inc. conference in New Orleans last week.

Long-term care financing is essential because "the middle-class elderly are an economically endangered species facing financial disaster in their later years," said Mildred Shapiro, associate commissioner of the division of medical assistance for the New York State Department of Social Services in Albany.

Up to 32% of men and 42% of women will end up in a nursing home at some time in their lives. And the chances of needing long-term care increase with age, she pointed out.

For example, individuals between the ages of 65 and 74 have a 17% chance of needing long-term care, while those between the ages of 75 and 84 have a 36% chance, and those between 85 and 94 have a 60% chance, Ms. Shapiro said, citing statistics in the February issue of the New England Journal of Medicine.

The cost of that long-term care can be overwhelming, she said. For example, nursing home rates in New York state average $151 per day, or $55,115 per year, she said.

In Chicago, annual nursing home costs average $36,000, but they are increasing as many institutions alter their billing to include per diem rates plus ancillary charges, much like hospitals do, added Michelle Y. Hart, a consultant with Martin E. Segal Co. in Chicago, who also spoke during the session.

One way to finance these costs is by combining existing employer-paid group life insurance benefits with an employee-paid long-term care insurance program, according to Robert A. Hall, assistant vp-employee benefits at Aetna Life & Casualty Co. of Hartford, Conn.

Under Mr. Hall's proposal, which he said is not yet being marketed by any particular insurer, employers would permit employees needing long-term care to cash in part or all of their term life insurance benefits to pay for the care.

In addition, employees would be given the option of purchasing supplemental LTC coverage to pay for expenses that exceed their life insurance benefits.

Such an approach "is a means where the employer, at minimal cost, can introduce the concept of long-term care insurance to his employees by providing them with a modest long-term care benefit integrated with his group life insurance plan," he said.

And "by also sponsoring the supplemental plan, the employer provides both an incentive and the means for his employees to understand how long-term care insurance works, along with the opportunity for those employees who want more insurance to obtain it on their own," Mr. Hall added.

However, the portion of life insurance benefits used to pay for long-term care would be subject to federal income tax under the current tax code, he said.

Group long-term care insurance is currently available from approximately a dozen insurers nationwide, according to the Health Insurance Assn. of America.

A second innovative approach to funding long-term care is being developed in New York state, according to Ms. Shapiro.

Under the program—financed by the Robert Wood Johnson Foundation in Princeton, N.J.—insurers would underwrite coverage to finance the first three years of institutional long-term care or the first six years of home-based care.

After that three-year period expires, the state Medicaid program would pay the remaining cost of long-term care without forcing the individuals who need it to first prove they are indigent.

Those eligible for long-term care assistance under New York's Medicaid program can have no more than $3,000 in assets and receive no more than $50 per month for personal expenses, according to Ms. Shapiro.

But under the partnership proposal, individuals would be permitted to have approximately $66,000 in assets and receive up to $200 per month in a personal care allowance, she said.

The idea behind the partnership proposal is to protect the estates of individuals needing long-term care, while still providing financing that is affordable and profitable for the insurers underwriting it, Ms. Shapiro explained.

Because the private plan would cover only three years of long-term care expenses, it could have a finite limit that is easier—and cheaper—for insurers to underwrite, she added.

So far, she said, six insurers have expressed an interest in underwriting a program: Metropolitan Life Insurance Co. of New York; Aetna Life & Casualty Co. and Travelers Corp. of Hartford, Conn.; John Hancock Mutual Life Insurance Co. of Boston; CIGNA Corp. of Philadelphia; and several Blue Cross & Blue Shield Assn. plans.

The coverage would be available on both an individual and group basis, Ms. Shapiro said.

While state and federal legislation must first be passed to permit the program to be offered on a pilot basis, Ms. Shapiro said she is hopeful it can be launched sometime this fall.

Coordinating the session was Mary L. Feldman, vp-marketing and public affairs for Martin E. Segal in New York. The session's moderator was Martin S. Brown, corporate manager of employee benefits at The Clorox Co. in Oakland, Calif. ■

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Opinions

Plan fails to address costs

AS THE POLITICAL firestorm over Massachusetts' universal health care statute demonstrates, expanding access to the health care system through employer mandates is no simple task.

Three years ago, Massachusetts captured national attention with its bold approach to improving access to health care. Legislation enacted that year, but not due to go into effect until January 1992, requires employers with more than five employees to pay a "medical security tax" equal to 12% of the first $14,000 of each employee's wages, up to $1,680 per employee. This tax would go to the state, which would use the funds to provide coverage for employees working for companies not offering group plans (see story, page 1).

However, this tax is offset by the per-employee amount an employer spends on its health care plan. If a plan costs at least $1,680 per employee, as most health care plans offered by large and medium-sized employers do, the employer is exempt from the tax.

Back in 1988, the Massachusetts approach, known simply as "play or pay," was recognized as a refreshing break from other proposals to expand access to health care, most notably the proposal championed in Congress by Sen. Edward Kennedy, D-Mass.

Under the Kennedy proposal—a model of government interference in the design of benefit plans—employers would be forced to offer health care plans that met specific coverage requirements. And, the way the Kennedy legislation was drafted, there would be nothing to prevent legislators from boosting those requirements each time they were pressured by special interest groups.

By contrast, the Massachusetts approach leaves the design of health care plans up to employers and their workers. There is no government micro-management of health plans; the employer either pays a tax or offers a health care plan.

But as the effective date of the Massachusetts employer mandate nears, it is becoming clear that the program, while preferable to the Kennedy proposal, still won't work.

For example, many small companies in Massachusetts probably will not be able to afford either to provide coverage or pay the tax. Small business lobbyists say the last thing Massachusetts needs at a time when unemployment is nearing double digits is another tax on employers.

At the same time, we wonder how long the $1,680 per-employee tax, at a time of soaring health care inflation, could be kept at that level. With corporate health care costs now averaging about $3,000 per employee, spending $1,680 per worker won't go very far.

Even if employees were forced to pay 20% of the premium under the Massachusetts system, there still likely would not be enough money to ensure that all Massachusetts residents would have an adequate level of health care coverage.



"WHEN I SAID, 'ALA-KAZAM, DISAPPEAR!', I WAS REFERRING TO YOU!!!"

In short, if the $1,680 benchmark remained on the books, it would mean that Massachusetts would have to subsidize coverage, a politically unrealistic proposition at a time when the state is fighting a huge budget deficit.

In short, where the Massachusetts approach has failed is that it does nothing to control the one thing that is restricting access to health care: the cost of services. Employers don't provide coverage, not because they don't want their employees to have access to health care services, but because they can't afford to. And as health care costs continue to escalate, more and more employers will be unable to afford to offer a health care plan.

However, some simple things can be done on a national level to lower health care costs, which will increase access to the health care system. Congress, for example, should pre-empt state rules that mandate specific benefits for insured group health care plans—one factor that continues to drive up the cost of health care. More rational medical malpractice laws are needed to protect health care providers from outlandish awards. And, insurers and employers need to exert more pressure on providers to eliminate waste in the health care delivery system.

Simply requiring employers to offer health care coverage—whether through a Massachusetts-type system or through a system like the one Sen. Kennedy proposes—will create more problems than it will solve.

Letters

Insurers not listening to consumers, agents

To the editor: Your April 22 article, "Wanted: Spokesman for Industry," suggests an industry spokesperson is desperately needed.

Would you accept this job for all the money in the world? Fat chance!

In the article, Robert V. Hatcher Jr., retired chairman of Johnson & Higgins, notes that only organized crime has a lower public image. This is expected. Our poor image is a travesty, but we have received what we paid for. What have we spent to affect our public image?

Have we told our story succinctly? Have we told it at all? Advertising Age, a sister publication of *Business Insurance*, reported recently that of the top 200 advertisers, only three were insurance companies: Allstate, State Farm and Prudential. Hello out there, national agency companies!

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David Halberstam in "The Next Century" says "good service—with true accountability—is considered rare by most Americans." He adds, "The problem exists in no small part because the people who run service companies have exempted themselves from knowing what the reality of their service is."

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SUBSTANCE ABUSE IN THE WORKPLACE— THE VOICE OF EXPERIENCE.

Part of an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **MARK A. MARIANI,** *Owner and President of Mariani Packing Company, a leading processor and distributor of dried fruits.* **BOB APPLEBY,** *with Woodruff Sawyer & Co., Mariani's broker.* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company.* **JOE SILVA,** *Executive Safety Management Consultant, Argonaut Insurance Company.*

MODERATOR We've been talking about how a substance abuse program has benefitted Mariani Packing Company in terms of dollars saved and increased productivity. On the flip side, is there a dollar figure you can put on what it costs to run your substance abuse program?

MM: I'd say our safety program, as a whole, easily costs us over $100,000.

JS: $100,000 seems high.

MM: It depends on how you want to define costs. That $100,000 includes loss of productivity while we administer the program. It's like our stretching program that gets people off the line for a few minutes to give them a chance to stretch their muscles and take a break. Just that 6½ minutes of stretching costs the company $65,000 in lost production time. And we take at least the same amount of time to talk about company policies during the toolbox meetings and so forth. So in real costs to the company from lost time, I would say the figure could easily be in excess of $100,000.

MODERATOR Can you turn that around and estimate what you've gained in productivity by people not having accidents, or taking time off, or filing claims?

MM: Well, just take our worker's comp. One year is a 100% return on our investment.

MODERATOR That's an impressive return.

MM: Obviously every year is going to be less and less. But the big issue is the focus on your safety program. To make sure everyone's thinking about it, and believing in it, and wondering what they can do about it. You walk out into our facility and every department has a white board that says how many days they have gone without an accident. It's just focus and realization and awareness. And, as Joe said earlier, the substance abuse program is one component, but a very important component. I honestly believe you're not going to have a successful program unless you have a strong statement by the company on it.

MODERATOR What would you tell another company about getting started?

MM: Well, if your only concern is for the bottom line you're going at it the wrong way. The bottom line improvement will come as soon as you're able to communicate to the employee base that you care. If they don't think you care, they'll give you every reason in the world why it's not going to work. And I think it's the apathy in the workplace that's going to get you. You have to get the community members caring about what they're doing and caring for each other first.

MODERATOR So it's the culture that has to be changed.

MM: Right. We had a difficult time at first because Joe here was really excited about the programs and wanted to get them implemented as soon as possible, and rightfully so. We felt we needed more lead-in time. We felt that we just didn't want to throw a bunch of programs on our people, a bunch of posters on the wall. We wanted to go into it slowly, because if you don't, people become suspicious of it.

MODERATOR You mean gradually educate them?

MM: With a well laid out program. Say over a three to six month period. That questionnaire we handed out, I'm convinced we wouldn't have had that kind of response if we just handed it out one day without warning. Everybody would wonder if it was a salary review, or an appraisal. If you don't communicate with them, they're not going to understand what you're trying to do. You have to get them thinking in the same terms you are.

MODERATOR But isn't that changing a corporate culture?



We're 225 people who spend nearly half of our lives together, and we'd better work as a community for the safety and well-being of all of us.

MM: And who's responsible for the culture? The CEO. If you leave this whole issue to your safety committee and think you don't have any impact on it, it's a waste of time. The CEO has to have the vision, the belief and the commitment to it. Because if you don't have the CEO and the senior management believing it, it's not going to happen.

MODERATOR How does your community of employees know that you care, that you're involved? Do you spend time out on the floor?

MM: You have to. If there's an accident out there, I want to be one of the first on the scene. We have little calendars within the company, and if someone's worked, say, 112 days without an accident and it beats the record, you'll see my name and "Great job!" written on it. They also hear through our newsletters. And questionnaires—a questionnaire's a powerful tool.

SL: I think it's admirable the way you've gone about getting a mandate from your employees, especially with the equipment operators. Something you might consider is post-accident testing for accidents requiring off-site medical treatment. I'm not talking the hangnail-type claim, but the Monday morning injury, the weekend strained back that shows up on your insurance bill. These tend to disappear when any off-site medical treatment also requires a substance abuse screening test. Post-accident testing probably isn't going to come out in an employee questionnaire because they're not going to be thinking about that, except for the guy that may be abusing on the weekends who's filed a few claims.

> Substance abuse is just one part of a company's safety program.

MM: That's an interesting idea.

MODERATOR But what would the impact be on your community?

MM: I'm not sure. We just want to make sure we don't come across as police.

SL: The other thing is, anything you do has to start from the top. If any of your senior staff teach driving or how to handle equipment, they're going to have to come under your safety policy. If they ever get on a forklift, even in an emergency situation, they had better be included in your routine and periodic tests.

MM: It isn't coincidental that our policy is worded 'any operators of equipment and vehicles,' and that all my management people drive company vehicles.

MODERATOR Have you had any threats or projected legal challenges from prospective applicants in the last eighteen months stemming from your policy?

MM: Not that I know of.

SL: See, that's the other bit of misinformation that hits the papers. That you'll have trouble hiring, or you'll be sued. Yet none of your applicants cried 'foul.' That's the kind of message we've been trying to get to customers. That a lot of what they read about substance abuse programs is not really the truth.

MM: You know what still tickles me, where did that 30% that failed our test go? Who would they go to work for?

SL: Let 'em work for someone else. Let some other company pay the cost. It's interesting that you based your discussion on productivity, which is really the way you should look at all of this. Because that's really where your major loss is: productivity. But hasn't your safety program paid for that productivity loss in direct savings in insurance dollars?

JS: It will. It's just a matter of time.

MM: Do you want me to quantify productivity? This last month, we had the biggest month ever in the history of the company. We did 32% more business with no new people, no new equipment, no new manager, no new techniques, no new racking, no new anything. And without any overtime or any accidents.

SL: Obviously, whatever your costs are for testing those applicants, it pays Mariani in the long run in increased productivity and better employees.

MM: No question.

SL: Substance abuse in the workplace is something you don't want to go into hastily. But I think what you talked about this whole session is what's going to be a buzzword of the 1990s: Total quality management. With no separation between productivity and safety. They're intertwined parts of the management scheme. If corporations are going to remain productive and profitable and ahead of the competition, they're going to have to have total corporate quality management. Look what it did for you, a 32% increase in productivity. You're getting a better product, a better employee, a better community, a better culture. That's outstanding. And that's what more companies are going to have to take a stand on and realize.

MODERATOR Would you be willing to spend some time with another company that comes to you and says "I've heard about your program and the benefits you've derived from it. How can we get started?"

MM: Absolutely. If they were really serious about it, I'd be glad to. I love to talk about success stories. I'm convinced it works, because we've done it here.

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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Checking cost containment effectiveness

By CHRISTINE WOOLSEY

NEW ORLEANS—Employers can measure the cost effectiveness of their health care plans by scrutinizing claims data and carefully comparing the services of different managed care networks, says a panel of cost containment experts.

In addition, employee benefit managers should establish a sound plan to corral soaring health care costs, according to a benefits consultant.

The health care experts discussed these strategies during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

Controlling employee health care costs will become even more crucial to companies in the future, predicted Dr. Donald K. Kelly, chairman and chief executive officer of managed care consultant Health International Inc. of Los Angeles.

He believes this because he expects that the Financial Accounting Standards Board will eventually issue new rules that will require employers to account for employee health care liabilities on an accrual basis, much like FAS 106 requires most employers beginning in 1993 to account for retiree health care liabilities in their financial statements from the time an employee is hired until he or she becomes eligible for retirement.

"As the FASB rules are expanded to apply to the normal working population, the question of how to assess your company's health care liabilities and how to assess your risk is going to be paramount in setting up your reserves," Dr. Kelly said.

As a result, employers should take a hard look at their health care experience by analyzing claims data, he advised.

"Fifty percent of paid claims in a health benefits plan are due to hospital or hospital-related services. Providers present that data as bed days per 1,000 or bed days per year," Dr. Kelly explained.

But, some cost containment vendors that want to prove that their services are saving money may manipulate that data to "prove" they are saving bed days, when they actually are not, he noted.

To arrive at a figure of bed days per 1,000 lives annually, claims analysts multiply the number of hospital admissions per 1,000 lives annually by the average length of stay, Dr. Kelly explained.

The use of second opinion and case management techniques should decrease an employer's annual bed days, he said.

But, he cautioned employers to look closely at how their cost containment vendors are calculating bed days per 1,000 lives. "You must know the number of dependent lives within your population or the number of bed days won't mean anything," he said.

Employers also must guard against a phenomenon Dr. Kelly termed "right pocket/left pocket." For example, when a case manager keeps a patient out of the hospital and assigns home health care instead to save costs, employers should be sure that daily home health care costs do not total more than the cost of one bed day.

"If you send a person home and spend $35 per hour for a 24-hour nurse, that could equal the cost of one in-patient bed day," Dr. Kelly explained.

Employers also should ask cost containment vendors what costs are included in a bed day, he said.

If a patient's medication is included in a bed day, that cost should be taken into account when comparing the cost of an alternative health care setting that does not take medication into account, he said.

"The ultimate judgment of whether your cost containment systems are working is a comparison of what you spent this year vs. last year," he said.

Taking the number of dependents into account, employers should itemize current average costs of all services, including X-rays, hospital charges, mental health costs and home care.

Itemizing also can show employers where they are spending more than necessary, Dr. Kelly said.

Comparing different PPO networks is equally important when employers are trying to determine how efficiently their health plan is running, said Paige M. Jackson, senior vp with Alta Health Strategies Inc. in Houston.

For example, employers can scrutinize the individual characteristics of the surgeons who provide services through the PPO, she said.

Alluding to a study, Ms. Jackson said that surgeons who have practiced at teaching hospitals were most often associated with good outcomes.

Other factors to consider include whether they are board certified and the number of years they have been in practice, she said.

When setting up a network of surgeons, employers that are concerned about the prices the doctors will charge should keep in mind that "the price of surgery increases as more surgeons come into a geographic area. And the utilization also increases" when there are more physicians available.

Employers also should examine the quality of physician staffs at hospitals within a PPO network, Ms. Jackson said.

All physicians with admitting privileges at network hospitals should meet certain standards, Ms. Jackson said. Board certification should be a requirement for network physicians, and employers should check into the hospitals' methods of verifying physicians' licensure.

In addition, admitting privileges should be limited to staff physicians to be certain employees use network hospitals, she said.

Employer also should note the volume of procedures the hospital performs and the scope of its services.

"Try to limit the number of hospitals in a network because they do vary so much" in terms of cost and quality, she advised.

Employers also should be sure there is an adequate number of surgical specialists on staff, she said.

Employers should be wary of straight discount payment arrangements with PPO networks, Ms. Jackson cautioned.

"Look at the compensation structure spelled out in hospital contracts for both inpatient and outpatient services," she advised.

Payment may be based on established diagnostic-related groups, per diems or usual and customary rates in that hospital's community.

If the network agrees that the employer will pay a specific percentage of charges with rate and

Continued on page 12

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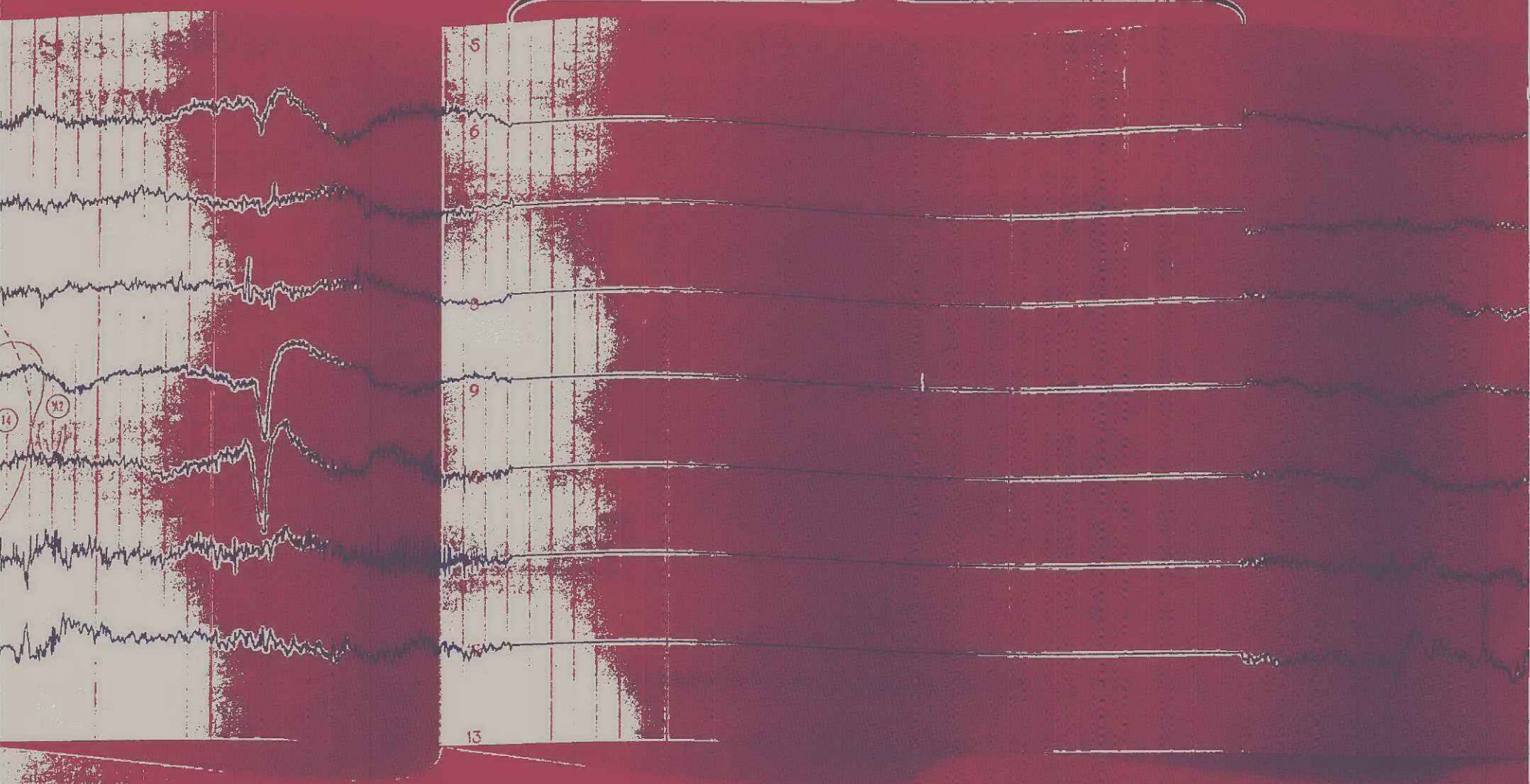
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Cost control

Continued from page 10

cap monitoring, "the rate cap should be based on the two previous years' cost increases and anticipated increases next year," she said.

How the network hospital credentials its physicians also should be noted, she said.

And, physician and hospital turnover within a network could tip an employer off that providers are not happy working within that managed care network.

Ms. Jackson also asserted that "you can save money on physician costs only if there is aggressive utilization review" within the network. She said an estimated "$5.8 billion in excess claims paid in 1989 were due to unbundling of CPT codes," which identify the prices physicians should charge for specific procedures.

But, those procedures often involve more than one step, and some physicians will charge separately for each step of a procedure.

"Comprehensive utilization management with an emphasis on outpatient management to control the frequency of services" can produce substantial savings, Ms. Jackson noted.

As always, employers should analyze their employee demographics, like age and sex, and compare utilization patterns to previous experience, she said.

"Health care costs have reached a point where each additional increase directly impacts the overall effectiveness of a corporation," said Gregory S. Perez, regional director for employee benefit consultant Godwins Inc. in Los Angeles.

"I have sat in meetings where to continue the present benefit program with a 'business as usual' mentality would invite disaster," he said.

Mr. Perez pointed out that many vendors and providers want to assist employers in corralling their runaway health care costs.

But "none of them are going to serve you well unless you have a sound, objective plan of where you want to be," he said.

Employee benefit managers can take charge of their company's health care situation if they accept accountability for the problem, he said.

"If you believe that the health care problem is a result of physician overcharging, oversupply of hospitals, non-committal benefits consultants or the aging population, you're right. But you're on the wrong track because you're shifting blame to someone else," Mr. Perez said.

"Your office or desk must become the center of accountability. It's your health plan, and you are responsible for the results. Marshall all resources available—both internally and externally—to assist you in confronting your health plans," he advised.

Mr. Perez suggested that employee benefit managers, among other things, define their company's health plan. "If you don't know what your health plan is supposed to provide, then any design, vendor, insurance scheme or experience will be your health plan," he explained. "As various laws and compliance issues arise, they are added to the plan like so many slaps and dashes to a shanty house."

Employee benefit managers must create a mission statement that explains the purpose of the health plan in language that is understandable to all parties, Mr. Perez said.

One example: "To provide health care protection for our employees and their families in the event of sickness, injury, death, disability or retirement."

Another: "To provide health care cost reimbursement not to exceed 10% of total compensation."

"The statement will begin to narrow your focus and will eliminate the superfluous plan designs and vendors that will not help you achieve your purpose," Mr. Perez explained.

Patricia L. Machen, insurance manager for Petersen Publishing Co. in Los Angeles, moderated the session.

Mr. Perez coordinated the session. ■

Cheapest mental care not always best: Expert

By JOANNE WOJCIK

NEW ORLEANS—The least expensive mental health care treatment program is not such a bargain if it provides inappropriate treatment, a mental health expert warns.

By adhering to rigid protocols that put cost before appropriate treatment, employers "will only end up paying the piper later," asserts Miriam Ingebritson-Fretthold, vp of professional practice at Personal Performance Consultants Inc., a St. Louis-based mental health care management organization.

Rather, mental health treatment should be tailored to patients' individual needs, she said.

Ms. Fretthold made her remarks during a session at the annual Risk & Insurance Management Society conference last week in New Orleans.

In many managed mental health care programs, employees are only referred for inpatient treatment after outpatient treatment has failed, she said.

But those initial—and often unnecessary—outpatient treatment costs can be avoided in some cases, she said.

For example, this is possible if it is determined early on whether a particular employee would respond better to treatment in an inpatient setting, or has an illness that is too serious to be treated as an outpatient, Ms. Fretthold commented.

By selecting an appropriate treatment program, "employers can realize real savings, not simply front-end savings that end up being chewed up the following year when the person is hospitalized because he didn't receive the appropriate care at the appropriate time," Ms. Fretthold said.

Employers that negotiate discounts with mental health care providers—like preferred provider organizations—also may be jeopardizing treatment outcomes, she warned.

"The person who does the diagnosis should have no financial incentives to do anything but very accurate and objective diagnosis," Ms. Fretthold said. Some PPO contracts contain an inherent flaw because "volume discounts can compromise treatment decisions," she said.

"Sometimes, if you go to the cheapest act in town that is, in fact, what you get," Ms. Fretthold added.

Purchasing mental health care is not like buying a discount airline ticket, she stressed. "If you buy the cheapest seat on a plane, you're still fairly well guaranteed that you'll get there at the same time that everybody else gets there on

Continued on page 16

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Mental health care

Continued from page 12
that plane. Treatment is different," she said.

However, mental health treatment does not have to be expensive to be successful, Ms. Fretthold said.

The goal is to pay a price appropriate to the quality of treatment administered, she said.

For example, early intervention in treatment decisions can reduce employers' mental health care costs, according to Ms. Fretthold.

If a patient is admitted to an inpatient psychiatric hospital because he or she is having a nervous breakdown, that admission should be reviewed within 72 hours to determine its appropriateness, she explained.

He or she may be suffering from a drug-induced psychosis that can only be determined through a urine test that must be conducted as early as possible, she said.

"Our goal in doing an on-site review is not in any way to catch a hospital not doing something right," Ms. Fretthold stressed. Rather, knowing the cause of a problem is critical to determining the appropriate treatment pattern, she said.

To ensure the long-term success of mental health treatment—and to avoid having to pay the piper again later—a patient's care should be monitored for up to a year after he or she is released from an inpatient psychiatric hospital, Ms. Fretthold recommended.

Thirty percent of people who are admitted for psychiatric treatment are readmitted within one year, and 10% are readmitted within 30 days, she said.

Unfortunately, a lot of times "discharge planning" may consist only of a statement from the attending physician referring a patient to outpatient treatment, Ms. Fretthold said.

Proper discharge planning should include taking the patient to the outpatient treatment center on the way home from the hospital, because "people don't go places they haven't been before," she said.

And patients who must take medication after being released from an inpatient facility should be fully informed of any possible side effects "so when they wake up with a dry mouth, they don't stop taking the medication," she added.

Enlisting the support of providers is critical to making a managed mental health care program work, said Dr. Jack L. Croughan, PPC's medical director. "Doctors see managed care as intrusive and adversarial," he said.

They also fear increased liability as a result of an employer's decision not to pay for certain types of care, he added.

If length of stay decreases or outpatient treatment is used instead of inpatient care, "it looks like the doctor is making the decision on treatment, when often it's an economic decision made by the utilization review firm," Dr. Croughan said.

To enlist providers' support in the management of mental health care, employers should show them that the care is being monitored to enhance quality, not just to cut corners, he asserted.

Ms. Fretthold agreed: "We must work as much as possible for a collegial relationship between the provider and the managed care firm."

Also speaking during the seminar was Susan Armstrong, who is senior benefits consultant at Atlantic Richfield Co. in Los Angeles.

Ms. Fretthold coordinated the session and Bruno R. Maxxotta, director of risk management at St. Louis University, served as moderator. ■

Case studies on managed mental care

NEW ORLEANS—Two employers significantly reduced their mental health and substance abuse treatment costs by contracting with a mental health care management firm, two recent case studies show.

A McDonnell Douglas Corp. employee assistance program saved the St. Louis-based aerospace company $5.1 million over four years, according to a study by Alexander & Alexander Health Strategies Group.

And an early intervention program introduced a little more than a year ago by NCR Corp. of Dayton, Ohio, reduced its average per-admission mental health care costs by nearly 50%, a second A&A study indicated.

Both studies focused on the effectiveness of mental health care management services provided by Personal Performance Consultants Inc., according to Miriam Ingebritson-Fretthold, vp of professional practice for the St. Louis-based consulting firm.

The results of the studies were presented during a session at the annual Risk & Insurance Management Society conference in New Orleans.

At McDonnell Douglas, the employee assistance program saved $5.1 million over four years, the A&A study found.

The program, which provided counseling and referral services to McDonnell Douglas' 100,000 employees and their 250,000 dependents, produced a 4-to-1 savings-to-investment ratio, A&A found.

Other key study results include:

- Employees treated for chemical dependency through the program lost 44% fewer workdays than those treated outside the program, and there were 34% fewer lost days for employees treated for psychiatric conditions than for those treated outside of the program.
- The program reduced medical claims costs of employees' spouses and dependents by 35% over four years, compared with spouses and dependents who did not use it.
- The average per-case cost for EAP users was $7,370 lower for chemical dependency cases and $2,400 lower for psychiatric cases than for employees outside the program.

NCR Corp.'s early intervention program, which was introduced a little more than a year ago, produced similarly positive results, Ms. Fretthold said.

The system encouraged employees and dependents to access PPC services before seeking mental health or substance abuse treatment, allowing many problems to be addressed without intensive care. The program also was designed to match treatment to employees' needs.

Results after one year, according to the study, showed:

- Approximately 80% of cases handled by the consultants were resolved without employees ever utilizing mental health care benefits.
- Only 1.5% of PPC cases generated in-hospital claims, compared with 6.1% of those who sought mental health or substance abuse care without PPC management.
- The average charge per admission for PPC cases was nearly 50% less than for other admissions.

In addition, NCR estimated that it could have saved $1.9 million more if non-PPC users had been channeled through the managed mental health care program.

—By Joanne Wojcik



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Mardi Gras for benefit managers

Exhibits offer information with Big Easy style

By CHRISTINE WOOLSEY

NEW ORLEANS—Benefit managers attending the 29th annual Risk & Insurance Management Society conference didn't have to visit the French Quarter to stock up on souvenirs or to be entertained.

Instead, they could shop the RIMS Exhibit Hall to pick up all sorts of items that symbolize the Crescent City, while at the same time picking up information on products and services to control rising health care costs.

And some of the exhibitors provided Mardi Gras-like entertainment, as well as information.

While many companies offered the usual array of pens, note pads, key chains, luggage tags and other gifts to entice passers-by to stop for a chat, some exhibitors gave away something with a bit of New Orleans flavor, including the world's smallest bottles of that local favorite, Tabasco sauce.

Along with literature describing its preferred provider network and mental health products and services, USA Healthnet Inc. handed out miniature voodoo dolls to conference attendees.

"Our message is: 'If you don't know how to choose a managed mental health care system, you might as well practice voodoo,' " said Charlotte S. Schmidt, vp for managed mental health programs with the Phoenix-based firm.

USA Healthnet operates the second-largest general service preferred provider organization in the country, with more than 4.7 million employees and dependents in employer groups eligible to use the network (*BI*, December 1990).

Ms. Schmidt said many of the conference attendees stopping by to chat were interested in chemical dependency programs available through the PPO network. And, she said, risk managers expressed an interest in trying to trim the costs associated with stress-related workers compensation claims.

While many benefit managers were hunched over exhibitors' computer terminals to examine software programs, others opted for fun and games.

Intracorp, the Berwyn, Pa.-based health care cost containment services unit of CIGNA Corp., featured "Match Game '91," a takeoff of the TV game show.

The "host" of the game, Scott Bloom, a professional comedian, asked participants to pick a category of risk or benefit professional—including risk manager, employee benefits director, third-party administrator, broker or consultant—from a game show-type board. Contestants were then asked a question from the category that was selected. Pads of paper were available and each contestant was instructed to write down the first fill-in-the-blank answer that came to his or her mind. Contestants who came up with the answer given by Intracorp won a toy prize.

Sample questions included: "The Hyde Leather Co. built a PPO and chose not to include Dr. (blank), a specialist in personality disorders, because he had a little split personality problem of his own." A common answer was "Jekyll."

Those who stopped by to play the game enjoyed themselves, but many also asked some serious questions about how they could contain their rising health and workers comp costs, noted Frances G. Atkinson, vp of marketing services for Intracorp.

Among other things, Intracorp representatives offered information about the company's utilization review services for high-dollar health care services, like chiropractic care, Ms. Atkinson said.

"We used to only do retrospective audits of chiropractor bills," she explained. However, because many chiropractic charges often include inappropriate treatment or too many follow-up visits, Intracorp is now examining the first or second bill it receives to be sure the diagnosis and treatment plan costs are appropriate.

Intracorp is planning to target other highly utilized specialty care services in the future, she said.

Beech Street Inc., a preferred provider organization based in Irvine, Calif., had an artist on hand to draw caricatures, so that conference attendees did not have to journey to Jackson Square to have their portrait drawn by a sidewalk Rembrandt.

The gimmick attracted a lot of customers, said Karen Thomas, vp of workers compensation for Beech Street.

She pointed out that Beech Street, which is planning to merge with Sacramento, Calif.-based Occupational-Urgent Care Health Systems Inc. (see story, page 41), is attempting to offer a more customized network to employers. "We aren't just telling employers where we are located, we are asking them where they need us to be located. We want to tailor our PPO to the employer's location."

Animal lovers who could not make it to the Audubon Zoo or the Aquarium of the Americas—two popular New Orleans tourist attractions—could still view interesting species of animal life at the Mutual of Omaha Insurance Co.'s "Wild Kingdom" exhibit.

Among the animals displayed this year at the Omaha, Neb.-based group life and health insurer's booth were baby timber wolves, a 10-foot Burmese python and an

Continued on next page

Exhibit hall

Continued from previous page
orangutan. And, as in past years, conference attendees could have their pictures taken with the critters.

When they weren't smiling for the camera with the python draped around their shoulders, employers expressed interest in long-term care insurance programs, noted Tom McKellar, vp of group marketing. "They mainly asked us to describe our program and what kinds of benefits it offers," he said.

Mr. McKellar also explained that Mutual of Omaha is expanding its network of exclusive health care providers. The company created the EPO network about two years ago and now has 52 providers, mostly located in the Midwest, he said.

Mutual of Omaha is trying to distinguish itself from other managed care networks by highlighting the quality of its provider network. And, Mr. McKellar said, the company is writing in more performance guarantees for employers that want the insurer to assume some risk if administrative services, among other things, don't live up to expectations.

Software vendors have long been a staple of the RIMS Exhibit Hall, and benefit managers looking for computer-assisted help—and entertainment—were not disappointed.

For example, Medical Bill Review Inc., based in Naperville, Ill., displayed its Claim Edit system, which analyzes medical bills and diagnoses to make sure that surgical procedure codes are correct and that there are no erroneous or upgraded charges.

The system can be integrated with a claims administration system so that when claims information is input, Claim Edit automatically flags questionable charges, explained Steven E. Nelson, president of Medical Bill Review.

"There is a lot of interest in getting a better grasp of where health care and workers compensation medical dollars are going," Mr. Nelson said.

And, "employers that are looking to go self-insured are asking, 'How can we be sure the claims we are paying are right?' "

The software can run on personal computers, mid-range computers and local area networks, he said.

Pulling up a sample medical claim on the PC screen, Mr. Nelson demonstrated how the Claim Edit system can identify inappropriate charges or over-utilization.

The software contains a data base of established codes used in the medical field to identify specific diagnoses and their appropriate charges. This information is linked to the employer's own data, including information on services not covered by the health plan, like cosmetic surgery or procedures that are deemed experimental.

When a patient's claims data is called up, the system checks that the medical procedure performed is accompanied by the proper code. If the coding includes incidental procedures or procedures that probably represent billing errors, it will automatically alert the claims processor that those charges should not be paid. Or if the charges total more than usual and customary rates, the system will recommend the appropriate reimbursement.

Mr. Nelson said claims processors have the ability to override the system if special circumstances are present.

The system can also check for appropriate utilization patterns based on a particular diagnosis, Mr. Nelson said. For example, if a particular surgery generally requires three follow-up visits to a physician and the claim calls for four visits, the system will alert the claims processor that the fourth visit is inappropriate.

Baxter Prescription Services Division, a unit of Baxter Healthcare Corp. of Lincolnshire, Ill., offered desktop calculators to attendees who stopped by its booth, perhaps encouraging them to calculate savings from its mail-order prescription drug benefit plan.

"Most prescription drugs are currently covered under employer major medical plans," noted Frank R. Coliano, executive vp for Baxter Prescription Services Division. However, because prescription benefits make up about 10% of employers' health care expenditures, and drug costs are increasing at least 25% per year, many employers are showing an interest in carving out prescription drug benefits, he said.

Mail-order prescription plans like Baxter's can save employees money because the plans eliminate expensive dispensing fees that are typical of pharmacies. Purchasing high volumes of maintenance drugs—like those for high blood pressure, arthritis, heart disease and diabetes—and substituting generic equivalents for name-brand drugs through a mail-order program can cost 20% less than purchasing prescriptions from retail pharmacies, he said.

"Most companies just don't know what their drugs are costing them. They want to carve out this benefit so they can identify those costs," Mr. Coliano said.

Finally, benefit managers did not have to venture from the Exhibit Hall to "shop" at a familiar retailer: Wal-Mart Stores Inc.

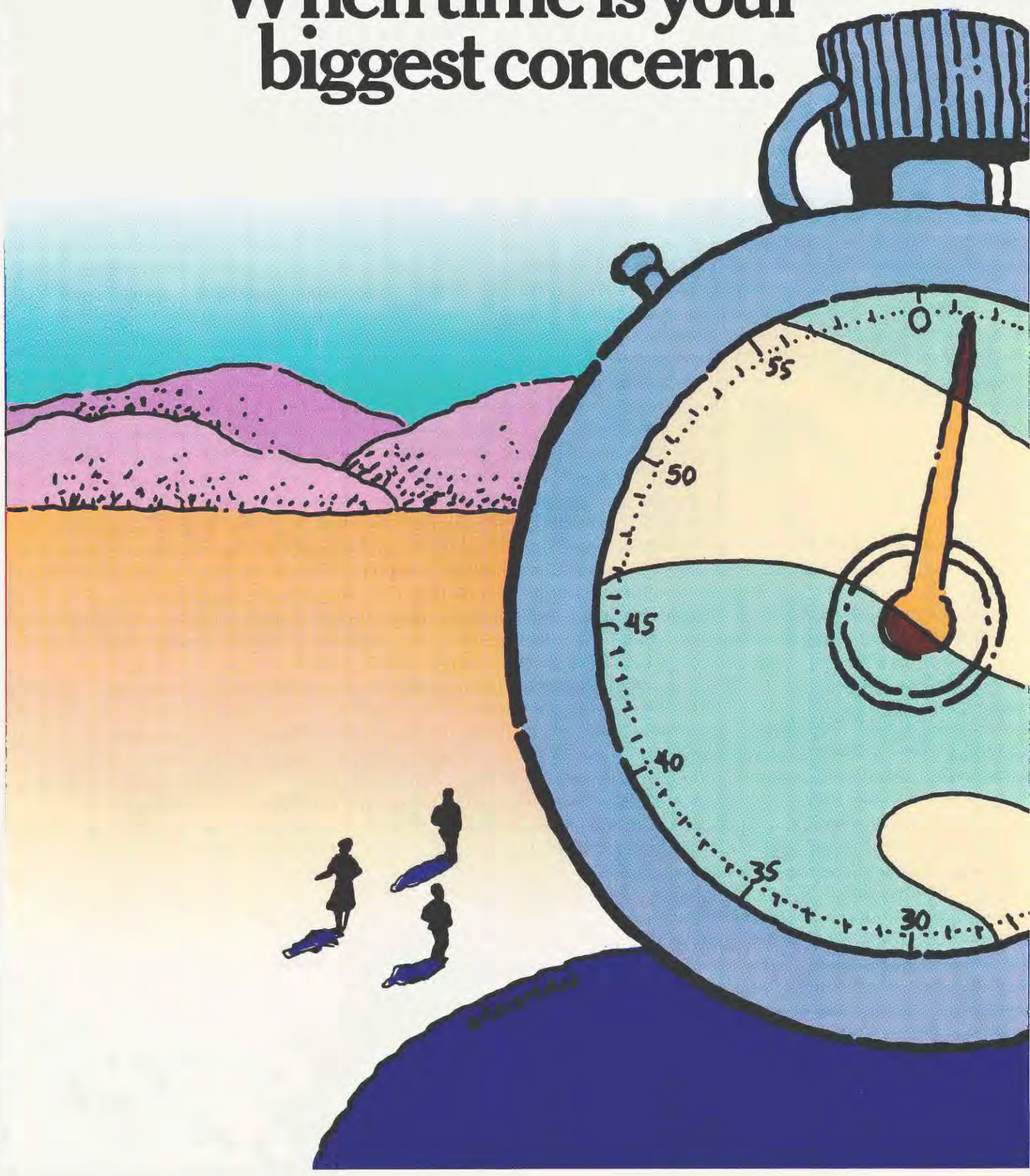
The first-time RIMS exhibitor discussed the Wal-Mart Prescription Drug Plan it offers, including its drug plan identification card.

Bentonville, Ark.-based Wal-Mart operates about 1,200 pharmacies around the country where employees with an ID card can purchase prescription drugs at discounted prices, explained Scott Culver, a manager in the company's pharmacy division.

Employers pay an administration fee of 30 cents per claim, and they can design their own coinsurance requirements and incentives for using generic drugs instead of name brand drugs, Mr. Culver said.

Another prescription drug company, Clinical Pharmaceuticals Inc., passed out wrist bands to RIMS attendees to publicize its services. Employers stopping by its booth were interested in whether or not the pharmaceutical firm unbundles its clinical pharmacy and claims processing services, said Ann M. Sletten, a pharmacy consultant in Minneapolis. ■

When time is your biggest concern.



Integrated audit examines risk control effectiveness

By MARK A. HOFMANN

NEW ORLEANS—Attempting to make decisions about safety and health matters without first analyzing risk controls is "scud management," a safety and health consultant says.

Scud management means "launching your company in a direction without the ability to guide the company to the designated objective," said William E. Phillips, president of AFTECH Ltd., a safety and health consulting firm in Washington, D.C.

An integrated audit is one of the most effective ways of monitoring and determining how well an organization is controlling risks, Mr. Phillips said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

The consultant said that integrated audits provide risk managers with a systematic way to:

- Identify the status of existing risk control measures.
- Evaluate compliance with regulations, many of which overlap with and thus affect risk control.
- Evaluate the effectiveness of the management organization for controlling risk.
- Determine which resources should be allocated to risk control and reduction.

Joseph M. Kulak, a manager in the toxicology, regulatory auditing and compliance department of CIBA-Geigy Corp. of Ardsely, N.Y., described how that company's integrated audit works.

Mr. Kulak said that CIBA-Geigy began conducting the audits in the mid-1980s to deal with exposures like non-compliance with health and safety regulations, corporate liability, the potential of jail terms for executives and even loss of credibility in the community.

Mr. Kulak described the mission of regulatory auditing as: "to minimize the risk of non-compliance with environmental, health and safety laws, regulations and company policies and standards as well as to advise and assist management in effectively discharging their compliance responsibilities."

Each of CIBA-Geigy's 33 major U.S. locations is audited annually, he said. The audits last between a few days to as long as two or three weeks.

Each audit begins with the auditors meeting local plant management to explain the process.

The audit consists of, among other things, interviewing appropriate staff at all levels and collecting documentation on plant conditions and processes.

The process concludes with another meeting between the auditors and plant managers. Auditors also prepare a handwritten draft report of their findings for local plant managers to review and comment on.

Auditing should not be an adversarial process, Mr. Kulak said. Local managers must be involved throughout the process. In fact, auditors are told to achieve their objectives "with the least amount of disruption to the operational unit," he said.

Mr. Kulak stressed that auditors have "no direct responsibility for or authority over any operations reviewed." Auditors can only recommend remedial actions.

Exposures cited by the auditors may seem trivial, Mr. Kulak conceded. For example, local managers may be told to store steel drums containing chemicals so the labels are always visible.

But, a CIBA-Geigy facility in New Jersey was fined $1,000 because the label on such a drum was turned toward the wall, Mr. Kulak noted.

Auditors' approach should always be positive, Mr. Kulak said.

For example, in the report of audit findings, "give credit to plant management when they correct something on the spot or within 24 hours," he advised.

But, Mr. Kulak noted, a bad previous experience with internal auditors caused such friction between his department and local managers that outside auditors must be used.

Mr. Phillips said that before choosing an outside auditor, a risk manager must determine:

- What the consultant's role will be. Will the consultant focus on one specialized area, or conduct an entire integrated audit?
- What technical skills the consultant must have.
- How much prior experience the consultant should have in auditing the risk manager's particular industry.

Mr. Phillips warned risk managers not to base their decisions solely on costs. "A poor quality audit at a lower price may save you money initially, but it can result in significantly higher liability for the future."

Mr. Phillips also cautioned about the potential risks of auditing. "Audits are frequently focused upon when a loss injury or legal action arises," he said.

Among the possible risks are overlooking matters that should have been noted, deliberately omitting information, not acting on recommendations and wording the final report poorly, Mr. Phillips said.

But, "the benefits of audits far outweigh the risks," he said.

Robert Powell, director of risk management and loss control for Collins & Aikman Corp. in Charlotte, N.C., moderated the session.

Paul Polk, a senior casualty loss-control consultant and assistant vp with Johnson & Higgins in Hartford, Conn., coordinated the session. ■

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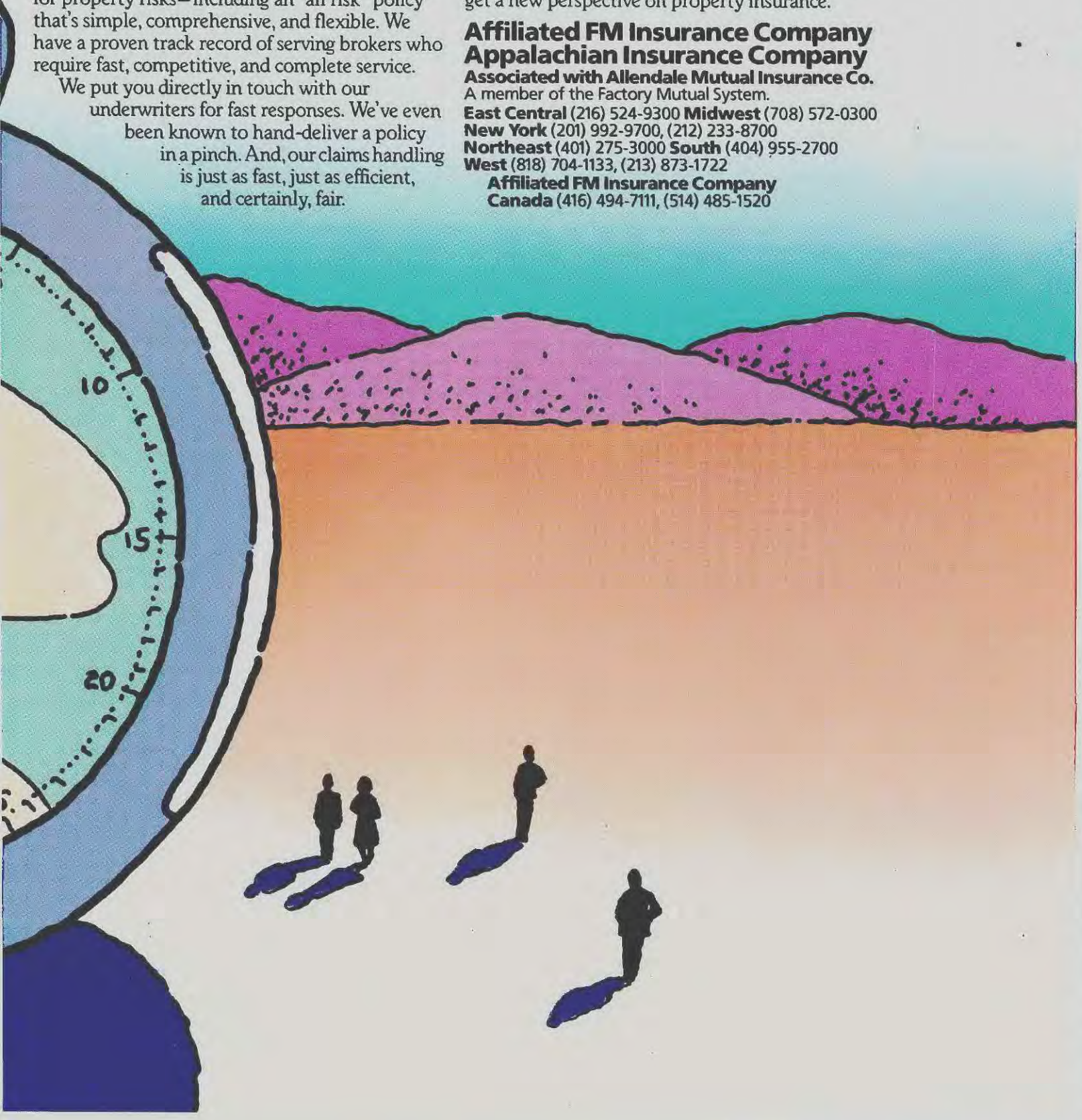
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Union input helps safety program: Labor lawyer

By MICHAEL BRADFORD

NEW ORLEANS—Employers with unionized workers should always consult labor representatives when planning a loss control program—even if it is not required under collective bargaining agreements, advises a lawyer who represents management in labor issues.

A loss control program "is going to work better, be implemented faster and be adhered to by all levels of the company if you work with the union on it," said Karen E. Ludington, a partner in the Worcester, Mass., law firm Mirick, O'Connell, DeMallie & Lougee.

"If you start with the attitude of trying to see what you can sneak by them, you're going to have problems," she warned during a session at the annual Risk & Insurance Management Society conference in New Orleans last week.

She noted that the National Labor Relations Act requires employers to involve unions in matters concerning wages, working hours and work conditions. So, "you can't just run around making unilateral changes."

Some labor contracts, though, are structured so that employers have the right to make some changes without consulting the union, she said.

Ms. Ludington made her remarks during a panel discussion on how management and labor can work together to implement loss control measures aimed at reducing workers compensation costs.

"It's very important to involve the union very early in the process, whether it's formal bargaining or informal discussion," she said.

"Share information about what workers compensation is doing to you and your bottom line," Ms. Ludington urged.

When employers are ready to begin developing a loss control program aimed at reducing lost-time injuries, the first step is to sit down with a loss control consultant and "figure out what you want your loss control program to look like," Ms. Ludington said.

Then union involvement can begin, she said.

"You probably want some sort of incentive programs" to encourage workers to practice safer behavior, she noted. "There are safety incentives—those are wonderful—and there are various other types of programs that provide rewards for reducing lost-time injuries."

Ms. Ludington said other elements of a loss control program employers might consider include:

- A medical provider network of physicians that understand the company's business and will provide quality health care with the aim of returning workers to the job as soon as they are able.
- A light-duty or restricted-duty program. The object of such "post-injury loss control" is to get the worker back to work as soon as the employee is physically able to perform a job, Ms. Ludington said.

"The longer they stay out, the worse your experience is and the more workers comp premiums you will pay."

These elements of a loss control program and others are negotiable items under federal law, she said. "But you look at the change you want to implement and then you decide what to do about it."

She told employers they "may have to go to the union and say, 'We want to do this. Can we?' And really start from scratch on a particular item.

"On the other hand, you may have certain rights to do things under your contract and you may need to go to the union and say, 'We are going to do this. Would you like to talk about it?' "

Ms. Ludington urged employers to check contracts, particularly the management rights clause, to help determine which items need to be negotiated.

James N. Ellenberger, assistant director of the AFL-CIO's department of occupational safety and health, said the labor group's affiliate unions are encouraged to take workers comp problems to management.

"Workers compensation is a labor-management issue," Mr. Ellenberger said. "Everyone else is a provider of a service. It is our hope to encourage labor and management at the state level to cooperate on the reform of workers compensation measures."

Mr. Ellenberger also stressed that workers comp laws have to be written to serve workers and employers, not attorneys, doctors, insurers and other service providers.

James C. Cronin, manager of employee disability programs with Raytheon Co. in Lexington, Mass., also urged employers to get involved with legislators to improve workers comp laws.

"I was very encouraged to hear (Mr. Ellenberger) say that the only people that are important in this process are the companies and the workers," Mr. Cronin said.

For too long, the workers comp systems in many states have "taken people who are impaired and made them disabled. They do that through litigation," observed Mr. Cronin.

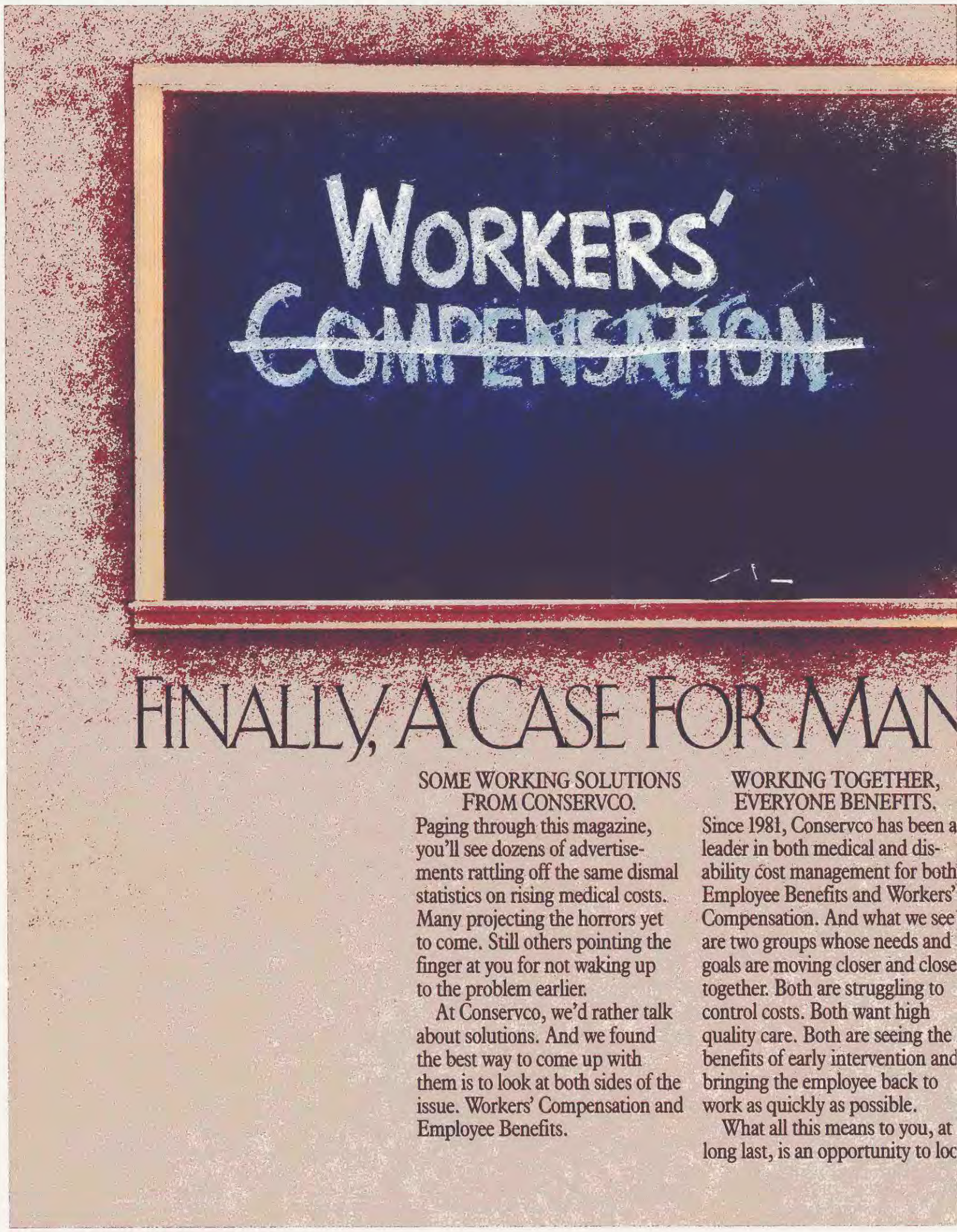
However, until workers comp laws are changed, employers will have to learn to live within the current system, he said. Loss prevention programs can help soften the blow of high workers comp costs and lost-time injuries, said Mr. Cronin.

Safety awareness programs and others like those that teach workers how to prevent back injuries require little worker resistance, Mr. Cronin noted. "You can put those in with no problem. You're not going to get any opposition from labor."

In fact, when considering a change or addition to a loss prevention program, employers should ask themselves whether it is a move that will get a worker back on the job "sooner or later," Mr. Cronin said. "Labor and business are going to be on the same side of that question."

Linda Ruthardt, director of risk management for the Girl Scouts of America in New York, moderated the session.

It was coordinated by Thomas C. Lynch, president of Lynch, Ryan & Associates Inc., a workers comp consulting firm in Westborough, Mass. ■



Controlling comp costs in midst of crisis viewed

By JUDY GREENWALD

NEW ORLEANS—Employers still can mitigate their workers compensation costs, even in the midst of the workers comp crisis, according to a risk management consultant.

But, employers will have to take several steps to curb soaring workers comp costs, said Edward A. Pouzar, a consultant with Betterley Risk Consultants Inc. in Worcester, Mass., at a session during the 29th annual Risk & Insurance Management Society conference last week in New Orleans.

Those measures include:

• Selecting an experienced insurer. "Try to hook up with a carrier who has been in the workers compensation area for some time and has solid financial backing and will not go belly up," Mr. Pouzar said.

• Selecting a third-party administrator carefully. Employers should make the TPA is capable of managing claims, Mr. Pouzar said.

He advised employers to look at the TPA candidates' case loads and avoid those who have adjusters handling more than 200 cases each. Those firms are not likely to investigate claims properly, he said.

The employer also should make sure the TPA has litigation, medical and bill review capabilities, Mr. Pouzar said. State- of-the-art computer capabilities also are important, he said.

• Increasing safety and loss prevention programs. This may be the hardest sell to management, "but there are dividends," he said.

• Conducting pre-employment testing. Employers should examine an employee applicant's medical data so that an employee is not placed in a position likely to aggravate a pre-existing injury, he said.

• Fulfilling basic claims reporting and investigative responsibilities. "It is important to get the claim reported promptly" by calling the company's TPA or adjuster immediately, Mr. Pouzar said. Delays encourage injured workers to seek legal advice, he warned.

• Increasing communication with employees. Many risk managers avoid telling employees their workers comp rights, he said.

But, "you're only hurting yourself," because if a legitimately injured employee cannot get information from his employer, he will go to an attorney, and the cost of the claim will increase, he said.

Mr. Pouzar, who formerly was risk manager for the city of Hartford, Conn., cited one case in which he avoided talking to the widow of an employee killed in a workplace accident. The city was subsequently sued.

But when another death occurred, Mr. Pouzar talked with the widow about her rights and benefits, he said. "She did not hire a lawyer on me," he said.

• Implementing light-duty programs. Employers should encourage injured employees to return to work as soon as possible, he said.

If less than 90% of an employer's injured workers are not back on the job within 10 days, "then you're not an average risk," he said.

• Managing litigation expenses. An employer should make sure its TPA is handling claims itself and not turning them over to attorneys, which many do, Mr. Pouzar said.

• Containing workers comp medical costs. If an employer can afford it, it should have a dedicated provider in the workplace to make sure the employee gets medical attention and to control who an injured employee sees immediately after an accident, he advised.

• Coordinating workers comp and group health coverages. With so-called 24-hour coverage, "you preclude any double dipping between the two systems," he said.

William D. Hager, president of the Boca Raton, Fla.-based National Council on Compensation Insurance, and a former Iowa insurance commissioner, outlined the extent of workers comp problems.

Mr. Hager noted that the average cost to provide coverage in the United States has soared to $500 per employee today from $93 per employee in 1972.

Workers comp costs equaled an estimated 2.3% of payroll in 1990, 2.1% of payroll in 1987 but only 1.1% of payroll in 1972, he said.

Lost workdays per 100 employees jumped to 79 days on average in 1989 from 59 days in 1982.

Mr. Hager also pointed out the average medical claim cost on lost-time cases soared 157% to $5,400 in 1989 from $2,100 in 1981.

Focusing on indemnity claim costs, Mr. Hager noted the average claim cost increased 114% to $10,700 in 1989 from $5,000 in 1981.

If medical claim costs and indemnity claim costs are combined, the average cost of a workers comp lost-time claim rose 127% to $16,100 in 1989 from $7,100 in 1981.

Mr. Hager also pointed out that the residual market's share of the total workers comp premiums increased to an estimated 23% in 1990 from 5.5% in 1994, (*BI*, April 15).

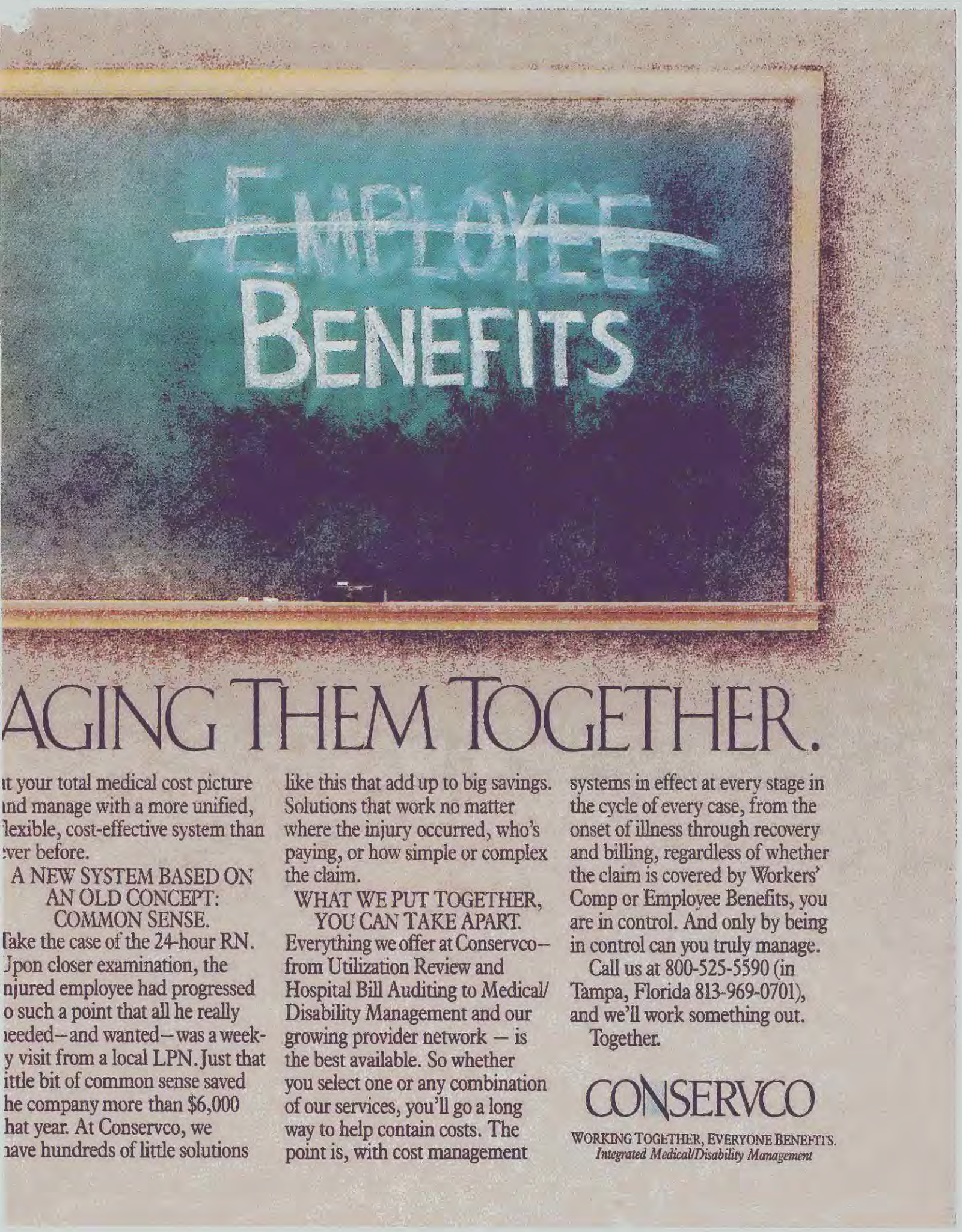
Focusing on some particular state pools, Mr. Hager noted that Louisiana—which now has a current rate inadequacy of 24%, according to the NCCI—has 57% of its market in the state pool; Rhode Island, with 86% rate inadequacy, has 67% in its pool; and Maine, with 30% rate inadequacy, has 91% in its pool.

There has been a "death spiral" in these states, he said. As pool assessments grow, insurers withdraw their capacity from the voluntary market, which causes the pools to grow. "And, ultimately we have the collapse of the market."

William H. Boornazian, senior vp-national accounts department, commercial insurance division for Aetna Life & Casualty Co. of Hartford, Conn., also spoke.

W. Michael McDonald, former group director of corporate risk management for Miami, Fla.-based Ryder System Inc., moderated the session.

Mr. Pouzar coordinated the session. ■



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Preventing cumulative trauma disorders

By MICHAEL BRADFORD

NEW ORLEANS—Carpal tunnel syndrome, a frequently occurring cumulative trauma disorder, is best handled by modifying workers' behavior rather than correcting the problem with surgery, says a physician who helps employers prevent the injuries.

Surgery for cumulative trauma disorders is simple and quick, said Dr. Scott H. Jaeger, executive director of Occupational Preventive Diagnostics Inc. in Cherry Hill, N.J.

But an operation does not always cure the problem, he stressed.

Dr. Jaeger, speaking at the 29th annual Risk & Insurance Management Society conference in New Orleans last week, also said few workers who go under the knife for carpal tunnel syndrome can return to their previous jobs.

In many cases, an operation has relieved the symptoms of the disorder "but it didn't cure it," Dr. Jaeger said. "And, in some ways it made it worse," because if after surgery workers attempt the same repetitive tasks that caused the injury, they would get a recurrence that would be more difficult to deal with, he said.

Carpal tunnel syndrome—which widely occurs among workers performing repetitive tasks—is an injury to the median nerve, which provides feeling and motor function to the thumb and a portion of the ring finger. Symptoms can include pain, numbness and tingling in the hand and wrist and may extend up to the elbow and shoulder.

When carpal tunnel syndrome is diagnosed, "the first line of treatment" should not be surgery, Dr. Jaeger emphasized. "The idea is you're trying to aid the body's repair process. Let them rest. Have them wear a splint at night."

If symptoms persist after rest and efforts to modify the worker's behavior, "then the indication is for an operation," he said.

But, there is a risk associated with any type of surgery, regardless of how insignificant it appears, Dr. Jaeger said, warning that "no surgery is minor surgery."

While most carpal tunnel surgeries go "very, very well," there still are many complications that can occur, Dr. Jaeger said. For example, if a nerve is accidentally severed, a patient could lose the function of the hand, he said.

A patient who undergoes surgery to repair carpal tunnel syndrome can expect to recover in four to six weeks, Dr. Jaeger said. "The problem is, if we operate on it, you have to put permanent restrictions on their activity. They really can't go back to repetitive activity."

Because carpal tunnel syndrome and other cumulative trauma disorders can take a worker off the job for good, preventing those disorders from occurring is essential, Dr. Jaeger said.

And, he noted that when serious symptoms of a cumulative trauma disorder appear, the time for prevention has usually passed.

Therefore, it is important to identify problems like inflammation early and to correct the workplace situations that could lead to such disorders, he said.

The first step taken by Dr. Jaeger's firm is educating employees about repetitive motion injuries, Dr. Jaeger said.

Then, workers are surveyed to determine their susceptibility to the injury, he said. For example, diabetics are more prone to suffer from cumulative trauma disorders, he said.

"Also, a physical therapist will do a physical inventory of the job" to determine the type and frequency of repetitive tasks workers perform, he said.

Dr. Jaeger's firm also uses a diagnostic machine that measures the function of the nerves in workers hands that would be affected by repetitive tasks.

The firm uses data from the exam, the therapist and the survey to evaluate each job, Dr. Jaeger explained. Jobs with the highest likelihood of causing a disorder are referred to an ergonomist, who attempts to change the work environment to prevent injuries.

Dr. Jaeger noted that "demographically, women are much more frequently affected than men." And carpal tunnel syndrome and other cumulative trauma disorders appear more frequently in the elderly, he noted.

In recent years, there has been a "huge increase" in the incidence of cumulative trauma disorders among women who have returned to the workforce after raising families, Dr. Jaeger said.

The difficulty of preventing cumulative trauma disorders begins once the factors that lead to the problems are identified, said Roger Stephens, an ergonomist with the Occupational Safety & Health Administration in Washington, D.C.

"The hard part, the real hard part, is effecting the change," Mr. Stephens said.

Some risk and benefit managers will find problems persuading "brain-dead, recalcitrant management" to change decades-old practices without guarantees that the cost of the changes will be recouped. "That's where you need to take a Dale Carnegie course to learn how to manage your managers," he said.

But one rule that Mr. Stephens said he has learned during his years as a government worker is: "If you can cost your comp dollars back into your line manager's budget, you can drive change."

B. Kevin Neal, safety director at Lee Co. in Shawnee Mission, Kan., agreed that gaining top management's support is crucial to the success of a program developed to curtail cumulative trauma disorders. "If you don't have that, you might as well forget it," he said.

When VF Corp., Lee's parent, decided to implement a program to prevent cumulative trauma disorders, "we decided to get committed," Mr. Neal said.

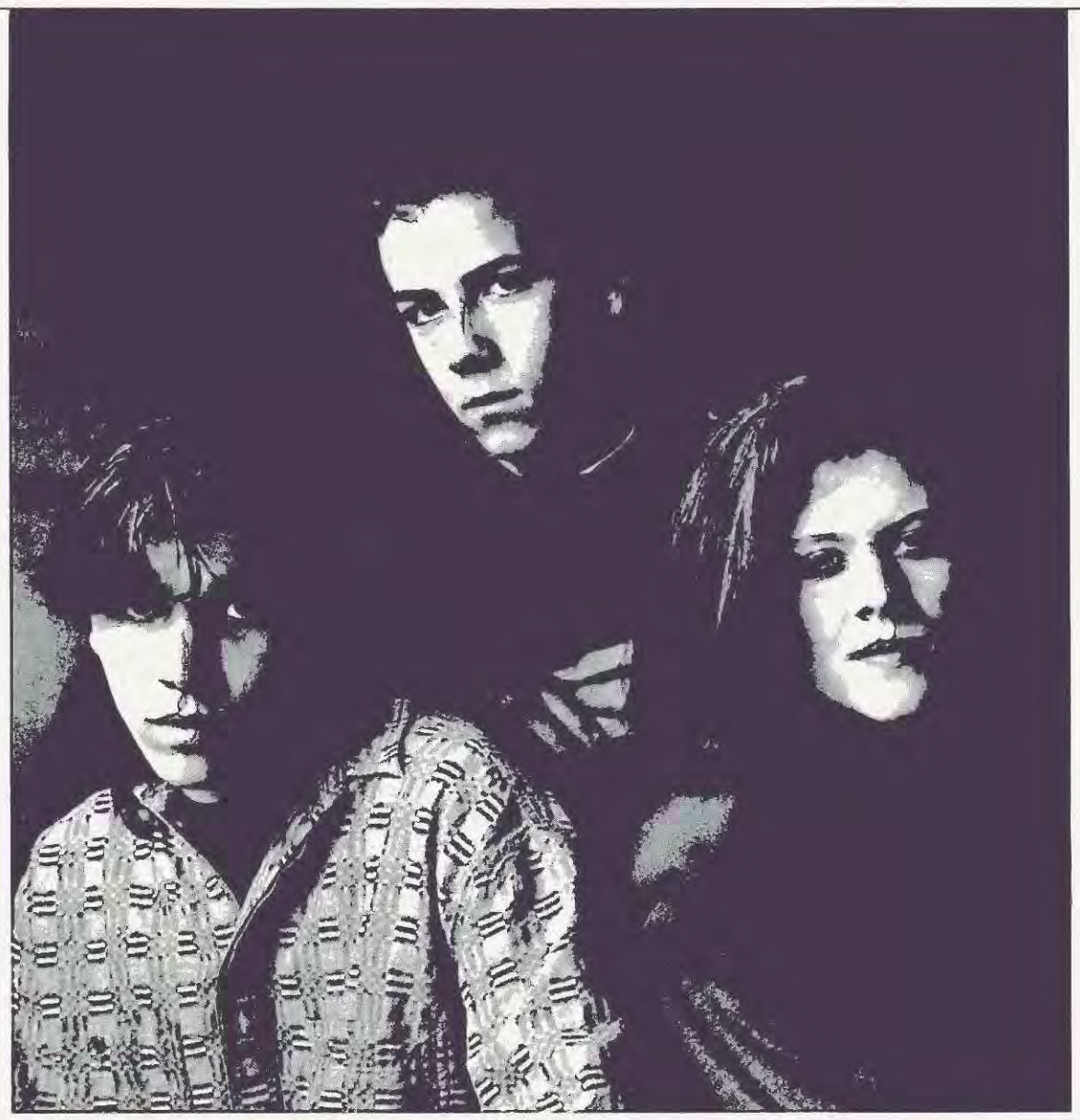
When VF Corp.'s chief executive officer realized the benefits of such a program, he endorsed the program, Mr. Neal said.

Not only job-related activities are causing problems, Dr. Jaeger pointed out. After-work hobbies that require repetitive motions are causing carpal tunnel syndrome and other disorders. "For some people who are predisposed, just the activities of daily living can lead to the disorder," he said.

And, while repetitive movements are the chief culprits in causing the problem, steady vibrations can also trigger the injury.

"If someone uses a tool that vibrates at about 60 cycles per second, this causes a lot of damage and increases the development of the disorders," Dr. Jaeger said.

Richard L. Broderick, director of risk management at VF Corp. in Wyomissing, Pa., coordinated and moderated the session. ■



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Helping hand gets injured back to work

By MICHAEL SCHACHNER

NEW ORLEANS—The most important element of an effective disability plan is a return-to-work program in which the employer maintains frequent, supportive contact with the injured worker, risk and disability managers say.

Employers must strive to keep in contact with injured workers as well as provide them an incentive to return to work as soon as they are medically able, they say.

"Employees are a company's greatest asset, and they also represent that company's greatest financial commitment," said Sharon Kaleta, life and long-term disability manager with Rohr Industries Inc. in Chula Vista, Calif.

Therefore, it is vital to get injured employees "back to work as fast as possible," she said.

"But, they won't want to come back if they feel you don't care," Ms. Kaleta said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

Employers can let their employees know they are valuable by sending personal notes or cards or by contacting them regularly by phone or in person, she said.

"Employees need to be continuously reinforced as to their value to the company," she said. "You have to gain their trust and work with them. Explain your long-term disability and return-to-work programs. Don't keep them in the dark."

"You have to get people back to work before they develop a 'beach mentality,' " explained Carol Ann Lewin, director of employee rehabilitation at the University of California at San Diego.

"People fall through the cracks. You may not know where those cracks are, but people are always falling through them," she said.

Ms. Lewin said developing a "transitional work program" is an important step in the process.

"First off, I like the term 'transitional work' better than 'light duty,' which tends to stigmatize the returning employee," she said.

"Also, we need to communicate among ourselves to ensure that the staff becomes disability aware. Everyone should know that disabled people can be at work and can be productive," she said.

To get an employee back on the job as soon as possible, employers also must communicate openly with doctors, said Maureen McNamara, San Diego branch manager for risk management consultant Applied Risk Management.

"Doctors must be provided with a detailed and accurate job description" of the job to which an injured worker would return, she said.

Open communication with an injured employee's physician also can lead to unobtrusive treatment monitoring by the employer, she noted.

"So much treatment in a workers compensation case is excessive," Ms. McNamara said. "Medical cost inflation in comp cases has been rising twice as fast in recent years as general medical costs."

Employers also should include safety programs in their overall plan, like holding line managers and department heads accountable for safety, said Deborah M. Luthi, benefits and risk manager for the University of California at Davis.

Supervisors must be made aware of safety, how the workers compensation system works and what it costs, Ms. Luthi said.

"I strongly recommend implementing health and safety training courses and information sessions for all management. This helps define their responsibility. It's also a good idea to require managers to fill out employee performance appraisals that include an employee's actions," she said.

Employee evaluations also can be a valuable tool for helping prevent an accident before it occurs, Ms. Luthi said.

UC San Diego's Ms. Lewin agreed, noting that an employee's attitude toward work or toward a supervisor is very often a major factor in a work-related accident.

"People who are unhappy with their jobs get injured more often. It's a statistical fact. When people aren't in control, they get physically hurt. While you might think that job dissatisfaction would lead to psychiatric disability, that's not normally the case," she said.

Therefore, a disability coordinator must be "empathetic with a reality base. You have to understand the whole system and realize that not getting along with one's manager is not a reason to go on disability," Ms. Lewin said.

Another important aspect of a successful disability program is getting upper and line management to "buy in" to the program, said Marcia Rubish, assistant risk manager with UC San Diego.

"If you can show upper management that your disability program is going to save the company money in the long run, it gets their attention right away," she said.

Ms. Rubish said upper management also generally appreciates new programs that are on the cutting edge.

"Management likes to be trendy. They like the publicity that a new program can draw. You may also have success in implementing a disability plan if you present it as management's commitment to its employees. This tends to eliminate any 'we vs. them' scenario," according to Ms. Rubish.

Risk and disability managers also can get line managers to grasp a new program by giving them a feeling of ownership. "Let them call it their own," she said. "And, you may want to tie the program directly to line management by offering financial incentives for safety and high rates of return-to-work."

When a disability claim is filed, the risk and disability management team must maintain control of the claim, stressed Ms. McNamara of Applied Risk Management.

"Set up medical appointments, write letters to the attending doctor and take employer and witness statements yourself. This is all the job of your program administrator. At $100 per hour, it's a lot cheaper to have the administrator or program coordinator do this than a lawyer," she said.

To reduce the chances of expensive workers comp claims litigation, employers should keep in contact with the injured employee, make timely benefits payments and ensure that appropriate medical referrals are made, she said.

"This will allow you to get a claim off the books faster. And, the only good claim is a closed one," Ms. McNamara said.

Ms. Rubish and Ms. Luthi were co-coordinators of the session. Ms. Rubish moderated the session. ■



In future, benefits will draw workers: Expert

By MICHAEL BRADFORD

NEW ORLEANS—Employers will have to be creative to lure qualified employees in a future labor market expected to be older, smaller and populated with more women, a consultant advises.

Benefit plans will be among the carrots employers can dangle in front of prospective workers, said Dale B. Grant, an executive vp at Martin E. Segal Co. of New York.

Ms. Grant noted that "five years ago, people would say: 'Benefits don't do anything to attract or retain employees.' " Today, many employees are making job choices based on the type of benefits offered, she said.

"They are very sophisticated consumers now and benefits are important," she said during a panel discussion at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

Tax laws have made benefits a cost-effective way of providing additional compensation to employees, Ms. Grant said.

But tax rates for many employers are lower than in past years, so tax advantages are less important.

Employers, though, are beginning to offer benefits regardless of whether there is a tax advantage.

In designing benefit plans, employers should take into account that "there's no question that the future labor force will be older," Ms. Grant said.

"The people who will be in the labor force for the next 70 years have already been born, and we know there has been a drop in the birth rate," she observed.

Ms. Grant said many demographics experts are predicting a smaller work force, though she questions the assumption that this will create a shortage of skilled workers. If those projections prove accurate, employers then will have to meet the challenge of offering employee benefits to a changing work force as well as attracting workers, she said.

"We have a projection now, that beginning in 1991, two-thirds of the new entrants into the labor force will be women," she said.

Because of a "movement toward traditional values" in recent years, more women are staying home to raise families and are entering the work force after the children are grown, she said. "Women are asking themselves, 'What is more fulfilling? A career or staying home to have children?' "

This trend is expected to affect the aging of the work force and the number of women that enter it, Ms. Grant said.

However, "we really don't know what's going to happen" regarding how many women will actually enter the work force and how other demographic changes will affect the work force.

Ms. Grant said other work force changes that employers must recognize include:

- Technological change.

The pace of technology will determine how fast humans are replaced by machines. The development of robotics could help blunt the impact of a worker shortage.

- More at-home workers.

Technological advances have made it easier for some workers to stay at home.

- Companies moving to cities from suburban work sites.

Some companies are finding they have fewer prospective employees to choose from in the suburbs because many people prefer the stimulation of working in large cities, Ms. Grant noted.

In addition to the makeup of the labor force, changing laws and business conditions means employers may have to restructure benefit plans to meet new demands.

Benefit plans in the future therefore should not be cast in stone, Ms. Grant said. "Benefit plans should be flexible. Nothing is forever."

Ms. Grant predicted that the focus of employer-provided benefits will change in coming years.

The "benefit goals" of businesses have always been to attract and retain employees, achieve tax advantages and improve productivity by providing employees with peace of mind about concerns like health insurance, Ms. Grant said.

While those reasons for offering benefits will remain, their order of importance has significantly changed, she said.

"Productivity is still on the list and it is still important," Ms. Grant said. However, she said no one has discovered how to measure how productivity is influenced by benefits.

Ms. Grant urged employers to find ways to distinguish themselves from other firms by offering benefits that are suited to the changing workforce.

Benefits that improve the quality of life, or "self-improvement" benefits, usually are treasured by employees, Ms. Grant said. These include wellness programs, health club memberships, travel and vacation incentives, outings, sabbaticals and educational benefits.

She advised employers to look at benefits "as a way to make it easier for someone to come to work."

And one way to make it easier is to provide transportation via bus, taxi or a car pool, Ms. Grant said.

Employers also can provide assistance with housing needs, like advice on how to find affordable housing and how to structure mortgages, said Ms. Grant.

But, not all benefit changes are winners, even though they appear to be good ideas, Ms. Grant pointed out.

"One of the companies that we work with decided that since they have a full-time employee cafeteria during the day, why not have that cafeteria make meals and wrap them up for people to take home instead of cooking? I thought that was a great idea," she said.

But, the cafeteria operation was forced to close after several months. "I don't know—maybe the cooking was bad."

In addition, many employers that have established on-site day care centers find the facilities do not attract many tykes, Ms. Grant said. "Most companies that have put up centers have a hard time filling up the slots."

However, employers that give out vouchers for day care at local, off-site facilities have much more success, she said.

Also on the panel was Bob Sjogren, vp of employee benefits at Equitable Life Assurance Society of the United States in New York.

The discussion was moderated by Joseph G. Charles, group director of government and industry relations at Ryder System Inc. in Miami.

Mary L. Feldman, vp-public affairs at Martin E. Segal Co. in New York coordinated the session. ■



Employers plan responses to FAS 106

Calculating liabilities is first step to managing them

By COLLEEN JOHNSON

NEW ORLEANS—Increasing cost-sharing, modifying plan design and prefunding are some of the tools employers can use to reduce future liabilities for retiree medical care under a new accounting rule, a consultant says.

Roughly 60% to 80% of major corporations and 30% to 50% of firms with about 500 to 2,000 employees provide retiree medical benefits, said Larry S. Schumer, a principal with the actuarial, benefits and compensation consulting practice of Coopers & Lybrand in Boston.

Beginning in 1993, Financial Accounting Standard 106 will require most to accrue as an expense against earnings non-pension retiree benefit liabilities from the date employees are hired until they become eligible for the benefits.

Employers now report only as an expense item their pay-as-you-go costs for retiree benefits.

The new accounting standard also will require employers to either fully recognize their accumulated retiree liabilities in the first year after the rule takes effect or amortize them over up to 20 years.

But, before employers facing hefty liabilities for retiree medical care can decide how they will manage them, they must calculate them, Mr. Schumer said at a session during the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

To calculate those liabilities, employers first should gather data on employees, retirees and their claims history, Mr. Schumer said.

Actuarial assumptions to be used in estimating the retiree medical liabilities for these employees also must be chosen, he said. These assumptions include employee turnover, retirement age, life span and a health care cost trend rate, he said.

Although the cost of amortizing accrued retiree liabilities in one year will be great, some companies may do so to avoid reducing income in future years with the past liabilities, Mr. Schumer said.

For example, International Business Machines Corp. took a one-time charge of $2.3 billion in the first quarter to recognize its accumulated retiree health care obligations (*BI*, April 1). The company "wanted to remove any cloud or drag from future earnings," a spokesman said.

Noting IBM's decision to recognize all of its past liabilities at once, Mr. Schumer said, "We expect a flurry of companies to start thinking about doing this in their 1991 financial statements."

After companies calculate their accrued and expected future liabilities, they may want to modify their retiree medical plans to cut costs, according to Mr. Schumer.

"The simplest thing to do is to ask your retirees to pick up a bigger piece of the costs than they do now," he said.

In fact, if an employer can demonstrate a history of increases in cost-shifting to employees, it can use this in calculating retiree medical liabilities, Mr. Schumer noted.

He recommends that employers tell workers only that they will pay a percentage of retiree medical costs.

Another option is linking retiree medical benefits to length of service, according to Mr. Schumer.

Prefunding retiree medical plans is another option, he said.

A medical account can be created within the 401(h) portion of a pension plan, he said, but contributions generally cannot exceed 25% of the total amount contributed to a defined benefit plan and the 401(h) account.

A Voluntary Employee Beneficiary Assn., or a 501(c)(9) trust, also can be used to fund retiree health care costs, but there are restrictions on the amount of money that employers can put in the funds, he said.

In addition, investment income earned by the funds generally is taxable unless the funds are set up for a union group, he said.

Employers also should look at how Medicare payments are integrated with a retiree medical plan and whether a retiree is paying all or part of his or her deductible before the firm pays medical costs not covered by Medicare, he said.

Managed care is another possibility, although it may not be as effective for retirees as it can be for active employees, he said.

Health maintenance organizations may not be practical because retirees tend to be spread over a wider area than active employees, he explained.

And utilization review may not be very valuable, because it generally monitors the length of hospital stays, while the largest components of retiree health care spending are prescription drugs, followed closely by physician visits, explained Mr. Schumer.

Giving employees stock from an employee stock ownership plan to be used to pay retiree medical costs is an idea that "gets a great deal of press" but may not be feasible for retirees who were not with the company long enough before the ESOP was formed to accumulate enough stock to cover their medical costs, said Mr. Schumer, who coordinated the session.

Richard T. Eddy, insurance manager at The World Bank in Washington, D.C., moderated and spoke during the session. ■



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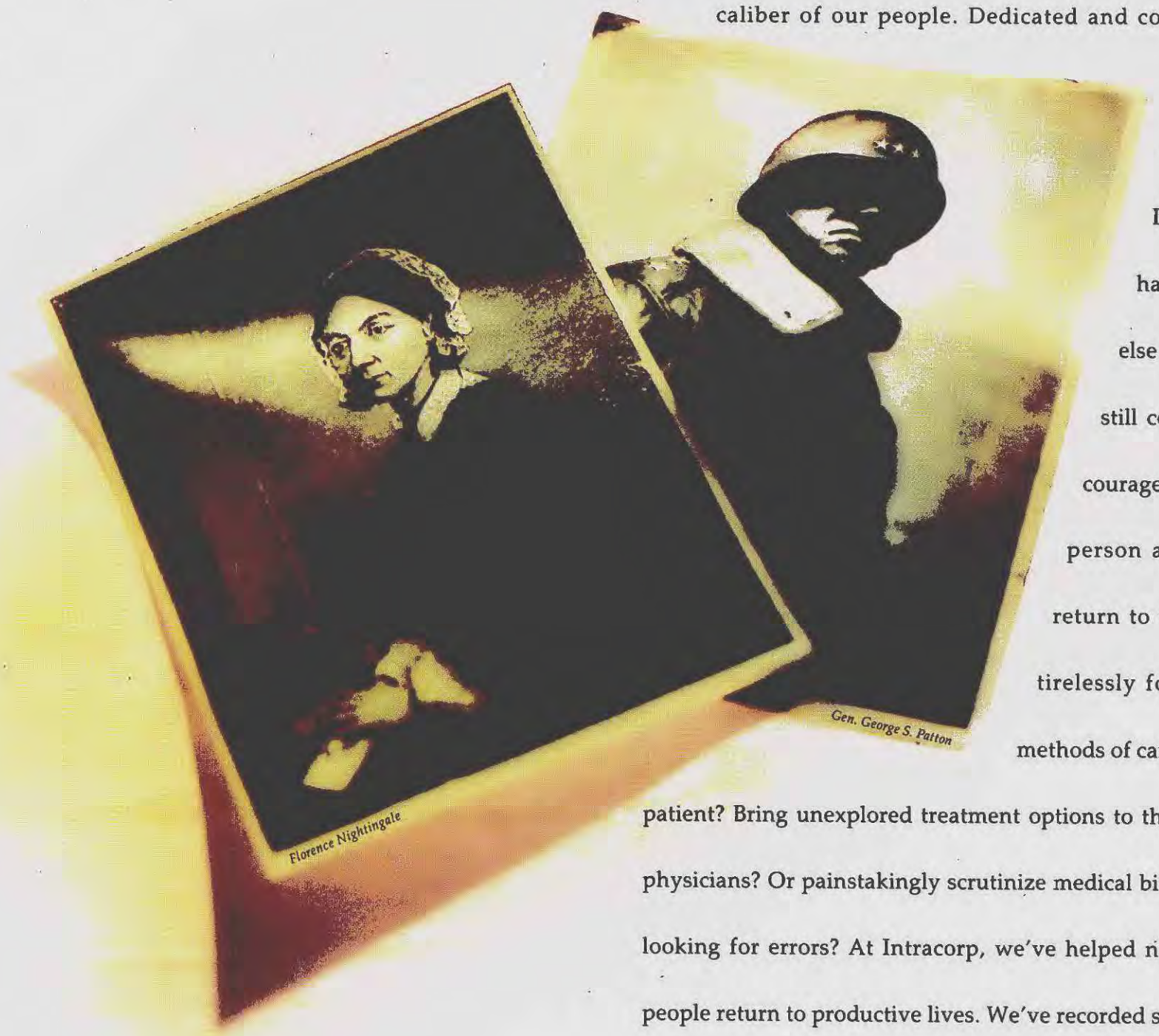
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INTRACORP

Spotlight report

No common ground on child care

Employee needs not met: Poll

By JOANNE WOJCIK

NEW ORLEANS—The attitudes of employers, employees and government planners toward employer-sponsored child care benefits are light years apart, a benefits lobbying organization poll shows.

Many employees want employer-sponsored child care programs that allow parents flexibility in selecting the child care provider, the location of the facility and the value of employee benefits devoted to child care, but few employers plan to offer the benefit, according to the poll.

Meanwhile, government planners favor child care at the workplace—an idea that most employers reject because of cost and liability concerns.

"We all seem to be pulling in different directions," observed Kenneth E. Feltman, executive director of the Washington, D.C.-based Employers Council on Flexible Compensation, which sponsored the survey.

The child care benefits survey, the first of three "Workplace Pulse" surveys the ECFC will sponsor this year, was released during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

The survey, which solicited responses from 1,204 parents of school-age and preschool children, 324 large employers and 83 key congressional staff members, was conducted by Swinehart Consulting Inc. of Atlanta.

The survey also includes information from focus groups of 11 employers that participated in the poll.

Workplace pulse surveys allow individual employers the opportunity to compare their own employees' attitudes on workplace issues with a broad cross-section of the population.

"Frankly, we don't know where we're going, the government doesn't know where it wants to take us for sure, employees have a pretty good idea, but employers aren't getting the message," said Mr. Feltman in assessing the divergent attitudes expressed by the three groups most likely to influence benefits legislation.

The survey also found disparity between the number of employees who use child care benefits and employers' perceptions of how often the benefit is used.

For example, while most employers believe only 5% or 7% of their employees use child care services at any given time, the poll found that 23% of parents with children under age 18 currently use some form of child care.

The varying views by the survey respondents show that they are on a "collision course and the employee is caught in the middle," he said.

And, because of the lack of consensus, "nothing is moving" in the area of benefits legislation in Washington, he said. "You are not likely to see child care, dependent care or elder care move again until we have a larger tax package," Mr. Feltman added.

The survey found that:

- Thirty-eight percent of employees would like their employers to subsidize the cost of child care services.

Under current tax law, employers can contribute up to $5,000 toward child care services before the benefit is taxed as income to the employee.

Employees can contribute up to $5,000 in pretax income to a flexible spending account set up by employers to pay for child care services, according to Robin J. Dusang, a vp in the Metairie, La., office of benefit consultant Martin E. Segal Co., who also spoke during the session.

- Seventy-seven percent of employers currently offer or plan to offer dependent care assistance programs, like child and elder care referral programs and flexible spending accounts.

Eleven percent said they had no such plans because not enough workers would use the benefit, and 12% said they wanted to wait for the legislative picture to settle before deciding.

But, "if you wait for that, you wait forever, because continued tinkering is what Washington is all about," Mr. Feltman said.

- Twenty-eight percent of employers plan to spend more on child care benefits, 40% said they would not and 32% were unsure.

The primary reasons employers gave for not spending more on child care were the high cost of the benefit, a belief that only a small percentage of their workforce would use it and the increased legal liability associated with it.

- Forty-one percent of employees would like to reduce all employees' benefits so employers can afford to offer child care assistance to those who need it.

This response is driven more by frustration than by selfishness, according to Mr. Feltman. "They just can't find good, affordable child care," he said.

But, among employees whose companies offer them a vehicle for funding child care, 70% said they would favor realigning or reducing their own employee benefits through a flexible benefits plan to pay for child care.

- Only 18% of surveyed congressional staff members support dependent care assistance plans, while 74% oppose such programs because of their "potential for abuse." It is perceived that mostly high wage-earners would use the benefit, Mr. Feltman explained.

- Seventy-one percent of congressional staff members polled favor on-site child care, but only 34% of employees and 16% of employers want such a benefit.

The primary reasons employers cited for not opening an on-site daycare center were cost and legal liability, while some said they did not have enough space.

Most of the employees who prefer on-site care were mothers of preschool children, Mr. Feltman said.

- Fifty-eight percent of employees prefer child care services near their homes or their children's schools.

Also speaking during the session was Sherry Herchenroether, senior administrator in charge of family services at Aetna Life & Casualty Co. in Hartford, Conn., who described the insurer's dependent care program, which was launched in 1988.

The session was moderated by Joe C. McClammy, corporate secretary at Mississippi Power Co. in Gulfport.

Mary L. Feldman, vp-marketing and public affairs at Martin E. Segal in New York, coordinated the session. ■

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Health care reform legislation detailed

By JERRY GEISEL

NEW ORLEANS—Sweeping legislation that Senate Democratic leaders are hammering out would require employers to offer health care plans that meet specified federal standards or pay hefty taxes to fund public coverage for those employees, a congressional aide says.

"The key is 100% access. Every American will have access either through private or public coverage," said Michele Varnhagen, counsel to the Senate Labor and Human Resources Committee.

The centerpiece of the proposal, scheduled to be introduced later this month by Senate Majority Leader George Mitchell, D-Maine, is that employers will have a choice: offer a health care plan or pay a tax, Ms. Varnhagen said at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

Like a proposal introduced during the last two congressional sessions by Sen. Edward Kennedy, D-Mass., the new Democratic proposal will dictate the design of employer-provided health plans, Ms. Varnhagen said.

This so-called minimum plan also would limit employee deductibles and coinsurance.

Ms. Varnhagen acknowledges that the Democratic proposal will face stiff political opposition.

But, she said Sen. Mitchell is prepared to wage a long battle to get the bill enacted. "Sen. Mitchell will fight for as long as necessary for health care reform," she said, noting he fought for nearly a decade to win congressional approval last year of a new Clear Air law.

Ms. Varnhagen warned that failing to reform the health care system could result in the government taking over the system. "If we can't make a private system work, waiting in the wings are proposals to nationalize the system," she said.

Indeed, Ms. Varnhagen said some Democratic members of the House of Representatives already believe there is no future for employer-provided coverage and that a national system is needed.

Like the Democrats, many Republicans also believe that Americans have a basic right to health care coverage, said Alexander Polinsky, legislative director for Sen. David Durenberger, R-Minn.

But the Republicans are more realistic than Democrats about the financial difficulties of improving access to health care for the uninsured, he said.

He noted, for example, the dilemma policymakers face if they try to impose taxes to fund coverage for the uninsured on employers that fail to offer health care plans.

If the tax is too low, states, which already are financially burdened, will have to subsidize coverage.

And, if the tax is set to reflect the current cost of health care, the cost would be prohibitive for small employers, he said.

Mr. Polinsky, though, did say it is time that the federal government cut back its tax subsidies of employer-provided health care plans.

This subsidy—which allows employers to take tax deductions for their health care plan costs and allows employees to exclude employer-provided benefits from their taxable income—now costs the federal government between $38 billion and $39 billion in lost tax revenue.

"The more expensive the plan is, the greater the federal tax subsidy is. Does that make sense?" he asked.

A better approach, which the Bush administration now is considering, is to place a cap on the amount of tax-free health care employers could provide to their employees, he said. Such a system would make employees more careful consumers of health care services, he contended.

With third parties, like employers and government, paying nearly 80% of health care costs, employees do not have a sufficient economic incentive to use health care wisely, Mr. Polinsky said.

Mr. Polinsky acknowledged there could be inequities with a health care tax cap. For example, employers with many older workers would likely have much higher health care costs than employers with a young workforce.

As a result, the demographics of a workforce, rather than plan design, could determine whether the cost of health care benefits exceeded a certain level and became taxable to employees.

To deal with such an inequity, Mr. Polinsky suggested a new health care tax cap approach.

First, a limit would be set on how much tax-free health coverage an employer could provide.

However, an employer could exceed this cap if it imposed certain cost-sharing features, like 20% coinsurance, in its health care plans, Mr. Polinsky said.

The idea of a tax cap on health care is not new, Mr. Polinsky pointed out. Indeed, as part of a tax reform package in 1985, the Reagan administration endorsed limiting the amount of tax-free health care coverage employers could provide to employees to $70 a month for individual coverage and $175 a month for family coverage.

But, the administration withdrew that proposal in the face of stiff opposition from unions and insurers.

Employers, though, will eventually favor a limit on tax-free health care coverage, Mr. Polinsky predicted.

In the pension arena, Congress might act to assure that employees and retirees do not lose annuity benefits their companies purchased from the insurance units of First Executive Corp., Ms. Varnhagen said.

California regulators, who last month seized Executive Life Insurance Co., are limiting retirement payments to annuity holders to 70% of promised benefits.

"If participants are not made whole, legislators will intervene," Ms. Varnhagen said.

And, in the wake of Executive Life's problems, legislators in the future may set new standards on annuity insurers, she said.

Currently, an employer terminating a pension plan can select any insurer licensed in at least one state to provide annuities to replace benefits that participants previously were promised by the plan.

Marjorie Kulash, a consultant in The Wyatt Co.'s Research and Information Center in Washington, D.C., also spoke at the session.

Willy Bach, assistant vp of risk management insurance and benefits funding at Equifax Inc. in Atlanta, moderated the session.

Frank Farago, a research consultant with The Wyatt Co. in Washington, D.C., coordinated the session. ■

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ACCOUNT NO.	POLICY NO.	ACCOUNT NAME	POLICY NAME	POLICY PERIOD	PAYMENT PERIOD	REPORT DATE	PAGE
9999999	999999999	ABC CORPORATION	XYZ CORPORATION	1/1/90-1/1/91	8/1/90-8/31/90	9/5/90	1

REPORTING DIVISION 100 ALL DIVISIONS
REPORTING LOCATION 011 ALL LOCATIONS

OFF	CASE	CLAIMANT NAME	STATE	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	S PBA	E	R HBR	V	I PPO	C	E OTHERS	S	GROSS SAVINGS
001	123451	S. HURCHALLA	PA	2	1,230.00	984.93	0.00		245.07		0.00		0.00		245.07
001	123452	G. KOSTURA	OH	1	225.00	183.49	0.00		0.00		31.01		10.50		41.51
001	123453	M DOWN	FL	6	2,231.58	1,751.74	258.59		0.00		221.25		0.00		479.84
001	123454	J. GREENE	TX	1	190.00	152.19	26.04		0.00		11.77		0.20		37.81
001	123455	K. MURRAY	CA	5	15,203.48	11,719.38	369.63		0.00		3,114.47		0.00		3,484.10
001	123456	J. HARRINGTON	MI	2	6,081.38	4,687.74	0.00		0.00		1,245.78		147.86		1,393.64
001	123457	A. HAYES	PA	1	3,040.69	2,343.87	0.00		73.93		624.89		0.00		698.82
001	123458	D. PSZONEK	FL	3	9,122.07	7,031.61	221.79		0.00		1,868.60		61.07		2,151.46
001	123459	E. FINN	PA	1	1,200.00	1,177.93	0.00		66.96		311.46		0.00		348.50
TOTALS FOR LOCATION 011 ALL LOCATIONS				22	38,844.53	30,026.88	876.05		355.96		7,367.21		218.43		8,817.65
TOTALS FOR DIVISION 100 ALL DIVISIONS				22	38,844.53	30,026.88	876.05		355.96		7,367.21		218.43		8,817.65

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Employers use claims data to lower health care costs

By MICHAEL SCHACHNER

NEW ORLEANS—Employers can best control rising health care costs by making relatively small plan design changes based on claims data analysis, a claims expert contends.

Contrary to popular belief, overhauling an employee benefit plan does not produce savings unless those changes are based on a thorough analysis of claims data, said Stephen F. Coady, president and chief executive officer of Health Economics Corp., a claims processing and utilization management firm in Dallas.

Mr. Coady said careful claims data analysis allows employers to target overutilization and identify providers who continually charge more than others in the area.

"When you see that 5% to 10% of your employees account for as much as 80% of total health care costs, it becomes easier to see why major plan design changes aren't so important," Mr. Coady said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans last week.

Employers that instead focus on where the bulk of their health care dollars are spent are better equipped to make productive changes in their health care plans, he said.

For example, the results of data analysis will help employers negotiate plan changes with unions that employees will not view as large-scale takeaways, Mr. Coady said.

Employers traditionally explore cost-saving options like increasing deductibles and copayments or reducing benefits.

Such measures are almost always fought by employees.

But claims data probably would indicate that a majority of health care costs are generated by very few employees, Mr. Coady said.

Thus, increasing copayments may help the employer trim cost increases somewhat, but the 10% of the company's workers responsible for 80% of costs will still run up health care bills far exceeding their out-of-pocket limits, he said.

"Don't fix what's not broke," Mr. Coady urged. "Worry about the 10%."

Employers instead must focus their analysis on the correlation between benefit utilization and the age of workers, he said.

By pinpointing which group of employees generates the greatest expenses, employers can modify their health plans and enter into case management arrangements to cut costs, Mr. Coady said.

For example, he provided data from a sample company whose cardiology test expenses for men between the ages of 45 and 54 are nearly six times greater than for men aged 35 to 44.

As a result of this data analysis, the company likely could cut expenses significantly if it created a program that encouraged heart and blood pressure screening for its male employees when they hit age 35, Mr. Coady said.

Employers also should use utilization data to develop performance standards with various vendors.

"When you know how many outliers you have and what your number of hospital admissions per 1,000 workers is, you can push your utilization review and case management vendors for serious performance standards. But to do this you have to know the figures," Mr. Coady said.

"Vendors do better when they're being watched. There's no doubt that knowing your data allows you to manage benefit plans more effectively," he said.

Employers with complete data also can show physicians and hospitals what the providers have been charging their workers compared with what other providers charge, he said.

"If you give a doctor who has been charging high fees the information, then you can negotiate a better deal," Mr. Coady said. Or, "if you're not satisfied, you can save a lot of money by chaneling your employees to other doctors."

The Cedar Rapids, Iowa-based Avionics division of Rockwell International Corp. has used data to greatly reduce the rate of health care inflation, according to Larry F. Milroy, director of benefits management and health services for Rockwell in Cedar Rapids.

Mr. Milroy said a careful analysis of the company's claims data allowed it to make several slight plan design changes that have led to a significant reduction in annual health care inflation.

Today, Rockwell, which self-funds its health plan, has an annual health care cost inflation rate of about 7%, compared with about 20% previously, Mr. Milroy said.

"You just need to know how to look," he said. "You don't have to be ultra-sophisticated; you just have to apply simple logic."

For example, Rockwell's premature birth rate of about 4%, which is in line with the national average, accounted for 40% of its child birth costs, Mr. Milroy said.

So, the company implemented a prenatal education program, which has led to fewer preterm births and reduced costs as a result, he said.

"Case management, prenatal monitoring and performance standards do not require anyone's special permission, and they're all win/win situations. And the only way to get to establishing them is through data review," Mr. Coady said.

Data analysis also is helping Harris Corp. of Melbourne, Fla., create its own network of providers for its 11,000 Florida employees, said Ronald A. Wyse, director of compensation and benefits.

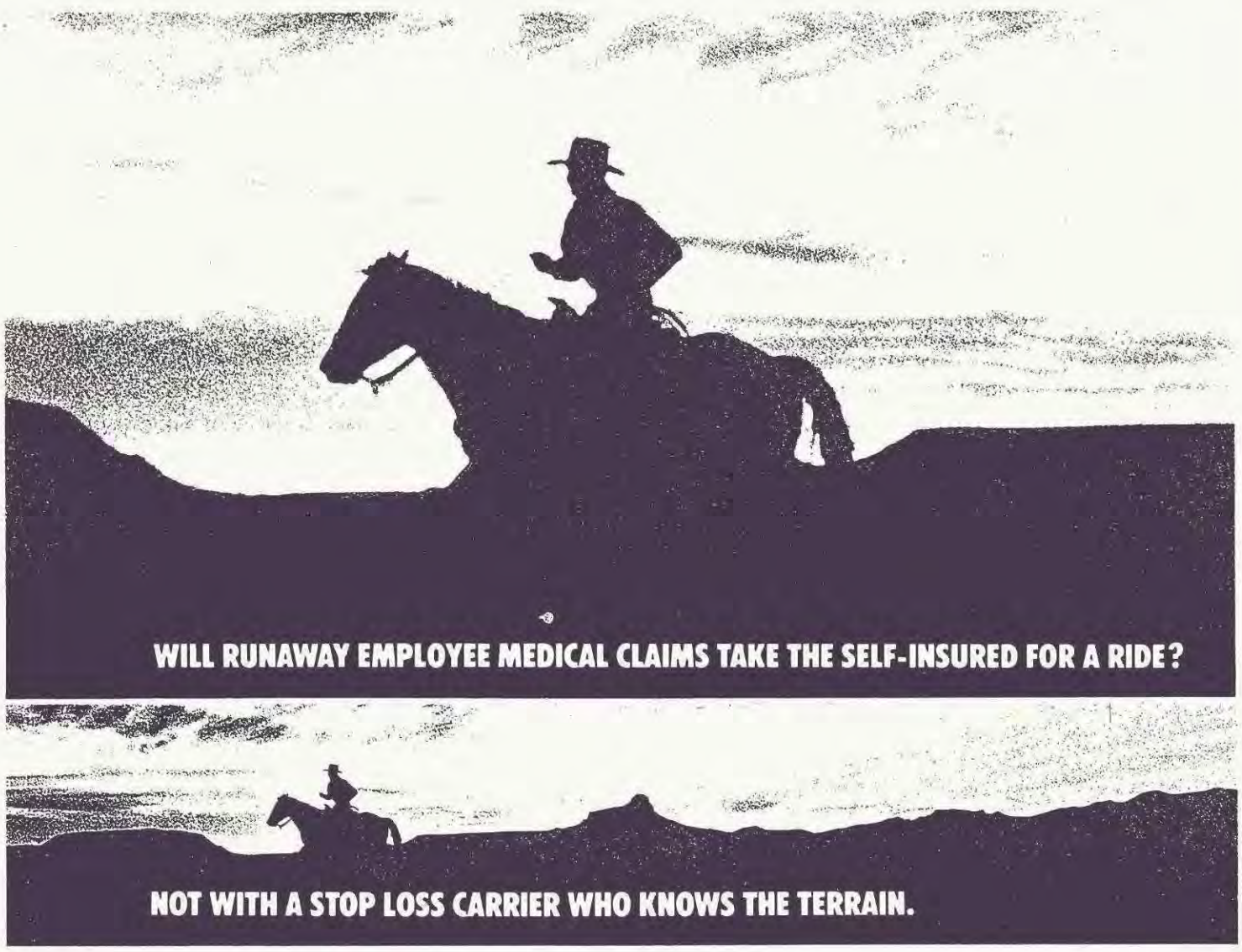
Mr. Wyse said an analysis of physician charges, the procedures they perform and total visits allows Harris to negotiate to its advantage. "We have the data on what they're doing, and we have hired a staff nurse and consulting physician to do the negotiating," he explained.

Despite the success that data analysis can lead to, collecting the right data is not always easy, Mr. Coady warned.

"Only 5% of your total claims fees goes to processing, while the rest goes to the actual claim. So, there's sometimes difficulty in getting the data. Make sure that when you enter into a contract with a claims administrator, you own the data," he said, noting that many vendors have sole rights to the data they collect for clients.

Martin Brown, corporate employee benefits manager with the Clorox Co. in Oakland, Calif., moderated the session.

Mr. Coady coordinated the session. ■



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STRAIGHT TALK

We asked Jack Williams, the new CEO of Avesis—an ancillary managed-care benefits company formerly known as National Benefit Services—to comment on issues affecting the health care industry.

Q: Health benefit costs are going through the roof! What can be done?

A: A lot of companies will tell you, "Sure, we'll help you control costs." But very few of them can actually do it. We can. We do it by offering managed care in the area of ancillary benefits—vision, dental, hearing, pharmaceutical. For instance, if you're using another third-party pharmaceutical card program and you're *really* interested in managed care, Avesis will definitely save you money.

Q: Okay, but what about the end user?

A: Employees are getting frustrated at the way their benefit costs keep going up. Any company that can offer ancillary benefits at a lower price will offset some of that dissatisfaction. That's what we do. Our limited access PPOs have lower upfront administration fees, and reduced back-end claim costs. The bottom line is *decreased benefit costs*—and everyone comes out ahead!

Q: Is that a new idea?

A: No. We started it back in 1978! But a lot of things have changed in the marketplace—and so have we. Our new name, Avesis, is reflective of these changes.

Q: What can we expect from the new Avesis in this changing marketplace?

A: Our company is more market driven and customer sensitive. Our people are more accessible, more responsive to what customers want. And we've developed products and services for the changing environment...for example, the "graying of America."

Q: What does this demographic shift mean?

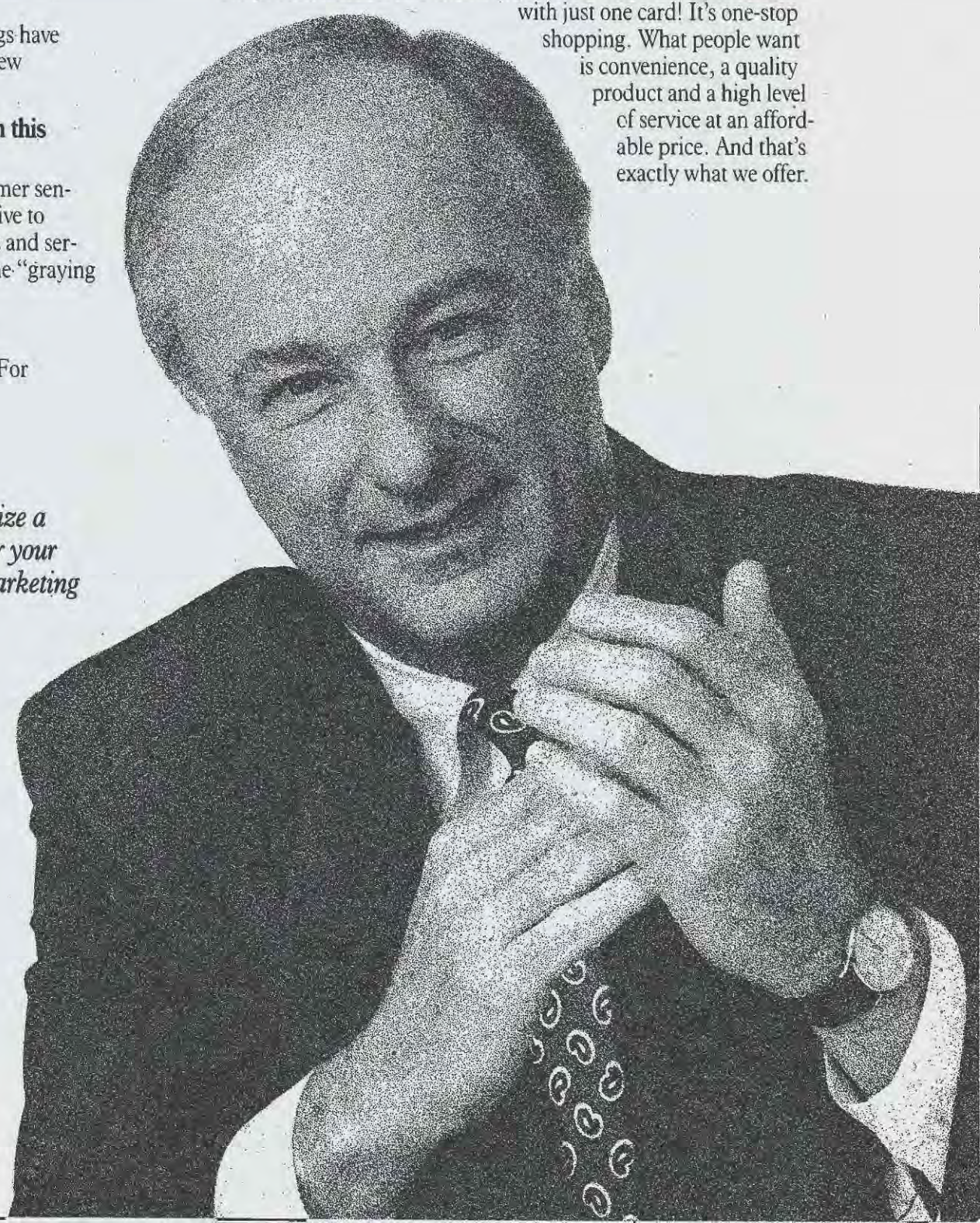
A: It means a growing need for ancillary benefits! For instance, just over 70% of the working population and 100% of persons reaching retirement age need some form of corrective vision. But fewer than 20% have vision benefits. Obviously, there's a shortfall. And if you can go to the marketplace with this benefit—at a modest cost—you've got a winner. Guaranteed!

Q: So Avesis is built around serving this need for affordable ancillary benefits?

A: Exactly. There are other companies which offer the individual components—vision, pharmacy, dental, hearing. But nobody does it all under one roof the way we do. Avesis is the only company in the U.S. that offers all these benefits on a nationwide managed care basis.

Q: And that's more convenient for your customers...

A: Precisely. You could get the individual components in different places, but Avesis offers them all...and they can be accessed with just one card! It's one-stop shopping. What people want is convenience, a quality product and a high level of service at an affordable price. And that's exactly what we offer.



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Spotlight report

Tips for minimizing employer liability

By JUDY GREENWALD

NEW ORLEANS—Employers should make sure their personnel policies do not create liability exposures in any phase of the employment process, a risk management consultant and an attorney advise.

Employers can no longer depend on the policies they have followed in the past, said Jane Y. Rastallis, a senior consultant with Betterley Risk Consultants Inc. of Worcester Mass.

At a session during the 29th annual Risk & Insurance Management Society conference in New Orleans last week, Ms. Rastallis and Eleanor D. Acheson, an attorney with Ropes & Gray in Boston, discussed several measures employers can take to avoid suits by employee applicants, current employees and former employees.

Employers face those potential exposures:

- When hiring.

"Clearly, adequate training of the people who hire" is essential to avoid suits by rejected applicants, Ms. Rastallis said.

Employers should make sure that staff with hiring privileges know what questions they can and cannot ask an prospective employee, she said.

Pointing to a hypothetical situation covered in a Ropes & Gray videotape on potentially problematical personnel policies, Ms. Acheson noted that laws in most states allow employers to ask applicants only about criminal convictions and not arrests.

But, even questions about convictions must be limited to convictions within a limited time frame, Ms. Acheson said. And employers cannot ask applicants about juvenile convictions.

She also noted that federal law prohibits most employers from subjecting applicants or current employees to polygraph tests.

An employer, though, may require a worker to submit to a lie detector test if the worker is suspected of being involved in a theft or other situation that resulted in an economic loss to the employer.

Governmental entities, companies with certain federal government contracts and security services are exempt (*BI*, July 4, 1988).

Employers also must be careful how they reject applicants, Ms. Acheson noted. For example, she pointed to a situation in which an overqualified middle-aged man with a heart condition was rejected for a management trainee job.

In this case, the applicant could be rejected legitimately on the grounds that he is overqualified and his salary expectations are too high without raising any discrimination issues, she said.

Employers also have to be careful about sexual discrimination and discriminating against the handicapped while hiring, Ms. Acheson said.

She pointed to a scene in the video in which a female applicant was closely questioned about her family and her child care arrangement, while the question never arose with a male applicant.

The Americans with Disabilities Act, which becomes effective for most employers on July 26, 1992, prohibits forcing an employee to undergo a medical examination unless an examination is required of every employee applying for that position.

Ms. Acheson also cautioned employers to be wary of representations they make verbally upon hiring, as well as statements in employee handbooks.

Statements can be construed as verbal contracts, she warned.

For example, she pointed to an incident depicted in the videotape in which an employee being hired was told he would make $75,000 the first year and $90,000 the second. That could be interpreted as a two-year contract, she said.

She also pointed to an exchange in the videotape in which the employer claimed the company was in good financial shape when he knew it was not. "That is fraud," she said, noting this charge is appearing more and more in suits.

- From their current employees.

The Ropes & Gray video raises the issue of an employee who does not want to work around smokers. If working with smokers would create a serious medical problem for the worker, he or she could be considered a handicapped person under the Americans with Disabilities Act.

A worker in that situation must be accommodated, Ms. Acheson said.

But, if the worker in this case would not be medically affected, he or she would not be considered handicapped. State law, though, might address this issue, she noted.

She also noted that if handicapped employees are performing their jobs reasonably well, they must be permitted to stay on. Otherwise, they must be allowed to "bid" for another job, not simply be assigned to one.

Ms. Acheson also warned employers that employees who become whistle blowers—that is, who report that their employers have violated a law or regulation—cannot be retaliated against.

- When terminating employees.

"You need to be very careful now as to how you deal with that issue," Ms. Rastallis warned.

Ms. Rastallis noted that most employers fail to properly document when an employee's work becomes unsatisfactory. Therefore, often when an employee is terminated, his or her file contains only good evaluations.

Ms. Acheson also cautioned employers to be careful about what they tell employees when they are terminated.

For example, she said it is inadvisable to tell the employee his job is being eliminated, then advertise for a replacement.

Clearly, the confidentiality of records is important as well, Ms. Rastallis said.

And, when approached by another company for a reference on a terminated worker, the former employer should make sure that only trained human resources personnel handle the situation, Ms. Rastallis said. A professional will know what to say, and how to say it without creating a situation that could lead to a suit, she said.

Risk managers, working closely with human resource managers, should develop a risk management plan on dealing with these employment-related issues Ms. Rastallis suggested.

Also speaking at the session was Michael A. Fitzgerald, vp with Frank B. Hall & Co. of Massachusetts in Boston.

Susan E. Brooks, manager of finance for Old Dominion Electric Cooperative of Glen Allen, Va., moderated the session.

Ms. Rastallis coordinated the session. ■



Health care alliance

Continued from page 3

the most cost-efficient physicians and hospitals after an analysis of health care claims statistics—truly leads to the most cost-efficient providers.

For example, a physician may be the most cost-efficient for a certain set of procedures, but not for all procedures, he said.

Similarly, just looking at cost and mortality statistics for hospitals will not, by itself, provide a meaningful picture of the cost and quality of care, Dr. Crandall said.

A hospital may have a high mortality rate because patients who are admitted may be sicker than those at neighboring institutions with lower rates, he said.

"We have tons of data, but not good ways to use it," Dr. Crandall concluded.

But Sue Nelson, corporate health benefits manager at Texas Instruments Inc. in Dallas, said there has to be a starting point for employers to hold down costs and assure quality of care for employees.

"We will monitor mortality and we will measure practice patterns. There must be a starting point," she said.

But, Dr. Crandall noted that the medical community has advocated other efforts that employers have rebuffed to hold down health care costs.

For example, the AMA has tried to persuade the Big 3 automakers and their unions to place more emphasis in their benefit packages on preventive care.

But, instead of more preventive benefits, "we get benefits like eyeglasses and hearing aids," he said.

"You (employers) negotiate the benefits. We provide it," Dr. Crandall said, adding that it is "baloney" to blame the medical community if employees use those benefits.

'If you (employers) think your plans are not impacted (by Medicaid cost shifting), you are mistaken,' Dr. Crandall says. Improving Medicaid and taking other steps to give the uninsured access to health care, 'ought to be our No. 1 priority.'

Dr. Crandall also argued that having an increased portion of the Gross National Product go toward health care "is not necessarily bad," noting that health care is a benefit the public wants.

But Texas Instrument's Ms. Nelson said employers cannot be competitive if they are saddled with double-digit health care cost increases.

"As a global competitor, we can't afford those kinds of increases. No business can tolerate" continued double-digit health care cost increases, she said.

In addition, Ms. Hoy of the HIAA said that as health care costs consume a bigger portion of the GNP, there will be inevitable trade-offs, including lower salaries for employees and smaller investments in defense and housing.

Dr. Crandall said there are numerous steps the federal government must take in the future to control health care costs, like overhauling the Medicaid program for the poor, mandating employer-provided health care coverage and limiting the amount of tax-free health care coverage employers can provide to their workers.

For example, because Medicaid does not cover the true cost of health care provided to those eligible for the program, providers have to make up for that shortfall by boosting charges for patients who are insured through employer-sponsored programs, Dr. Crandall said.

Illinois' Medicaid program covers only 62% of hospital costs for the indigent, said Gaylen Young, director of the Office of Health Coalitions and Private Sector Initiatives with the American Hospital Assn. in Chicago.

At the same time, because of tougher state eligibility requirements, millions of people below the federal poverty level do not even receive coverage from Medicaid. The cost of treating these individuals also is passed on to employers, Ms. Young said.

"If you (employers) think your plans are not impacted (by Medicaid cost shifting), you are mistaken," Dr. Crandall said.

Improving Medicaid coverage and taking other steps to give the uninsured access to health care coverage, "ought to be our No. 1 priority," Dr. Crandall said.

He noted that the estimated $50 billion it would take to help assure universal coverage is a fraction of what the country spends on defense.

The HIAA's Ms. Hoy said another problem with the health care system is that states have to reduce the number of benefits that they require insured plans to cover.

"That adds to the cost of care," she said.

In addition, employer plans have to be redesigned so that employees, through higher deductibles and coinsurance, are discouraged from using marginal services, Ms. Hoy said.

Mr. Riedi of Intracorp said there is plenty that employers can do to hold down health care costs, citing hospital precertification and case management of big medical claims as the most effective measures employers can take.

Ms. Nelson said Texas Instruments is trying to better manage its medical care costs by requiring employees to have certain procedures reviewed for appropriateness by a UR firm before they can receive full coverage for the procedures.

Ultimately, compromise will be necessary if the health care delivery system is to be reformed, according to Mr. Riedi.

"We need to become allies, not victims, not the vanquished," he said.

In that spirit, Dr. Crandall said: "We are on the same side of the table."

But Ms. Nelson observed that everyone involved in the health care delivery system currently is acting in their own self-interest.

"There are no incentives for the medical community to communicate price information," while the government acts in its self-interest by limiting reimbursement for Medicaid, resulting in cost shifting to employers like Texas Instruments, she said.

Journalists that participated in the panel were Terese Hudson, senior editor at Hospitals magazine in Chicago; Kathryn J. McIntyre, associate publisher and editor of *Business Insurance*; and Joan G. Savoy, executive director and newsletter editor for Business Coalition on Health, a New Orleans-based health care coalition.

Martin Brown, corporate manager of employee benefits at The Clorox Co. in Oakland, Calif., moderated the session. ■



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Spotlight report

Esenberg says RIMS will set global course

By CHRISTINE WOOLSEY

NEW ORLEANS—Risk managers must be prepared to deal effectively with the economic and social changes their businesses will face in the future, says the new Risk & Insurance Management Society president.

"Nothing ever stays the same. This is especially true in business," said Robert W. Esenberg, whose term as RIMS president began May 1.

For example, "in 1968 Forbes magazine selected the 10 then-most profitable U.S. companies in terms of equity, growth and five-year performance. Today, three of these no longer exist as independent companies, and four are in poor financial shape. That's change for you," Mr. Esenberg, risk management administrator for the city of Virginia Beach, Va., told risk managers attending the society's membership breakfast meeting last week at the 29th annual RIMS conference.

The breakfast, which kicked off the business portion of the RIMS conference, started on a high note—literally. The early morning program opened with a performance by the Storyville Stompers Brass Band, whose Dixieland jazz numbers, along with lots of coffee, helped awaken any RIMS members who were groggy after sampling the flavor of Bourbon Street the previous evening.

Members attending the breakfast also enjoyed a video describing RIMS chapter members' activities over the past year, accompanied by a "Riskbusters" soundtrack that mimicked the theme from the movie "Ghostbusters." And each member received a button that read "Who You Gonna Call? Riskbusters!"

"That's the way we should think of ourselves—as riskbusters," said Cheri Hawkins, who just ended her one-year term as RIMS' first woman president.

During her address, Ms. Hawkins —who is director of insurance for Tacoma, Wash.-based Weyerhaeuser Co.—detailed some of the society's achievements over the past year, including the addition of eight new chapters in 1990 and two so far this year (*BI*, April 29).

"Despite the downturn in the economy, corporate downsizing and a decade of mergers, RIMS isn't just growing; it's thriving," Ms. Hawkins said.

RIMS will continue to play a premier role in educating its members to effectively respond to change, said Mr. Esenberg.

Among the goals Mr. Esenberg has set for the society during the coming year is to better educate members about global risk management issues.

"As I stated earlier, the environment RIMS finds itself in today is one of rapid change," he pointed out. One change "is that business is more fiercely competitive than ever. A second is that competition is often global in nature," he said.

"To survive, let alone prosper, our member organizations must be as effective as possible in serving customers and managing costs."

While RIMS member organizations cannot necessarily direct the changes taking place in the business environment, they are in a position to respond to such changes, Mr. Esenberg said. "This is going to require us to be as informed as we can be, as skilled as we can be and as flexible as we can be."

Mr. Esenberg also said he wants to continue to encourage communication between U.S. and Canadian risk managers and colleagues in other nations.

During his term as RIMS president, Mr. Esenberg plans to expand the society's international Friendship Chapter program.

The program, initiated by Ms. Hawkins, is designed to help RIMS chapters and foreign risk management groups share their knowledge about risk management.

"Given that our world continues to become more and more interrelated, the more we can build common understanding of risk management problems and achieve common solutions worldwide, the easier our jobs will be in the future," Mr. Esenberg said.

He also noted that he supports and plans to carry forward the progress Ms. Hawkins made in introducing the concepts of "total quality management."

Ms. Hawkins defined total quality management as using reliable methods to fully satisfy customer needs and being certain that everyone involved in the risk management function is doing things right the first time.

"Quality and cost-effective risk management will be an even more critical edge for the competitiveness of our organizations," Ms. Hawkins said.

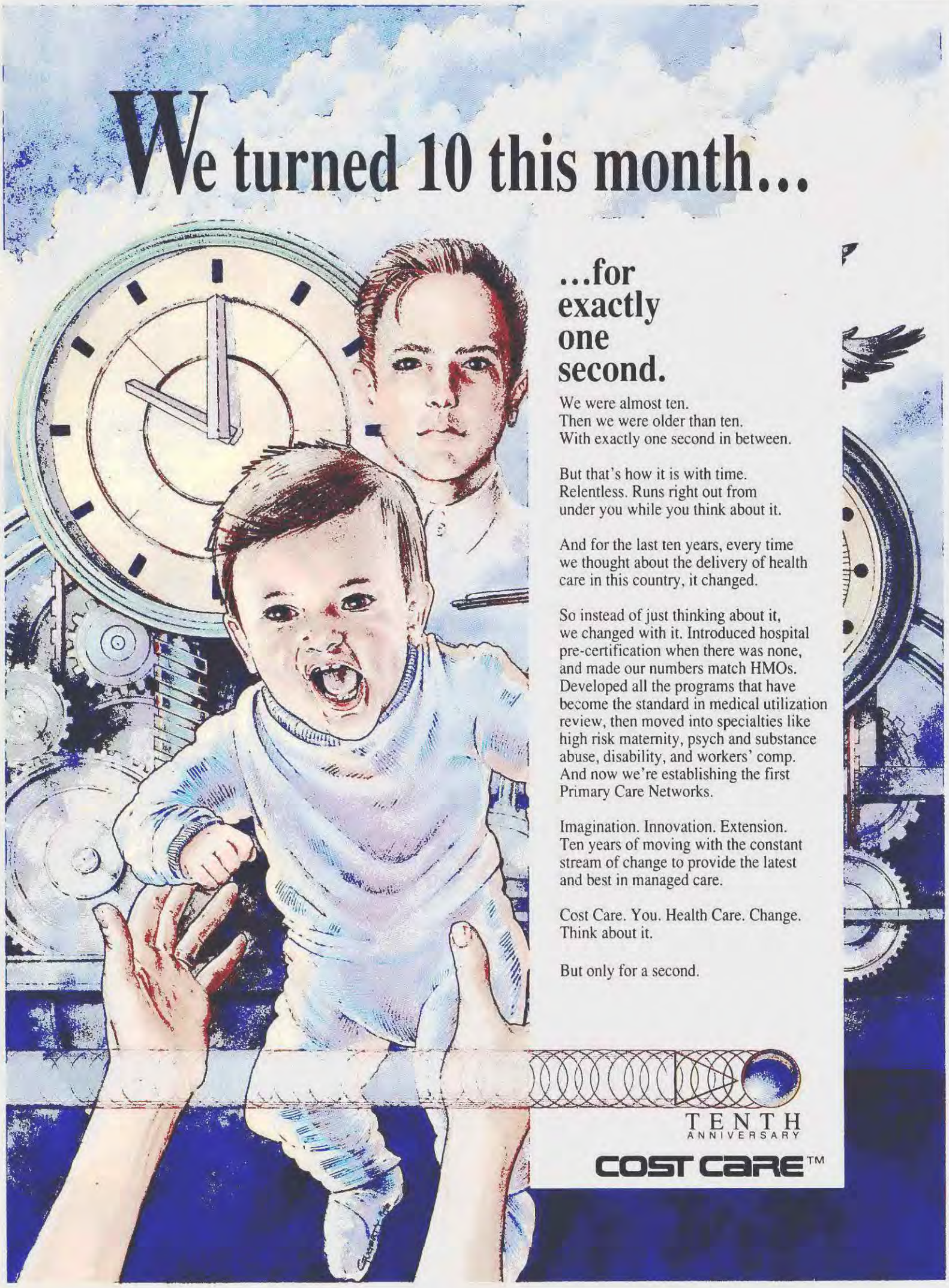
"I believe those of us who know and practice total quality management today will be viewed as ahead of the game, and therefore in great demand, as more and more companies adopt this concept as a corporate way of life," Mr. Esenberg added.

The new president also plans to continue the work of former RIMS presidents in furthering the understanding of risk management.

"I will ask the RIMS staff as well as volunteers on our communications and education committees to identify professional organizations and publications that can help spread this understanding," Mr. Esenberg explained. "We can then provide speakers or seminars to these professional organizations and articles to selected publications to educate senior corporate officers on the need for and importance of our discipline," he added.

The role of risk managers will grow in the future, because corporations and other organizations recognize that they must manage risk if they are to survive, Mr. Esenberg said. However, he noted that risk management activities "may become part of a much broader discipline. And our titles? They may change, too."

Mr. Esenberg advised RIMS members to accept their changing roles and educate themselves to enhance their risk management ability and prove risk management's worth to employers. ■



Managed care firm to buy Beech Street

The consolidation trend continues in the managed care marketplace with the planned sale of Irvine, Calif.-based Beech Street c., a preferred provider organition, to Occupational-Urgent Care Health Systems Inc.

Terms of the acquisition were not disclosed. However, in a letter of intent signed late last month, OUCH, a medical cost management rm based in Sacramento, Calif., rected Beech Street not to enter into negotiations or discussions with other companies for the next w months as the deal works its way through the due diligence process.

The purchase would fulfill Beech Street's plans to expand its re-ional operations by becoming af-iated with a larger company, explained Bradley S. Karro, chief operating officer of the PPO. "You can't be a small, regional player and survive. To be a success you have to be a larger operation, presumably with nationwide services," he said.

Beech Street has a strong regional presence in California, Texas and Florida and being acquired by OUCH should help the PPO effectively expand to other areas of the country, Mr. Karro said.

Founded in 1951, the privately-held Beech Street provides cost management services to payers struggling to control rising group health and workers compensation costs. The firm covers about 1.9 million employees and dependents in employer groups and ranks as the sixth-largest general service PPO in the country (*BI*, December 1990.) The company reported $12 million in gross revenues for 1990.

Mr. Karro said about seven companies responded when Beech Street tested the waters six months ago regarding its desire to merge or sell, including commercial health insurers, managed care companies and companies interested in breaking into the health care industry for the first time.

OUCH, which also offers a PPO and workers compensation claims administration services, provided the perfect fit, he said.

W. Robert Keen, president of OUCH, agreed: "Beech Street's strength is in cost containment programs for group health claims, with a growing business in injured workers' claims. Our strength is a mirror of that—we're strong in workers comp and growing in group health."

Both firms also currently market workers comp PPOs, which are becoming increasingly popular with employers trying to manage workers comp medical costs.

OUCH's PPO was founded in 1986, and 4.2 million employees and dependents currently have access to its network. About 90% of those users are under workers comp contracts, with the remaining 10% under group health contracts, said a spokeswoman for OUCH.

The company reported 1990 gross revenues of $21.3 million. OUCH operates primarily in California, Arizona, Florida, Michigan, New Mexico, Oregon and Texas.

The spokeswoman could not discuss whether Beech Street will continue to operate under its current name or whether it will retain all of its current offices and employees.

OUCH is not planning any further acquisitions, she said.

New CIGNA operation

CIGNA Corp. recently established a new organization, Global Risk Management, that will specialize in risk management products and services for multinational companies.

Markets

GRM, which will be one of CIGNA Worldwide Inc.'s three strategic business operations, offers multinational clients insurance products, advanced risk financing and transfer techniques and other related services. Those include claims management and administration, loss prevention and engineering consultation services, on-line claims data reporting and risk management education.

The new organization is composed of four principal components: a global network of Multinational Risk Management Units providing underwriting and support services to clients in about 70 countries; U.S. Underwriting Services, which handles the U.S. exposures of multinational companies; U.S. International, which handles the foreign exposures of U.S. clients; and ESIS International, which provides a variety of unbundled insurance services.

CIGNA Worldwide's other two strategic operations are the Special Products Division, which offers accident and health insurance and personal lines products via direct mail and other distribution channels; and the General Commercial operation, which provides a variety of property/casualty coverages to customers in selected international markets.

For more information on GRM, contact Paul Gallanda, CIGNA Corp., 215-523-3851.

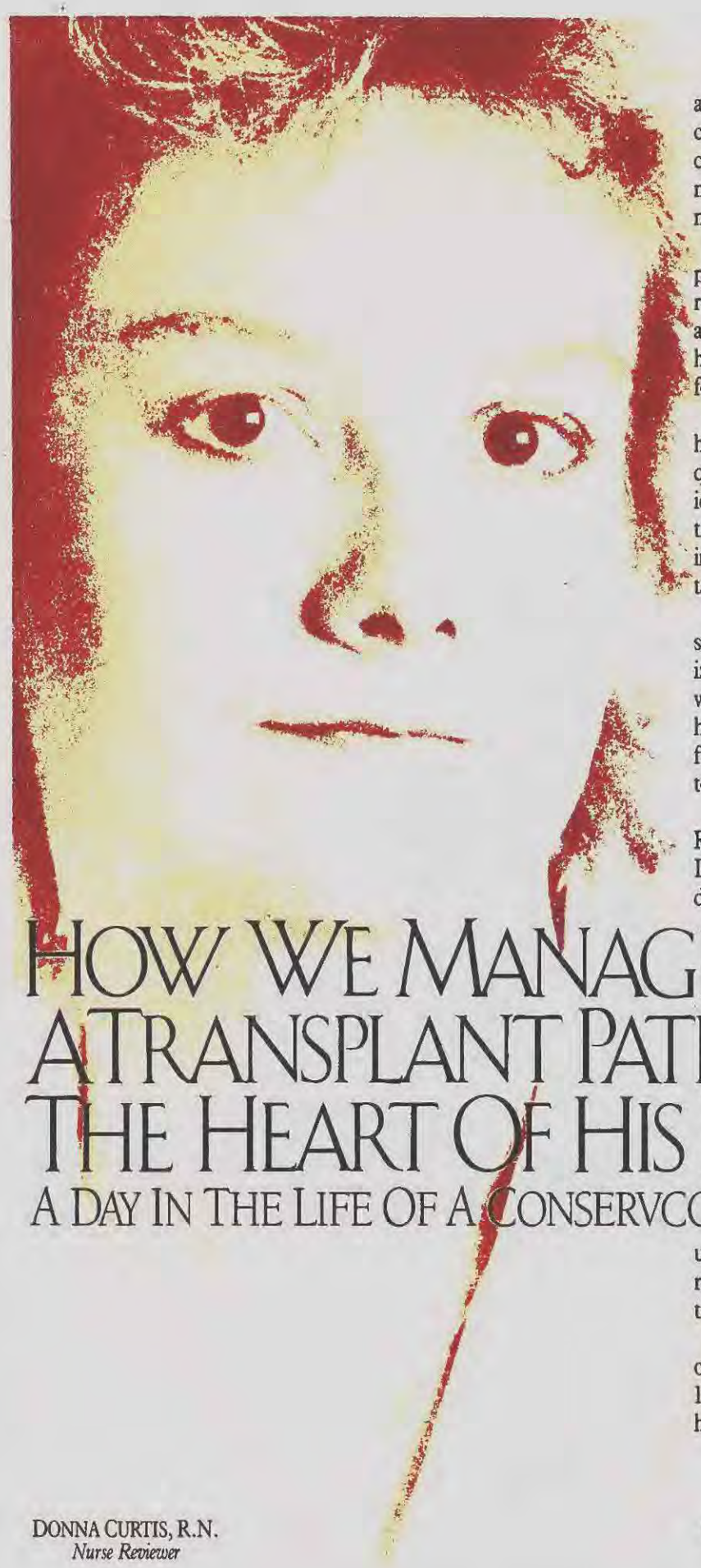
Auditing firm expands

Minneapolis-based Insurance Claims Auditing & Professional Services Inc. will now offer its health insurance and other benefits-related auditing services to employers.

The company, founded in 1988, focused primarily on auditing aggregate and specific stop-loss claims for reinsurers, noted ICAPS President Betty C. Clark. However, she said, the company recognized a growing need for independent claims auditing services and decided to expand its customer base.

ICAPS now offers health, dental

Continued on next page



MIDWEST U.S. – For a patient awaiting a heart transplant, every moment is critical. But when Conservco's Donna Curtis, R.N., called this 38-year-old patient at home early one morning, his situation had literally become a matter of life or death.

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As it turned out, the patient had suffered a severe potassium depletion, and with the proper intensive care, was stabilized and back on track with his plan of care. Although still awaiting his heart transplant, his attitude is positive and hopeful. In fact, he took the time to write Donna a touching note of thanks.

Every day, the nurses in Conservco's Utilization Review program call on hundreds of patients like Donna's. Yet there is no "formula" to what they do. Each case is different, each patient's needs unique. The idea is to be proactive rather than reactive. And in the long run, that kind of attention not only saves money, it can save lives.

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Markets

Continued from previous page

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For more information, contact Betty C. Clark, President, Insurance Claims Auditing & Professional Services Inc., 6311 Wayzata Blvd., Suite 315, Minneapolis, Minn. 55416; 612-545-5888.

Alternative risk unit

E.W. Blanch Co., the third-largest U.S. reinsurance broker, has formed a new unit to serve the alternative insurance marketplace.

The Alternative Risk Reinsurance Unit will serve alternative insurance entities like captive insurers, risk retention groups and pooling arrangements.

The decision to create a separate unit "was based primarily on the growth that Blanch has experienced in this segment of the business," said Michael W. Cashman, president and general partner.

The new unit, based, like its parent, in Minneapolis, will be managed by Duane E. Hitz, senior vp. David W. Rademaker, vp, has been reassigned from the Chicago branch to join Mr. Hitz.

E.W. Blanch is the third-largest U.S. reinsurance broker based on 1989 gross revenues of $42.7 million, according to a *Business Insurance* ranking (*BI*, Nov. 12, 1990).

Financial insurance

Aon Risk Services Inc. has formed a Financial Insurance and Reinsurance Specialty Team, known as FIRST.

Formed in January, the group has placed one retrospective financial insurance program for a firm that wanted to eliminate its self-insured workers compensation program, said Matthew M. Murphy, senior vp at Aon Risk Consultants. He said a few reinsurance programs have been placed in 1991, but that Aon placed these before the group was formed.

FIRST, a six-member group, will develop products and services through Aon Corp. subsidiaries Aon Risk Consultants and IRISC Consulting Services, which will both concentrate in the traditional insurance distribution network through retail and wholesale brokers, and Aon Reinsurance.

The program is suited for companies with a significant retention, adequate capital and cash flow, loss control and claims management capabilities, difficult exposures and financial sophistication and that see possible tax advantages in using financial insurance, Mr. Murphy said.

Among the uses Aon cites for retrospective contracts are limiting a policyholder's obligations to pay past or future claims; refinancing debt; removing liabilities from the balance sheet by insuring previously uninsured liabilities; using cash not needed for operations to increase the amount of protection; settling accounts before merger, acquisition or divestiture; and finalizing a captive runoff.

One type of program FIRST will put together is earnings per share insurance, which would protect a company's earnings by insuring its retention, Mr. Murphy said. This could cover a company that must pay out of its retention a claim that had been incurred during a prior year, he said.

Most financial insurance is geared at protecting retentions, he said. "By and large, what we're doing is a complement to the traditional insurance plan."

For more information, contact Mr. Murphy at Aon Risk Consultants; 123 N. Wacker Drive; Chicago, Ill. 60606; 312-701-3440.

New offices

Arthur J. Gallagher & Co. moved its headquarters from Rolling Meadows, Ill. to The Gallagher Centre, 2 Pierce Place, Itasca, Ill. 60143-3141; 708-773-3800.

Business Insurance Brokers/ Greenwich Agency Inc. offices are now located at 7801 E. Bush Lake Road, Suite 450, Bloomington, Minn. 55435; 612-832-9200.

Benefit Plan Systems Corp., which markets benefit administration software, moved from Tustin, Calif., to Suite 161, 16 Technology Drive, Irvine, Calif. 92718; 714-753-0180; 800-523-8047.

Two employee benefits and risk management consultants based in Connecticut have merged. Charles S. Watson Associates Inc. and Atlantic Business Consultants Inc. have formed **Watson & Burke Inc.** The address is 154 West St., Suite D, Cromwell, Conn. 06416; 203-632-5889. ■



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Around the states

Court upholds schedule of workers comp fees

BALTIMORE—Maryland's Workers' Compensation Commission has the authority to establish a uniform statewide fee schedule for medical services, the state's highest court recently ruled.

The ruling stems from a 1984 workers comp medical bill dispute.

That year, Dr. Joel L. Falik performed back surgery on an injured employee of Prince Georges County, Md. Dr. Falik billed the self-insured county $4,120 for his services, even though the state Workers' Compensation Commission's *Guide of Medical and Surgical Fees* had established a fee of $1,778 for the procedures he performed. The county paid Dr. Falik the scheduled fee.

Dr. Falik petitioned the Workers' Compensation Commission to allow him to charge a fee higher than that published in the guide, arguing that his fee was consistent with prevailing charges in his community.

However, the commission rejected his claim.

The commission's decision was upheld first by the Prince Georges County Circuit Court and then by the Maryland Court of Special Appeals.

Dr. Falik then appealed the case, *Joel L. Falik, M.D. vs. Prince Georges Hospital and Medical Center,* to the Maryland Court of Appeals, the state's highest court. He argued that the commission did not have the authority to adopt a fee schedule for the entire state and that under the state Workers' Compensation Act, medical fees could vary based on location and standard of living.

However, "the Court of Appeals' decision supports the lower court findings and upheld the state validity of the Workers' Compensation Commission's medical fee guide," said Stacy Hennessey Moot, associate counsel for the American Insurance Assn. in Washington, D.C., which filed an amicus curiae brief in the case.

The decision "reaffirms the state's authority to regulate workers compensation medical fees and underlines the importance of a statewide guide as an essential tool for providing cost-effective medical care to injured employees," she added.

—By Deborah Shalowitz

Georgia insurance reform

ATLANTA—Georgia legislators recently approved a sweeping reform measure that, among other things, will create a prior approval system, roll back auto insurance rates and abolish mandatory no-fault auto coverage.

In addition, a provision in the law regarding insurance fraud authorizes state regulators to carry weapons.

The reform legislation was signed into law April 17.

The law sets a form of prior approval for all insurance rates.

Rates for personal private passenger motor vehicle insurance must be filed with the insurance commissioner and cannot be used until approved or until 45 days have passed since the rate filing.

Rates for all other insurance must be filed at least 45 days before the effective date. If the filing would result in an overall rate increase of 10% or higher over a 12-month period, the commissioner is supposed to order an examination of the insurer, under the new law.

But, if the overall increase is less than 25% and the commissioner believes he has enough information to make an evaluation, the examination may be waived.

The rate rollback will apply to the bodily injury portion of auto liability insurance beginning with renewals on or after Oct. 1, according to a spokesman for the Georgia Insurance Department. The law also will require insurers to offer optional medical payments coverage.

Any insurer "aggrieved" by the rate rollback will be able to request a hearing, the law says.

The law also would make insurance fraud exceeding $500 a felony and authorizes Insurance Department employees to arrest persons charged with insurance fraud and "to carry firearms or other weapons in the performance of their duties."

—By Colleen Johnson

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Do good guys always finish last?

In collections they do, says one insurance agent who learned the hard way. What's a 'good guy' to do in tough economic times?

By LAURA MAZZUCA

BEING SEEN AS A "GOOD GUY" BY CLIENTS is part of what makes an agent or broker a good producer. After all, acting as a problem-solver gets and keeps clients—and clients are what keep an agency afloat.

But when it comes to collections good guys may finish last. Especially in tough economic times.

Take William Metsker. He was, says his stepson, Mike McCormick, a good guy and a fairly successful agent. But his easy-going attitude toward collections eventually caught up with his Crawford, Ind., agency.

Mr. McCormick was left with the dirty work. The former insurance company field representative took over the McCormick Metsker Agency when his stepfather was dying of cancer in 1979. And, 11 years spent tightening up on collections have taught him at least one thing: "You can't be a nice guy about this."

The lessons he learned the hard way are by no means unique to small, family-run agencies. With commissions down and commercial bankruptcies at their highest level in years, many agents—even the good guys—are clamping down on collections.

An easy touch

"Like a lot of guys from that post-World War II generation, my stepfather was an easy touch," said Mr. McCormick.

One of the first things he did as head of the agency was to plod through a stack of past due commercial accounts to see where things stood.

The news wasn't good: Some accounts were nearly two years overdue, which meant the agency couldn't collect on them because the statute of limitations had run out. Other customers had stiffed the agency for premiums totaling $15,000—nearly half that came from a single account.

The deadbeats represented a fair cross-section of the businesses in the primarily agrarian community, from farmers to small manufacturers to Main Street stores.

The agency's problem was far from unique. Mr. Metsker, trying to be a nice guy and retain clients, had trusted his clients to eventually make good on their debts.

In an attempt to collect, Mr. McCormick first called on the commercial account debtors face to face, telling them it was time to pay. While this straightforward approach worked on some, others were not as cooperative.

Eventually, he sued seven of the almost 25 original debtors in small claims court. All ultimately settled out of court, though there were some close calls.

One man who ran an auto repair shop out of his home and owed $1,000 on a commercial policy actually came into the agency office and threatened Mr. McCormick with physical mayhem before he forked over the final payment.

When the dust had settled, the agency had collected only about $5,500 of the original $15,000 in uncollected premiums.

Today, McCormick Metsker Agency has $2 million in annual premium volume and no collection problems—mainly because it no longer places business without getting some money up-front, Mr. McCormick said.

"Preferred" clients are required to remit at least 25% of the premium before the policy is written; new clients must pay in full. And customers known to be slow payers must ante up the full amount before the policy is written, said Mr. McCormick.

Direct billing also helps. Almost 60% of personal lines accounts and about 30% of commercial accounts are on direct billing systems with the insurers. But even so, customer service representatives call on clients after payment is 10 days late, averaging about 30 calls per month on personal lines alone, Mr. McCormick said.

"It's a lot easier to collect upfront than later. I don't ever want to go through that again."



Bankers they're not

Many other agents, however, will continue to encounter difficult collections.

Always important, collections can be vital in today's market, with operating costs up, commissions down and clients that could have trouble making ends meet.

Most commonly plagued by collection problems are mid-sized agencies with money in the business. "It's the ones that have the money that have the problems," said Lee Schexnayder, president of Insurance Resource Consultants in Fair Oaks, Calif.

Thinking themselves bankers, such agencies often mistakenly feel they can afford to advance premiums to problem clients.

Insurance agencies have not always been lax collectors. Only with the industry boom years in the mid-1980s did "looser" standards become endemic, said Harold Birchfield, president of Big E Insurance Service Inc. in Irvine, Ky.

That changed with the soft market, and the recession has made agents even more conscious of collections.

"Agents in general are much more concerned about accounts receivable than they were a few years ago," added Mr. Birchfield, who is also chairman of the National Assn. of Professional Insurance Agents' communications committee.

Insurers, too, have grown concerned about receivables, first in response to the soft market and then to the recession.

"Companies haven't changed their payment terms as much as they've gotten very determined to see that those terms are precisely applied," said C.J. Christie, senior vp/treasurer at Sedgwick James Inc. in New York. "They're tightening up and getting their money faster, especially over the past 90 days."

On accounts current, many insurers want payment 45 days from the end of the month in which the business was effective, said Gene McCrory, president of North American Insurance Agencies in Oklahoma City, and a member of the Independent Insurance Agents of America's national agency contracts committee.

In years past, the agency could have mailed the payment to the company on that 45th day and the check still would have been in on time.

Other insurers even want to collect before a policy is bound, especially on large accounts, for which they want the money to be submitted with the policy, Mr. McCrory said.

And some surplus lines insurers are requiring payment before the coverage becomes effective, some as soon as 15 days after invoice, he said. Thirty days used to be the norm.

Mr. McCrory and others attribute these changes to insurers' increasing reliance on investment income in a soft market. Insurers want policy payment upfront so they can immediately start to collect interest, he said.

'Between the devil and the deep blue sea'

The clampdown on collections means agencies are more responsible for problems that result in the process. Today, if payment is late, the agency gets a phone call from the insurer within two or three days—and in five days, the agency contract could be canceled, Mr. McCrory said.

Canceling the policies of late-paying customers sounds like a simple solution, but many agencies are caught between the need to collect and the need to retain clients.

Agencies and brokerages of all sizes share this problem. True, smaller agencies tend to "bend over backwards" to keep their clients—even going as far as to use premium advances, said John J. Darlington, senior vp with Marsh & McLennan Cos. Inc. in Baltimore. But even the alphabet houses worry about losing good clients, he added.

Since all M&M offices are operated as independent profit centers, it's just as important for a brokerage of this size to retain its good accounts as it is for a small regional agency, Mr. Darlington said. "We have the same problems; we're constantly between the devil and the deep blue sea."

Recession hits clients, too

The collections problem is exacerbated by the fact that an agency's clients are operating in the same poor economy as the the agency, and they face many of the same problems, such as sluggish cash flow and higher overhead.

Larger accounts generally are not a problem because these

Continued on next page

WHAT'S INSIDE

Cut back on ads?
It may seem like a smart move, but consultants warn: It will cost you later.
—page 44C

Merger movement
Local and regional chapters are urging the squabbling PIA and IIAA to resume their consolidation talks.
—page 44G

Collections

Continued from previous page

businesses tend to budget more carefully, and smaller accounts are more likely to be on a direct billing program with the insurer, said Mr. Darlington of M&M. But "we're beginning to see a marked slowdown in payments" on some mid-sized accounts, he added.

A catering firm, for example, is having problems paying its premiums because its own customers are taking their time in paying, Mr. Darlington said.

Other agents complain about slow payment from restaurant owners, truckers, land developers and contractors, especially in the current building slump.

Compounding the problem, commercial bankruptcies are at their highest levels nationwide since 1984. This poses a real problem for producers, because the insurers will hold the agent responsible for any earned premiums, said John Pottridge, director of industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

No exceptions

So how can agencies, even the "good guys," protect themselves in this environment?

Solid business planning is one key, experts say.

Successful agencies adhere "faithfully" to written procedures for receivables, said Mr. Schexnayder of Insurance Resource Consultants. No exceptions.

One of the basic rules is to require some sort of initial payment before a policy is bound.

"This is the key element in any kind of a collection problem in any economy," Mr. Darlington said. "If they know we won't pay the bill for them, this eliminates any problems in the future."

If an agency or brokerage informs the client upfront that it can't help with payments, this should never be a problem, he said. "We'll never carry a client on the cuff. It's an absolute no-no in this company," Mr. Darlington said.

Since M&M puts this in writing, if a policy must be canceled for non-payment, the brokerage is covered against any errors & omissions claims by the former client, he said.

When operating in a slack economy, principals also should speed up collections. "Good business practices should always prevail, but agents need to accelerate the collection process in bad economic times," said Mr. Pottridge of PIA.

Late billing is traditionally done after an account is more than 30 days past due, he said. In hard times Mr. Pottridge recommends cutting that in half. "Don't wait for as long as you'd normally wait, because if that client is in trouble, the last person he'll tell is his insurance agent."

The Byrd Agency, a $2 million annual premium volume agency, takes a straightforward approach: All accounts overdue by 15 days or more are simply canceled. This is mandatory with many insurers, especially regionals, which "by necessity have taken a more conservative approach" to collections, said Dick Byrd, president of the West Lafayette, Ind., agency.

Customers are warned ahead of time of that consequence, he noted. The agency sends out a notice of intent to cancel and gives the client 10 days to pay, Mr. Byrd said. If payment still is not forthcoming, the policy is canceled outright.

Large brokerages generally handle billing in-house. At Sedgwick James, for example, a standard system in all offices send out renewal notices well in advance of the due date, Mr. Christie said.

The brokerage also changed its cash-gathering system in the past year, he said. The new system is connected directly to the brokerage's bank, feeding directly from its computer to the Sedgwick computer system to help it track payments, Mr. Christie said.

Money that is deposited into the bank is posted on the day of deposit, eliminating confusion about whether or not the money was received, he added.

"It's an excellent procedure to get installed, especially in this market," Mr. Christie said.

At Marsh & McLennan, local accounting offices use a 30-, 60-, 90-day billing system and forward the results to a national unit, Mr. Darlington said. Ideally, all payments should be collected within the first 30 days of renewal.

"We try to get on the situation early before it becomes a real problem," he said.

Give up the 'float?'

As collections get dicey, direct billing becomes a more palatable option. If the client doesn't make good on the payments, the insurer handles the problem.

Direct billing, though, does have a downside.

One reason many agencies handle billing themselves is the "float"—interest accrued on premiums before they're paid to the insurer. But many others are willing to forego that 2% to 3% annually and let insurers handle the billing, said Mr. Schexnayder.

Another reason some agencies handle the billing is that commissions generally are about 5% higher for accounts that are billed in-house, said Mr. Byrd of the Byrd Agency in Indiana.

But agencies are finding that it costs too much to carry bad accounts for up to 90 days, he said. "I don't think there's any doubt that it's harder for agents today to collect."

In smaller agencies, chasing collections also takes time away from what should be the principal's primary job: selling.

Not at the Byrd Agency, which handles 86% of its business by direct billing.

"If you're not careful, you can spend more time chasing after business you've already sold rather than generating new business," warns its president.

Dirty work, done well

Some agents point to another reason to let insurers handle the dirty work: They're better at it.

"For some reason, (customers) think they can get away with more if they're not paying directly to the insurance company," said Tom Clarke, president of Clarke Insurance Services, a $1 million annual premium volume agency in Miles City, Mont.

For that reason, 97% of Clarke Insurance Services' personal lines business, and nearly half its commercial lines business, is billed direct, he said.

Premium financing is another alternative to collection woes.

This is a payment alternative offered to clients, in which they borrow money from a finance company after first putting up a 15% or 20% down payment on their premiums, said Mr. Pottridge of PIA.

The financier, in a written agreement with the insurer, then owns the collateral and can cancel the coverage for non-payment. The financing company then pays the insurer, "and the agent is out of the loop," Mr. Pottridge said.

In spite of poor economic conditions in his home state of Montana, Mr. Clarke noted that last year his agency only wrote off $188 in bad debts, in part because of its increased use of premium financing and direct billing procedures.

A primary reason Clarke Insurance Services uses these collection is because it took a $10,000 bad debt write-off in 1984, when a supper club/motel client went belly up.

Only two payments into an installment payment plan for liability coverage, the owners skipped to Texas, then Wyoming.

"By the time we got a policy cancellation, the people had literally fled the state," Mr. Clarke recalled. After tracking them for about a year, the agency gave up due to the high costs. And while a drought continues to hinder the Montana economy, Mr. Clarke's agency now has few problems collecting.

"You have to maintain a positive attitude about collections," he said. "A policy isn't sold until it's paid for—and you deserve to get paid." ■

Automating collections

With bankruptcies rising and premium payments routinely delayed, many insurance agencies are equipping themselves with an important collection tool.

Automated collection systems have made notification and late billing procedures far easier for even the smallest agencies. The systems can be programmed to automatically track receivables and print out notices.

Software collection packages that are compatible with most agency management systems can be bought directly off the shelf at most computer stores, said John Pottridge, director of industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

At North American Insurance Agencies, these systems "have drastically reduced our exposure as an agency," said Gene McCrory, president of the Oklahoma City agency.

Before acquiring its Delphi system for receivables, the agency simply sent out a statement every 30 days.

Now, if payment is not received 20 days after a policy's effective date, the system automatically generates a reminder. In another 10 days, it sends a late notice and intent to cancel and 10 days after that, the policy is automatically canceled, said Mr. McCrory.

If a customer pays up after the system is activated, agency staffers can stop the process, he said.

—By Laura Mazzuca

Collection agencies are thriving

By LAURA MAZZUCA

When all else fails, there is always the collection agency.

To agencies and brokerages with deadbeat customers, the most familiar one is IC Systems of St. Paul, Minn.

The national agency is endorsed in 42 states by the Independent Insurance Agents of America, said Pat Smith, manager of association services with IC Systems in Reno, Nev.

And business, she says, is booming.

"There's a real problem out there, not just because of the recession, but because of real credit abuse," said Ms. Smith, who coordinates the agent association collection programs. "People are frantic to get their money."

Agencies themselves decide when to turn over a bad account to a collection agency, though IC Systems recommends they do so if the account is between 90 and 120 days overdue, Ms. Smith said.

In economic hard times, she said, it's generally a good idea to "speed

Continued on next page

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Promoting the agency

Don't cut ad budget in lean times: Consultants

By LAURA MAZZUCA

During economic hard times, advertising might seem like the best place for an insurance agency to start cutting corners, but consultants warn against it.

Although advertising is an intangible that may seem like a luxury in tough times, consultants warn that by cutting back on ad budgets an agency runs the risk of losing name recognition when it is needed most.

"The survival of independent agents depends on our ability to go out there and market ourselves to both our clients and our companies," according to Lois Van Horn, president of Image Innovations, a consulting firm in Athens, Ga.

Cutting back on advertising just to save a buck in hard times is "a terrible mistake," warns Ms. Van Horn, who also is vp and principal of the Athens Insurance Center Inc. agency in Athens.

Ms. Van Horn praises direct writers and their constant, consistent advertising. In fact, that strategy is one reason the "good neighbors" and the "good-hands people" are steadily taking away business from independent agencies and insurers, she says. Regular use of those slogans and jingles over the years has resulted in instant name recognition, she says.

This recognition is especially important during economic hard times, when many businesses, including insurance agencies, succumb to budget crunches and scale

Continued on next page

Costs up for getting the word out

Increases are slowing, but advertising costs continue to rise.
Figures are for increases in the cost to reach 1,000 people, or CPM.



Source: Creative Insurance Marketing Co.

GRAPHIC BY JOHN SMITHER

Bad debts

Continued from previous page

up the billing cycle."

Clients who are 60 to 90 days late should be warned that their account is being turned over to a collection agency, said Ms. Smith.

The reason is simple: If customers are going bankrupt, "they'll pay whoever's been screaming the loudest," according to Mr. Smith.

Since debtors will be hearing a "chorus of complaints" from other creditors, it's a good idea to be among the first to be heard, she said.

IC Systems charges a commission and a one-time fee to get an agency onto its collection system, Ms. Smith said.

The one-time fee can run anywhere from $350 to $750, depending on the potential for more bad debts.

On the first account IC Systems collects from the debtor, it keeps 40%, and then 29% on each account they collect for the client thereafter.

The collection agency offered recommendations for producers who want to improve their accounts receivable collections:

- Analyze and identify major customers.

According to collection industry estimates, 80% of receivables are generated by 20% of an agency's customers. Identify these top clients and separate them into a top priority category.

- Know their business.

Details like a client's billing cycle and invoice cutoff dates are important for an agency to know because possible cash flow problems can be averted.

- Have a written credit policy for new business.

This should be an easily understood guide outlining the requirements for extending credit, stating credit limits in time and dollars, and identifying the person in the agency who is responsible for enforcing the policy.

A written credit policy also clarifies when accounts are considered overdue, spells out how debtors will be contacted, when the account will be turned over to an outside collector, and at what point and size debt litigation will be considered.

- Use a collection calendar.

This is a step-by-step process to pursue delinquent accounts. The first billing is at the time of service; second billing sent no more than 30 days later; inquiries and calls if payment is not received 45 to 60 days after the bill is past due.

Follow up with additional phone calls, and if debtor doesn't pay by 90 days, follow the credit policy's set of options, including third-party collection, legal action, or, as a last resort, writing off the debt. ■

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Agency image

Continued from previous page

back their advertising, said Ann George, president of Ad Infinitum Multi-Service Group of Santa Monica, Calif. While most agents know they must advertise, they also know that they must budget more carefully in hard times, according to Ms. George, whose advertising and marketing company specializes in insurance agencies.

Many agencies simply cut their ad budgets, which is a bad move, Ms. George said. Because so many other businesses are also cutting back, this is actually a good time to advertise, she said. A strong campaign will stand out with less competitive clutter and "when things turn around, people are going to know who you are," she said.

As an example, Ms. George pointed to the Coca-Cola and Pepsi ad wars. When The Coca-Cola Co., secure in its marketshare, virtually stopped advertising in the mid-1980s, PepsiCo. Inc. launched an ad blitz from which Coke never quite recovered, she said.

Regardless of the economy, consultants stress that insurance agents should not launch any advertising campaign without planning ahead.

One of the most common agency mistakes is putting a flat amount in the advertising budget each year, without bothering to analyze where that money could best be used, said Ms. Van Horn.

For example, an agency with an annual premium volume of $2.5 million to $4 million typically puts about 1% of its budget toward advertising, she said. If this comparatively small amount buys a generic direct mail campaign when the agency really wants to target a specific market, the money is wasted, Ms. Van Horn said.

When planning an agency's advertising budget, the agency principal must take into account both short- and long-term goals, and the most efficient—and economical—ways to achieve them, she noted.

Even smaller agencies can achieve name recognition by taking advantage of programs offered by agent associations, insurers and free publicity generated by local events.

Agency ad campaigns, said Ms. George, generally fall into one of two categories: image building and target marketing.

Most agencies that come to her firm are interested in traditional "image" brochures that explain the agency's operations and basic philosophy either to a client or to an insurer. But interest is increasing in targeting advertising messages toward a specific type of customer or industry, she said.

Ad Infinitum, for instance, is working with an agency that is targeting energy plants around the country. To attract those companies, the agency needs a very detailed brochure specific to the energy industry.

This sort of advertising typically features technical detail about the agency, coverage needs of the targeted business and insurers that underwrite the specialty programs. Testimonials from clients in the particular industry are also included.

"Image building" brochures, on the other hand, are more personal in nature. They tend to focus on the agency itself, its principals and history, and the community in which it operates, said Ms. George.

"But they're both going to work, depending on who they're targeting," she said.

Television, radio and other general media are typical outlets for image-building advertising, because they reach a broad spectrum of potential clients, Ms. Van Horn said.

To develop a strong image, an agency must regularly advertise in at least two different mediums, she said.

First, an agency should carefully survey the available media to determine which method would most effectively reach its target markets. Then, an agency should determine how much to spend.

Taking a careful approach is becoming increasingly important as advertising costs rise.

Costs are rising in all advertising media from billboards to magazines, and the steepest increases are in one of the lower-cost alternatives—cable television. According to Creative Insurance Marketing Co., a consulting firm, the cost to reach 1,000 cable TV viewers rose 10% in 1989 and another 8% in 1990.

When combined with tighter agency budgets, such cost increases are forcing agencies to carefully evaluate their advertising efforts.

Many have turned to radio as a way to reach affluent audiences at a relatively low cost, according to Ms. Van Horn. But for radio ads to be effective, they must be repeated regularly, she noted.

Direct mail comes highly touted by many insurance consultants. But its high costs make it primarily a tool for large agencies and its effectiveness is questionable, said Ms. George. According to an insurance marketing newsletter, nearly 40% of consumers throw out direct mail without reading it, she said.

Television advertising can be effective if used correctly, Ms. Van Horn said. Network time is expensive, however, and unless the ads run regularly, the message is wasted, she said.

Cable television has proven to be a more effective medium for agency advertising since it is seen by the agency's community and is far less costly than network advertising.

For example, one of Ms. George's large agency clients has commissioned a cartoon video for broadcast on a local cable station.

As advertising costs rise, one way agencies have been able to defray costs is through co-operative programs in which insurers sometimes pick up half of an agency's advertising tab. But many of those have fallen victim to the soft market, Ms. Van Horn said.

As a result, she advises agents to take advantages of any free advertising opportunities by tying an effective public relations campaign into their advertising plans.

Employees can volunteer as speakers and volunteers for any popular community projects, and the agency principal should take the opportunity to explain the vagaries of the insurance industry to local business groups.

"Anytime you can get out and promote the industry as good guys makes you look good, too," she said.

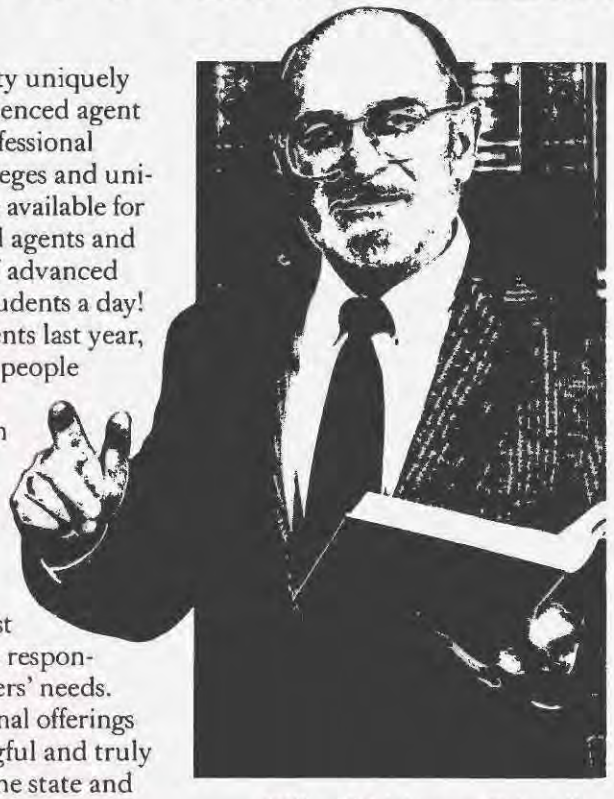
Community newspapers are another potential promotional tool. Articles about an employee receiving an industry designation or the agency principal addressing the local Kiwanis (club), for example, amount to "free advertising for the agency," Ms. Van Horn said.

Old-fashioned come-ons like calenders and pencils are sneered at by some consultants. But they remain an effective advertising staple, especially in a smaller community, Ms. Van Horn said.

"They're still a door-opener, things people can remember you by," she said. ■

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"In my opinion, membership in the Independent Insurance Agents of America not only guarantees a resounding 'voice' on critical issues — it is the best single source of insurance educational opportunities."

Emmett J. Vaughan, PhD

Dr. Emmett J. Vaughan (PhD Economics and Insurance) was named Partington Professor of Insurance at the University of Iowa in 1968 and is Dean of the Division of Continuing Education for the University. He also is a noted author with numerous periodicals and articles, as well as eight books, to his credit. Among them: Risk Management and Insurance Buying For Small Businesses *(1984)*; Fundamentals of Risk and Insurance *(5th revised edition 1989)*, and IIAA's Agency Management Service Manual.

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Industry needs to polish tarnished image

By BEVERLY H. PATRICK

A/BT perspective

It's no secret that public sentiment about the insurance industry has seldom been lower.

A recent Newsweek article on the industry summarized, "Americans are fed up and looking for ways to vent their anger." The article also pointed to a recent poll conducted by the magazine showing that insurance agents were rated only slightly higher in the public eye than car salesmen and lower than funeral directors, building contractors and lawyers.

Beginning with Proposition 103, and as evidenced by a wave of similar efforts across the country, there is a distinct anti-insurance sentiment.

Although part of the problem is the consumer's lack of understanding about the insurance industry in general—and specifically its pricing—part of the blame clearly lies with the insurance industry itself for not communicating and working more closely with its customers.

As summarized by Caleb Fowler, president of the property/casualty group at CIGNA Corp., "One of the reasons we find ourselves in the predicament we are in today is because we lost touch with our customers; we didn't spend a lot of time talking to them and explaining why the costs of insurance are going up."

Consider, for example, how insurance agents act as buffers. When a customer buys a new policy, who the insurance company is may not matter. What does matter to the customer is getting service from the local agent.

In this nebulous yet threatening environment, the insurance industry must assess and step up efforts to improve customer relations or face constant attacks from a variety of consumer groups. Fortunately, effective consumer relations can be categorized into two broad components: client understanding and communication.

According to best-selling author and management genius Tom Peters, just surviving in today's ever-changing marketplace mandates that companies add quality to their products and services.

In his book, "Thriving on Chaos," Mr. Peters says: "The challenge is to view every element of every operation through the customer's lens; to constantly attempt to literally redefine each element of the business in terms of the customer's perception."

In other words, they must learn all they can about their customers to better understand the business and how to make it better.

Those in the insurance industry must take this recommendation seriously and constantly evaluate all aspects of customer service to ensure that the client's desires are always met. They must understand that customer service is more than just smiles—at its best it is an attitude and supporting systems. This understanding means knowing the customer's business well enough to go into his or her company and do his or her job.

We have worked with this idea extensively within our own organization and have implemented several programs to help our staff understand the unique problems and challenges facing medical industry professionals and the most effective way to ensure that clients get the best service possible.

For example, we regularly sponsor in-house seminars that create typical client scenarios to help see situations from the client's vantage point. And members of our staff continually attend seminars and workshops on everything from customer feedback to telephone techniques to help determine the client's requirements and how they can best be met.

Good communication is the second critical component of effective consumer relations. Companies must take what they have learned about their customers and communicate it back in terms of how their needs will be met. Consumers must know both that you understand their desires and how you plan to help them.

When a company ignores this step it is asking for trouble. How can consumers make informed decisions about an organization if they don't have all of the facts? Consider some of the positive actions taken by the insurance industry as an example.

Several years ago the insurance industry was the first group to become seriously involved in promoting rehabilitation. Until then, a disabled worker would be sent a monthly check; no one gave any thought to assessing the person's skills and finding him or her a new vocation. Today the insurance industry actively works to rehabilitate disabled workers, giving them back their self-esteem and self-respect.

Unfortunately, many consumers are unaware of this and other community-based programs because the insurance industry has not effectively communicated the message to the public. Good consumer relations means regularly communicating with your customers through direct mail, newsletters, the media and/or any other appropriate channels that get the message across.

The author of the Newsweek article noted that for a product that's supposed to provide peace of mind, the insurance industry has a lot of people very upset. When the total insurance industry—brokers, agents, companies, administrators—gives consumers the attention and service they need, then and only then can we earn and get their respect. ■

Beverly H. Patrick is president and chief executive officer of Professional Risk Management Services, a Washington, D.C., firm specializing in professional liability programs.



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Agent/Broker Topics

Expert says banks' threat to agents is overblown

By LOUISE KERTESZ

SAN FRANCISCO—Banks present no immediate threat to insurance agents and brokers, says a former brokerage executive who ought to know.

Banks "can and will enter the insurance business," though not in the way many brokerages and agencies fear, said C. Timothy Morris, a former president of First Insurance, the wholly owned agency of First Bank System Inc. of Minneapolis. Instead, banks will underwrite and possibly invest in brokers, he said.

At a recent Russell Miller Inc. symposium here, Mr. Morris recounted his experiences with First Insurance, and how the bank pulled back from an attempt to increase its commercial insurance operations.

FBS is one of 16 national bank holding companies exempt from the federal law prohibiting national banks from selling insurance. Exemptions for the "grandfathered" banks allow them to continue the insurance activities they had prior to Jan. 1, 1971 (*BI*, Nov. 5, 1990).

In 1984, the bank decided to centralize its insurance operations. It wanted to operate First Insurance, then an amalgamation of 62 agencies, "as one company and capitalize on its unique. . .license at a time when banks were looking for alternative fee income," recalled Mr. Morris, who is now a consultant with Vital Management & Consulting Corp. of New York.

With "visions of being a diversified financial institution," the banking company tried to transform the brokerage from primarily personal lines, credit life and crop hail coverage to primarily commercial lines, he said. That didn't last long. When the bank encountered problems with a venture into merchant banking, it retrenched.

"The strategy is to go back to basic banking and to build its retail base, the significance of which is that insurance is not a traditional banking business," Mr. Morris said.

Cultural differences were the greatest obstacle to expansion.

"Bankers do not trust nor like to be associated with insurance or selling. They do so only because they are told to do so and/or sense that it means survival in the form of fee income," said Mr. Morris. "Bankers do not like to be associated with the term 'sell'; they, in fact, joined banks so they wouldn't have to sell. They like to take orders."

Another problem was that "the bankers had a myriad of products, and setting priorities often came down to those with which they were most comfortable," he added. Those, understandably, were banking, not insurance, products.

Commercial insurance presented yet a different problem to FBS. The people who buy such policies are not always the same people who make decisions about banking, said Mr. Morris. "The bank relationship can get you an interview but, once in, you must be able to demonstrate some competitive advantage."

Another problem was the banking company's retail strategy, which he described as "make the bank a McDonalds. . .(put the) same menu in every 'store.' " However, "underwriters don't always have products for every customer," he explained.

Because the bank's strategies were not always consistent with those of the insurance industry, Mr. Morris said he drew up a plan to "remodel the agency network." Selling it off and rebuilding would be simpler than "remodeling a culture," he said. "The culture of an agency is very different from a bank—sales entrepreneurs vs. an institution."

But FBS did not agree to the price set by a "friendly buyer," and Mr. Morris resigned March 1, "when it became apparent that they (FBS) were not sure of their direction."

"I believe insurance agents are safe. Banks will succeed on a selective basis, with products such as annuities, but will not get into the insurance agency business on a significant basis," Mr. Morris asserted.

"Some products such as life and auto/homeowners will succeed if they can be standardized. Commercial (insurance) is too labor- and relationship-intensive for most banks to be interested," he added.

But, he cautioned, "banks will get into distribution. I know at least one grandfathered bank that would love to buy a national broker and has made overtures to one but was rebuffed. They see it as a way to broach current commercial banking clients through the banking relationship and as a way to increase their national banking customer base by accessing the broker relationships."

Mr. Morris believes that either a money center or regional bank could buy a brokerage.

"However, one hurdle that must be overcome is the insured. Typically the insurance and banking services decisions are made by separate functionaries within the chief financial officer domain," he said. "It will take a national or very strong regional broker to give a bank agency the perceived credibility with the insurance buyer."

Mr. Morris said banks may find their greatest success in direct writing. Banks could purchase either a direct writer or an agency company, he said. "The key is managing insurance as a commodity. Eliminate (true) underwriting (and) focus on pricing as 'underwriting.' "

Rather than spending "enormous resources fighting the entrance of banks into (insurance)," Mr. Morris urged industry leaders to "come to grips with the real issues," which are "an inherently inefficient distribution system and a poor image."

Other symposium participants—including Arthur F. Quern, chairman of broker Rollins Burdick Hunter Co. in Chicago—agreed with Mr. Morris that "some banks have retrenched" into their traditional business but that "financial institutions will become more involved" with insurance in the future.

U.S. banks will learn from Europe about the integration of insurance into banking, Mr. Quern noted.

David D. Holbrook, president of Marsh & McLennan Inc., said M&M does not consider potential partnerships between banks and insurance brokerages "as a major opportunity."

"We've been approached by banks, (but) banks have so many other problems now," he said.

"I totally agree," said Robert H. Hilb, chairman, president and chief executive officers of Hilb, Rogal & Hamilton Co. Banks currently are not "quality competitors" to brokers.

Both Mr. Hilb and Mr. Holbrook said their firms have attempted partnerships with banks but were not successful. ■

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Merger talks are on again for agent trade groups

By LAURA MAZZUCA

DALLAS—The on-again, off-again merger talks may soon be on again.

Between 180 and 200 agents from local and regional chapters of the two national agent trade groups met here April 20.

The result: a resolution urging the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents to quickly resume consolidation talks.

The five-hour meeting featured:

- A panel discussion by executives of the Insurance Agents Assns., a group formed by the trade groups' Minneapolis chapters, which merged in 1990.
- Research findings on agent attitudes toward consolidation from Charles C. Clarke, former executive vp of the Insurance Information Institute and chairman of Communication Solutions Inc., a consulting firm.
- Comments from agents in New England, Oklahoma, Colorado and other places where the associations plan to merge.

IIAA President A. William Bailey Jr. invited state and regional representatives of both organizations to the meeting to resume merger talks. Executive committees from the groups had hit an impasse in February (*BI*, March 25).

Although members from 18 state PIA chapters attended the meeting, no national executive committee members were on hand.

Merger talks by a joint PIA-IIAA task force had been going well until February. Both sides then announced in an enigmatic press release that talks would resume "when all pending issues are placed on the table for further study and open discussion."

At the time, executives from both groups said that "organization culture and structure, membership, management, merger/consolidation funding and finances" were at issue and that the respective boards of directors would discuss them before more meetings would be scheduled.

The official silence was broken in March, when the national PIA sent members a letter and report describing the talks' status. Discussions were described as "friendly and positive." Everything was fine, members were told, until the IIAA introduced two "non-negotiable deal breakers." These were an objection to expanding non-voting membership to direct writers and exclusive agents and an insistence on maintaining the IIAA's Capitol Hill legislative office after the merger, the report stated.

The PIA report concluded that it would "resume merger/consolidation talks with the IIAA at any time when all pending critical issues involving organization, culture and structure, membership, management, funding and finance are subject to further study and open discussion."

While conceding the accuracy of that assessment, Mr. Bailey said the real problem was a wrangle over who would assume the title of executive vp for the combined associations.

To heat up the situation even further, Mr. Bailey announced the formation of an IIAA national task force to assist the organization's state associations in consolidating with local PIA chapters. State consolidations has long been a sore point with the national PIA, which traditionally had opposed any merger attempts on either the state or national level (*A/BT*, July 2, 1990; Oct. 3, 1988).

Local mergers had been discouraged by both agent associations, noted Richard Yingling, the national PIA's past president and a member of the joint task force. Early in the discussions, both sides feared that individual mergers would prove incompatible with national action, he said.

Saying it does not want to introduce any new and confusing elements to the debate, the PIA stands by the five-point merger plan set out by its president, Tommy Sutton. These are:

- Deliberations must be member-driven.

"Our concern must not be who will get to be president or executive of the merged organization, but whether the members' best interest will be served," Mr. Sutton said.

- Objective goals and criteria must be established in advance and adhered to.
- The PIA and IIAA should select an impartial, professional outside mediator to keep negotiations on track "and to separate people and emotions from the process."
- Artificial deadlines, "which lead to poorly thought-out and hasty decisions that are later regretted," must be avoided.
- "We need to stop negotiating through the media. This undercuts the negotiating teams and makes it impossible to proceed in an unemotional manner. Both IIAA and PIA have been guilty of violating this rule."

No date has been set for future consolidation talks, but Mr. Bailey said that he and Mr. Sutton have been attempting to arrange a date in the near future. ■

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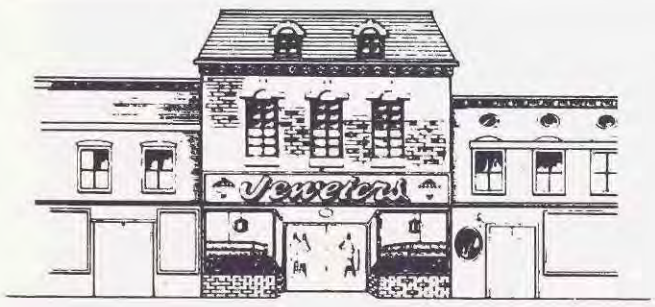
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Agent/Broker Topics

Stalled interface effort is revived, says ACORD

By LAURA MAZZUCA

New technology and old-fashioned "disruptive thinking" have jump-started the stalled movement toward industry computer standardization, says the new chairman of ACORD Corp.

Spurred on by two 1990 studies, ACORD—with its sister organization, the electronic network IVANS—is offering educational programs to agents on downloading, as well as studying new technologies like electronic imaging and informational compact disks.

"Things have been a little slow with ACORD; we know that," said Durant G. Vick, senior vp of Associated Insurers Inc. in Raleigh, N.C., who became chairman in March. "But we see a lot of good things happening now. We're beginning to see the critical mass moving things forward and hopefully proprietary systems will soon be a thing of the past."

It all started last year with an industry study group calling for adoption of ACORD download standards as the best way to expedite industry standardization (*A/BT*, Nov. 5, 1990). "Downloading" refers to the transmission of large batches of renewal and endorsement data to an agency's computer system from an insurer's database.

An ACORD workshop, started last year, was designed to teach agents about downloading, Mr. Vick said. Last month, the pilot program for the two-hour workshop, which will be offered to agents at state and national association conventions, was successful, and it will become a regular offering at conventions this year, he said.

But while ACORD stands by downloading as the most efficient means of interface, there were other ideas afoot as well.

Perot Systems Corp., a consulting firm, caused a few waves last year by saying that setting up an agent-controlled automation clearinghouse would be the "most ambitious and aggressive" way to achieve agency-insurer interface (*A/BT*, Jan. 7).

'Things have been a little slow with ACORD; we know that,' concedes Mr. Vick. 'We see a lot of good things happening now. We're beginning to see the critical mass moving things forward and hopefully proprietary systems will soon be a thing of the past.'

The idea was not universally liked. A clearinghouse would only confuse the issue, say Mr. Vick and Douglas Bennett, president of Bennett-Elbert Co. in Lake Jackson, Texas, and IVAN's new chairman. Both automation organizations already are "a proper forum for addressing the issues they brought up," so "we don't embrace the idea of forming a new institution," Mr. Vick said.

But the Perot study provided just enough "disruptive thinking" to "stir the pots" and rekindle interest in interface, he said.

In response to the study, ACORD early this year created a Strategic Technology Planning Committee to analyze how new technology can be applied to agencies.

Electronic imaging is one focus for the new committee. The technology lets companies copy actual documents into their computer systems with devices resembling copiers. Data would no longer need to be input manually.

The committee is also looking at the use of "read-only memory" compact disk technology for agency use, Mr. Vick said. With their vast capacity for data storage, standard compact disks are ideal for insurer manuals and other voluminous data. The information can be accessed on a standard PC through a "reader" which is attached to the PC and which can read the CD "just like a floppy disk," Mr. Vick explained.

While these compact disks must now be programmed by a clearinghouse, agents eventually will be able to input information from their own offices, he added.

The IVANS executive committee, also responding to the Perot report, recently agreed to work with the Alliance for Production Technology, an industry coalition, and others to create "bridging software" that would allow various software systems to be used compatibly (*A/BT*, Aug. 6, 1990).

ACORD also will continue to work with insurers and software firms to standardize interface, he said.

Also on the agenda is a continuing push for a certification program, by which ACORD would recognize insurers able to interface through ACORD standards. ■

Letters

No producer is self-supporting in four months

To the editor: I think that you misquoted or misunderstood several of my comments in the article "Overpaying Staffs Plagues Agencies" (*A/BT*, April 1).

I made two separate comments about producers achieving a level of being self-supportive. The smaller agency usually cannot afford to pay a producer in the early-on period of employment unless the agency can obtain a loan from one of its insurance companies. Usually the insurance company loans the amount monthly to the agent, who in turn pays his/her producer employee. At the end of 18 months, the agency begins repayment of the loan, hopefully from the revenue now being generated by the producer.

New producers usually take 18 to 24 months to become self-supportive and thereafter should be contributing to profit.

Larger agencies may have the wherewithal to finance a new producer, but most follow the general rule of 18 to 24 months to achieve a break-even point.

I have received two calls about producers being self-supportive in three or four months. If you as a new producer receive a firm order for your first sale today, you may not receive the policy for delivery to your client for 30 days. Your client has, say, 30 additional days to pay your agency, which has another 15 days to pay the company. The point is that point of sale to money in the till can consume several months. No producer can be self-supportive in three to four months.

Lee Schexnayder
President
Insurance Resources Consultants
Fair Oaks, Calif.

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Agent/Broker Topics

Issue of May 6

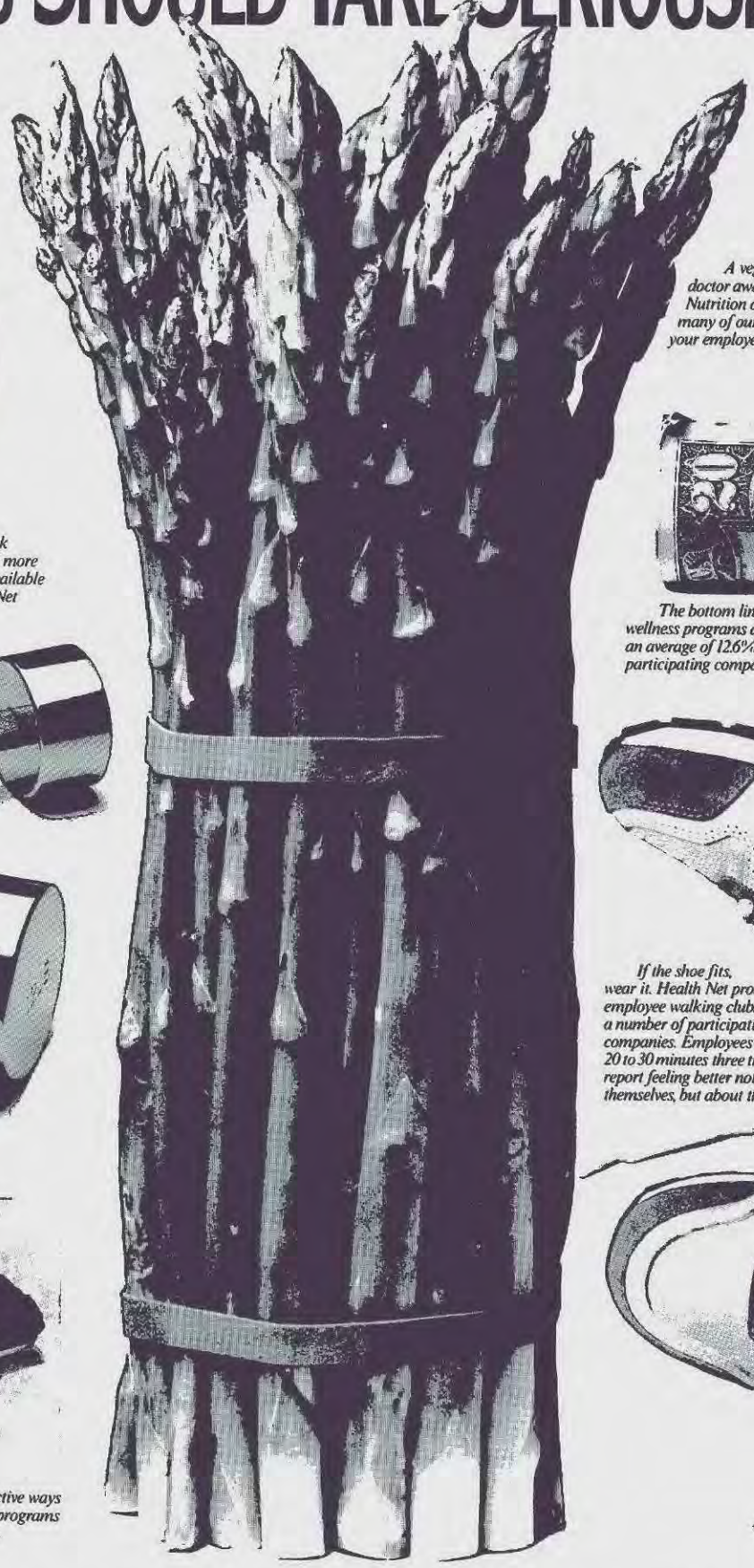
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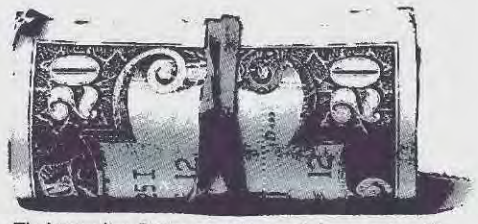
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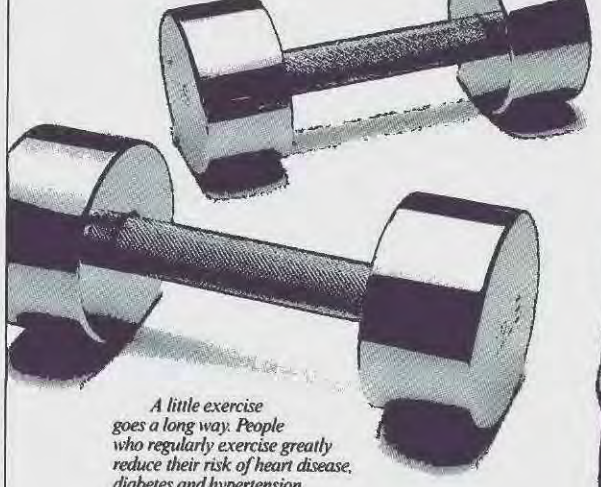
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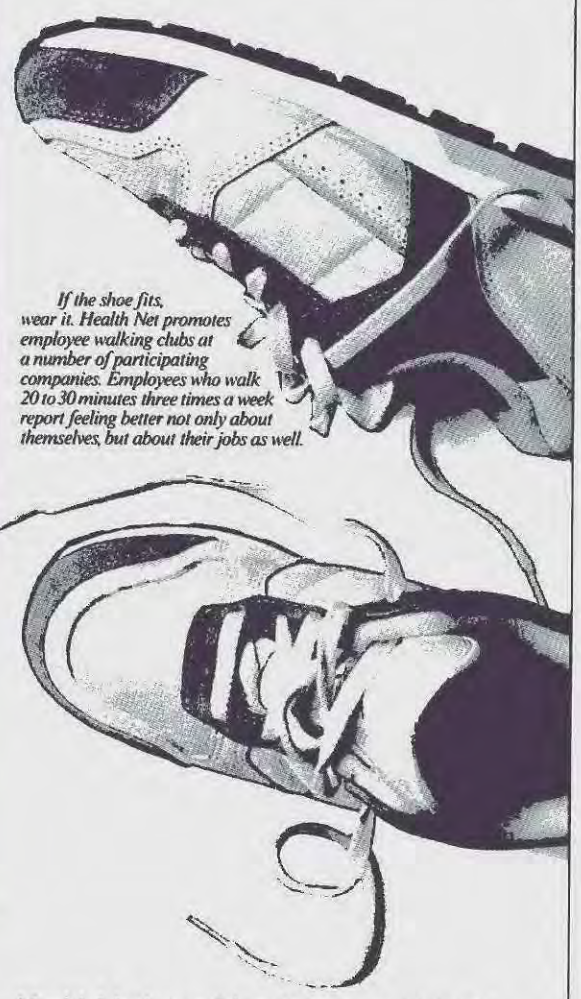
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JPA cost allocation system creates inadequate premium

Q **Our joint powers authority has adopted a cost allocation system that simply consists of revising the average of the last three years' premium by the three-year ratio of incurred losses to 50% of premium, subject to a maximum increase or decrease of 30%. Do you think this is a good system? It makes a lot of sense and it seems so much simpler than other systems.**

A While this discussion will only touch specifically on your situation as a group of public entities, it also applies to corporate cost allocation systems. To generalize my comments, simply replace "member" with "department" or "division" and "joint powers authority"—a group of public entities that buys insurance or self-insures as a group—with "company" throughout this article.

While this type of approach to cost allocation has a great deal of intuitive appeal, it unfortunately is riddled with significant problems and shortcomings.

Cost allocation systems should meet several important criteria. Unfortunately, the type of system you have described only meets the first three of the following criteria:

- It should be simple to administer.
- It should be sensitive to recent loss experience, so that it provides clear incentives to each member for effective loss control.
- It should not result in dramatic changes in premium charges from one year to the next for any member.
- It should treat all members fairly and equitably by developing premium charges that are accurately reflective of the expected losses of each member.
- It should be sensitive to changes in the relative exposure to loss of each member over recent years.
- It should assure that the total amount of premium collected for the JPA is adequate.

While the system you describe is simple, sensitive to loss experience and produces relatively small changes to each member's premium from year to year, it will over time result in significant inequities, fail to take into account changes in exposure to loss and fail to produce an adequate premium for the JPA as a whole. Unfortunately, it is often necessary to add complications to an initial cost allocation system in order for it to satisfy these latter objectives, which clearly are also of prime importance.

The system you describe essentially determines next year's premium for each member, independent of the overall financial needs of the JPA. Total premium for the upcoming year for the JPA will simply be the sum of the individually determined premiums. If the formula were unbiased, it might stand some chance of producing an adequate premium for the entire JPA, but the formula is not unbiased. The degree of bias in the formula is greater the more small members there are in your JPA.

The first source of bias is fairly obvious, once you think about it. It does not take into account the degree of growth or decline in the number of exposures of each member.

This can be a serious problem if many of your members are growing rapidly, or if others are shrinking quickly.

The second source of bias is only potential in nature, but potentially serious nevertheless. Who is to say that having incurred losses for the three most recent years be 50% of total premiums for those years is the desired goal? This might produce excessive premiums for a property program while producing inadequate premiums for a liability or workers compensation program. The premium needs of the JPA should be assessed by evaluating the total premium, loss and exposure profile of the JPA, and by carefully considering the potential for the development of incurred losses from their presently stated levels.

The JPA's overall financial needs should first be determined by such an assessment, and then the task of allocating total premiums to each of the members in a fair and equitable manner can begin. There is no way to assure that the JPA's overall financial needs will be met by building some formula into the JPA agreement.

Such needs should be the frequent and periodic focus of your board, with due consideration for the recommendations of your consultant or analyst as to current needs.

The third source of bias is quite subtle, but quite likely significant. The formula you describe possesses an inherent bias in favor of small members. Small members can tend to have good recent loss experience simply because they are small. The fundamental problem is that the recent loss experience of small members has only fairly limited value as an indicator of prospective loss experience.

An example from private passenger automobile insurance will illustrate this point, because each driver is essentially a small risk. Many studies have been performed on the value of recent accident experience in predicting future experience. Typically, in such studies, drivers have been grouped according to how many accidents they have had during the past three years. Each group is then tracked to see how its subsequent experience differs. What has been shown by such studies is that the subsequent loss experience of drivers with no accidents in the past three years is only about 15% better than that of those drivers who have had an accident in the past three years. The mere fact that you have not had an accident in the past three years has only very limited value in predicting your future accident experience, which after all is what is supposedly predicted in determining your auto insurance premium. Other factors, like age and territory, are much better predictors of future driving experience than one's recent driving record.

If your JPA has members who are now paying premiums less than, say, $5,000 per year, they are most likely similar to the individual drivers I just described. The typical driver has an expected claim frequency of only one claim every 10 years. When claims are that infrequent, recent loss experience becomes relatively meaningless as a predictor of future experiences.

Some specifics might clarify this problem. Suppose we say that a good driver has one accident every 20 years, an average driver one every 10 years and a bad driver one every five years. Assuming these definitions, about 86% of the good drivers will end up in the "accident-free the last three years" category, but 55% of the bad drivers will also be in that category and 74% of the average drivers will also be there. In other words, since the clear majority of each of these types of drivers are in the accident-free group, recent accident experience proves little in terms of distinguishing good from bad from average drivers.

The point of all this is that your loss-free small member may only be deserving of a small discount off the overall JPA rate (as applied to the number of exposure units) rather than being eligible to receive a 30% discount successively, year after year. Unfortunately, this is what your formula actually describes. A 30% discount, applied successively for five straight years, will result in an 83.2% discount of the original premium levels. If applied successively for 10 straight years, it will result in a 97.2% discount!

If your JPA has many very small members, you will probably find that most of them will qualify for the maximum premium reduction year after year, almost regardless of how small their premium gets. Obviously, this process cannot go on indefinitely. If left unchanged, however, it will strongly favor small risks while charging larger risks something closer to what is needed. Larger risks will tend to have higher loss ratios, in part because their size makes the occurrence of claims more likely.

The fourth source of bias are the caps applied to the percentage changes in the premium from year to year. Such caps are often advisable in order to prevent premium swings which are unacceptably large, but they will generally result in an overall premium which is inadequate unless the initial premiums of all the members are increased a uniform percentage in order to eliminate that bias.

This problem arises primarily from the fundamental nature of property and casualty claims. Typically, a high percentage of the total losses during any given year will be the result of a few large claims. The premium increases caused by these large claims will be capped, in your case, at 30%. Usually, the amount of premium lost by such capping is not made up by the additional premium collected by limiting decreases to 30%.

Most claims that occur will be small in size, small enough for the smaller members in your JPA to still qualify for the maximum premium reduction. What results from all this is that the great majority of your members will get premium reductions year after year while a few will get premium increases. The net result for the JPA is insufficient premium income overall.

It is important, in my opinion, for any cost allocation system to ascribe some weight to a component sensitive to the number of exposures of each member. This is usually done by determining an overall rate per exposure unit for the JPA and then by calculating what the premium for each member would be if that rate were applied to the number of exposures of each member. This type of indication can then be blended with a loss-sensitive component that varies up or down depending on recent experience, like the formula you have described. Using the type of loss-sensitive component produced by your JPA's formula is fine as long as you apply an off-balance factor—like the uniform percentage increase, or decrease, needed to get the total indicated premiums to equal the

Continued on next page

Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Casualty Actuary, Ask A Benefit Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues and actuarial problems.



Mr. Sherman

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions.

Mr. Sherman's and Mr. Miner's columns appear alternately on the first Monday of each month. Ms. Werner's column appears alternately on the second Monday of each month. Mr. Sherman's next column will appear in July.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Texas attracts foreign plaintiffs

By Douglas N. Smith

International issues

HAS THE TEXAS Supreme Court opened the floodgates for suits in the United States by foreign plaintiffs?

In the case of *Dow Chemical Co. and Shell Oil Co. vs. Domingo Castro Alfaro et al.*, the Texas Supreme Court decided March 28, 1990 that the doctrine of forum non conveniens has been statutorily abolished in suits brought under Section 71.031 of the Texas Civil Practice and Remedies Code (*BI*, Jan. 21). This decision has far-reaching implications for American risk management and insurance.

Under the common law doctrine of forum non conveniens, a court has discretionary power to decline jurisdiction when the convenience of the parties and the ends of justice would be better served if the action were brought and tried in another forum. As it evolved over the years, the doctrine calls for the court to weigh the merits of the defendant's assertion that the plaintiff has access to an alternative forum where justice may be served more "conveniently."

The court is supposed to compare the relative convenience of each forum in terms of such factors as the costs borne by each party, the accessibility of witnesses and evidence and the ability of the court to entertain the case and rule on the basis of applicable law and the prospect of a remedy for the plaintiff.

Any American company or individual doing business outside of the United States runs the risk of being sued in the United States by a foreign plaintiff for injuries sustained on foreign soil. To foreign plaintiffs, the opportunity to sue a U.S. company in the United States offers the nearly irresistible prospect of large awards for pain and suffering, mental injury and even punitive damages—the chance of a lifetime to become rich by their country's standards.

A key reason why we have not seen a lot more of these suits is that most states, and the federal courts, do not prohibit forum non conveniens dismissal and continue to follow common law, with *Piper vs. Reyno*, a 1981 U.S. Supreme Court ruling, being a major precedent.

Use of the doctrine of forum non conveniens as a basis for dismissal of suits in the United States by foreign plaintiffs for injuries sustained outside the United States, was upheld and clarified by the U.S. Supreme Court in *Piper*. The court held that a foreign plaintiff's action should be dismissed if there is a more convenient foreign forum available, even if that forum is less favorable to the plaintiff, unless the remedy it offers is so inadequate as to be no real remedy at all.

This ruling makes it clear that in considering forum non conveniens dismissal, the court serves the ends of justice by considering the plaintiff's opportunity for remedy without regard to the legal advantages or potentially greater awards available to the plaintiff in the United States.

More recently, the U.S. District Court for the Southern District of New York in 1986 dismissed the action brought by the Indian government on behalf of the victims of the Union Carbide disaster at Bhopal, India, on the basis of a forum non conveniens motion by Union Carbide Corp. The court researched India's legal system in comparison to the United States, and concluded that India offered a forum in which the victim's claims could be heard and remedies could be won. The court noted that the prospect of a lower monetary award in India would not weigh against a forum non conveniens dismissal, pursuant to the Supreme Court's *Piper* ruling.

The doctrine of forum non conveniens clearly offers U.S. companies a means to foil pure forum shopping by foreign plaintiffs. That is what has been abolished by statute in Texas.

Section 71.031 of the Texas Civil Practice and Remedies Code allows anyone to bring suit in Texas for personal injury or death sustained in a foreign country, and the *Dow vs. Alfaro* decision precludes the defendant's use of a basic defense. With this in mind, we should note what is required for a foreign plaintiff to pursue an action in Texas for injuries sustained outside the state:

- There must be a law of the foreign state or country or of Texas which gives the plaintiff a right to maintain an action for damages for death or injury.
- The action must begin in Texas within the time provided by the laws of Texas for the beginning of the action.
- The plaintiff's foreign country must have equal treaty rights with the United States on behalf of its citizens.

It is important to note the the court still must establish all the basic elements required for an action to proceed in its forum—most particularly, jurisdiction and venue or connection of the defendant and the action to the forum.

Through the *Dow vs. Alfaro* ruling, Texas has been declared an open forum in which a foreign plaintiff can sue any U.S. multinational with a business connection to the state of Texas, with no fear of a forum non conveniens dismissal. Texas has thereby made itself the logical choice of forum for actions by foreign plaintiffs injured overseas.

In those countries in which workplace safety and health standards are significantly lower and less vigorously developed or enforced than in the United States, and where the financial value of a human life is much lower than in the United States, injured parties will be enticed in many cases to pursue potentially lucrative claims against a U.S. company through Texas courts.

This is particularly likely to happen after foreign disasters or similar occurrences in which several plaintiffs can follow the lead of *Alfaro et al.* and join together under a single class action in Texas.

Even before the 1990 ruling, Texas was seen as a preferred forum. Shortly after the Piper Alpha offshore oil rig disaster in Scotland in July 1988, a Texas lawyer held a press conference and wrote to victims or their families advising that they could find a forum in Texas which would give them much higher awards than elsewhere.

Many plaintiff-oriented parties feel that this will truly serve the ends of justice. They contend that the forum non conveniens doctrine has been abused by the U.S. federal and state courts to effectively bar foreign plaintiffs from pursuing actions against U.S. multinationals for damages sustained outside the United States. In their eyes, this creates a double standard for American companies and lets them avoid much accountability for their actions overseas, because the plaintiffs often lack the resources to actually have their cases heard in their home forum.

On the other hand, those who support forum non conveniens dismissal of foreign plaintiffs' suits argue that it is a necessary counterbalance to the increasing tendency of plaintiffs to go forum shopping. To give foreign plaintiffs open access to U.S. courts, when a foreign court is better suited to hear the case, is tantamount to exporting U.S. legal standards for foreign plaintiffs: They can sue for damages according to foreign standards if the defendant is foreign, and to American standards if the defendant is American. In practice, this means that the plaintiff will simply expect a bigger settlement offer from an American defendant seeking to avoid a U.S. suit.

One probable result of the potentially increased exposure to U.S. companies with business in Texas is that those companies, or their insurers, will become inclined to make larger settlement offers—following U.S. rather than foreign standards—on claims by foreign plaintiffs for serious personal injury. While this probably will not happen overnight, it is virtually inevitable if the Texas laws remain unchanged. This will increase the severity of claims for foreign injury, and possibly even the frequency, resulting in real increases in the cost of risk and insurance.

Risk managers of American companies will see this as an important and very adverse development, particularly if their company is expanding its operations overseas.

What can be done to counter this situation?

American companies can support legislation in Texas to amend the statute to specifically permit forum non conveniens dismissal. Better yet, they can lobby Congress to pass legislation that would remove all suits by foreign plaintiffs to federal court. That would prevent state-to-state forum shopping and allow for dismissal of pure U.S. forum-shopping cases under forum non conveniens motions. In the meantime, we should expect a profusion of such suits in Texas and make sure our insurance and risk management programs are prepared for them. ■



Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

Calculating JPA premiums

Continued from previous page

amount needed for the whole group—to each indicated premium.

Typically, these two indications are then blended together by giving so much weight to each one in order to arrive at a final premium for each member. For example, you might give equal weight to each of these indications, or you might give two-thirds weight to the exposure indication and one-third to the loss experience indication.

Ideally, the weight given to each of these indications should vary by member, depending on how big they are (as measured by their exposure units). The larger the member, the more weight can properly be given to recent experience as a reasonable indicator of future experience.

The main problem with this type of method is that it will require the application of yet another set of off-balance factors to get the sum of the individual premiums to equal the premium need of the entire JPA.

There are yet other complications that need to be considered. If the party settling case reserves is not independent, reliance on incurred losses in your formula adds a subjective element to the process that could cause some political problems within your JPA.

Once the JPA becomes stable enough and there is a five- to seven-year history for most members, you might want to consider using paid losses rather than incurred so that the opinions that get expressed as case reserves don't affect the final allocations.

Designing a cost allocation system that meets all the key criteria mentioned above is not an easy task and it normally results in a system that is not as simple as everyone would like. It is important at the outset to decide how important each criterion will be before designing a system. There are many reasonable alternatives that can be chosen between systems that are primarily loss-sensitive and those that are exposure-sensitive. This is often a political decision. ■

Entering the 'disability decade'

New disability management strategies can keep soaring costs in check

By Larry Jenson

DURING THE 1980s, EMPLOYEE BENEFIT managers and their advisers focused nearly all their efforts on fighting escalating health care costs. They often overlooked the billions of dollars in savings that could be generated by improving the management of their disability insurance programs.

The '90s, though, could become the decade for tackling disability costs. With a new cost consciousness gained in their battles to control health care costs, benefits experts are rethinking the rest of the benefits spectrum. They are discovering that cost containment principles also apply to disability insurance and other benefits.

Total disability costs are about $160 billion per year, estimates the Washington Business Group on Health's Institute for Rehabilitation and Disability Management. Short-term disability plan costs frequently run between 2% and 4% of payroll. Long-term disability costs add another 0.5% to 1%, boosting disability plan costs to as much as 5% of payroll. The institute estimates that when a firm adds the indirect costs for labor replacement, administration and lost productivity, disability costs could soar to almost 10% of payroll.

Disability costs add up to a sizable slice of the pie, with the potential for sizable savings. And employers understand that savings in disability costs will free up funds that move right to the bottom line.

How can employers achieve meaningful disability plan savings? Benefits managers and their advisors are working with innovative disability insurers to create the new discipline of disability management. The new trend follows the tradition of managed care strategies of the '80s, which were created to help fight rising health care costs.

The four basic elements of these disability management programs are integration, cost reduction, prevention and management information. Let's look at these one at a time:

- **Integration.**

Employers and benefits advisers traditionally viewed disability insurance as a specialty line purchased from a specialty insurer. Employers often split their short- and long-term disability plans between separate insurers. In many cases, employers self-insured and even self-administered their short-term programs.

As we moved into the '90s, benefits experts realized that there is a close interdependence among short- and long-term disability and other benefits programs. An employee's disability, for example, creates a ripple that cuts across an employer's benefits and human resources operations, affecting health and life insurance, workers compensation, funding for pension and savings programs, and even the company's staffing and productivity plans.

An integrated disability management approach coordinates all of these programs in order to simplify program administration, reduce costs and, in some cases, eliminate important coverage gaps.

For instance, an integrated disability plan can give employers a single source for processing claims and paying benefits, thereby reducing employers' administration and applying consistent controls throughout a disability.

For employees, the integrated disability plan provides one point of service, one case manager and one claim filing, for a smooth flow of benefits and better care.

Disability management should also integrate the claims processing for LTD and workers comp plans when claims are filed under both plans, in order to eliminate double-dipping and speed up LTD payments.

By managing a disability from day one, an integrated program can take the right initiatives at the right time. For instance, an integrated plan can spot potential long-term disabilities at a much earlier date. This allows for earlier intervention, which would reduce the duration of the disability. Under separate plans, a disabled employee would have to wait as long as six months, which may be too late to prevent a long-term disability.

Integrated disability plans also can fill important gaps in coverage. For instance, retirement contributions often cease when a disability occurs, even though a disabled employee's retirement needs continue to grow. An integrated plan, however, can pay extra benefits to continue retirement funding.

- **Cost reduction.**

As employers seek to control all aspects of their benefits program, the concept of disability management can help by assuring that benefits are paid to people who qualify as disabled, for as long as they are disabled, but not longer.

Employers know that the secret to controlling disability costs lies in applying proven cost-containment techniques to short-term disabilities, including diagnostic-specific duration guidelines. These guidelines allow claims professionals to work with physicians, patients and employers to answer the difficult question of how long a disability should last. The guidelines aren't meant to deny a claim, but rather to identify the critical factors that should be reviewed to justify a longer-than-average recuperation.

Disability management can also reduce costs by providing early and ongoing rehabilitation to shorten or prevent long-term disabilities. That is perhaps the most rewarding way of saving money, since it also helps people return to useful and productive lives.

Another integral part of the cost reductions comes from assisting claimants in securing Social Security disability benefits. Such efforts not only help reduce employer liability but also ensure that legitimate claims are approved by Social Security.

These cost reduction programs—duration guidelines, early and aggressive rehabilitation intervention and Social Security assistance—illustrate how disability management works to benefit both the employee and the employer.

- **Prevention.**

The simplest way to reduce disability costs is to prevent disabilities before they happen. Employers and providers alike agree that health promotion and injury prevention programs can yield significant payoffs.

Employers can choose from an array of preventive programs and health services that can work as part of a disability management plan to prevent and limit disabilities. For instance, employee assistance programs can greatly reduce the incidence of mental health and substance abuse disabilities. Fitness and wellness programs with specific injury prevention and health promotion features can reduce the number of physical disabilities. And workplace safety reengineering can help avoid accidental and occupational disabilities.

- **Management information.**

A commitment to manage disabilities must include a keen understanding of how a company is spending its disability dollars. An integrated disability management system can help consolidate and coordinate short- and long-term disability and workers comp claims information. Reports must go beyond a simple statement of payments and provide cost/benefit analysis as well as claims frequency and duration studies.

A strong disability management system should also make sure all disability payments meet withholding, depositing and reporting requirements of federal and state tax regulations.

Solid management information enables benefits managers and their advisers to "close the loop" and use the data to design new integrated programs, to identify possible further cost reductions and to design programs to help prevent future disabilities.

These four principles—integration, cost reduction, prevention and management information—set the stage for an effective disability management program that can yield cost savings for employers in the "disability decade."

Disability management programs emerged in the last few years as employers sought a better way to attack the direct and indirect costs of disabilities. No doubt, employers will continue to face these billion-dollar challenges well into the '90s. They will look for increasing support from insurers as they use these new strategies to manage their disability plans as part of a coordinated and cost-effective benefits program. ■



Larry Jenson is assistant vp-long-term disability underwriting at CIGNA Special Benefits Cos. in Philadelphia.

Bus driver's claim for mental injury denied

Legal briefs

To recover workers comp benefits for a psychiatric injury requires an employee to establish that the mental injury was caused by abnormal working conditions, a Pennsylvania court ruled.

Thomas M. Waldo filed a workers comp claim for a mental injury, claiming depression and anxiety while working for a transit authority as a bus driver. He claimed that his injury occurred as a result of being harassed by his employer and fellow employees because of an accident that occurred while he was driving a bus. His treating psychiatrist testified that Mr. Waldo suffered from a mixed personality disorder that caused him to have difficulty with any kind of stress. The evidence revealed that he had previously been awarded disability benefits for depression which he claimed was non-work related. Mr. Waldo's present claim was denied.

On appeal, he argued that the evidence was unequivocal that he suffered from a psychiatric injury.

The court said that the fact that he suffered from a mental disorder was insufficient by itself to entitle him to benefits. To recover benefits, the court observed, he must establish that workplace conditions caused or aggravated his condition. Denial of benefits was affirmed. *Waldo vs. W.C.A.B. (Erie Metro Transit Authority)*, Commonwealth Court of Pennsylvania, Nov. 26, 1990 (*BI*/02/June-$10). ■

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

Hands-on approach revived by recession

By JOANNE WOJCIK

Risk managers at midsized companies are rolling up their sleeves and assuming more direct, hands-on responsibility for certain tasks in response to recessionary pressures, a new survey shows.

Many tasks for which these risk managers formerly had only supervisory or advisory authority, like risk financing and negotiation of coverage placement, became a major part of their job descriptions in 1990, the survey finds. By contrast, only a relative few risk managers at small and large companies saw significant changes in the tasks they directly handle.

However, benefits-related responsibilities continued to move farther out of the realm of risk managers' responsibilities at companies of nearly all sizes.

Those are among the key findings of the survey by Logic Associates Inc., which was released last week at the Risk & Insurance Management Society conference in New Orleans.

The increased responsibilities of risk managers at midsized companies is "directly related to staff size being reduced" in response to the 1990 recession, explained Barry Citron, vp at Logic Associates, a New York-based executive recruiting firm specializing in risk management.

Risk managers at small companies saw fewer changes in their job duties last year, probably because their staff sizes were already small, Mr. Citron explained. And large companies' budgets apparently had the wherewithal to withstand recessionary pressures, he said.

However, the trend toward risk managers assuming more responsibility may be short-lived, according to Bill Perry, president of Logic Associates.

"The risk manager is doing more today than he would have last year because of the economic climate. But as the economy improves, he will hopefully delegate more," he said.

That would be more in line with the 1989 Logic Associates study, which found risk managers delegating more tasks to their staff members (*BI,* May 7, 1990).

"It is still the ultimate goal of the risk manager to delegate, because it's still the only way to get ahead," Mr. Perry observed.

In addition to taking on more tasks, as companies cut back on expenses last year, many risk managers were forced to reduce travel, cut staff size or trim insurance limits, among other things (see story, page 53).

The 1990 Logic Associates survey, which details the varying responsibilities of risk managers at companies of all sizes, is based on the responses of 1,127 risk managers nationwide.

The survey, which also tracks risk manager compensation, provides an important guide to employers creating risk management positions and to risk managers who want to compare their compensation and responsibilities with those of their counterparts at similarly sized companies (*BI,* April 29).

The survey respondents are categorized according to company size, with the smallest companies reporting annual sales of $200 million or less, and the largest reporting annual sales of more than $7 billion.

The survey asked whether risk managers had direct, supervisory, advisory or no authority for a variety of tasks.

An especially noticeable category was that for risk managers at midsized companies with direct, hands-on responsibility, the survey showed.

For example, at companies with annual sales between $1 billion and $2 billion, 82% had direct, hands-on responsibility for risk financing in 1990, up from 64% in 1989.

Only 10% of risk managers at companies in this size category held supervisory or advisory responsibility for risk financing in 1990, down from 15% in 1989.

However, responsibility for risk financing didn't change much at small or large companies.

At the smallest companies—those with less than $200 million in annual sales—51% of risk managers had direct, hands-on responsibility for risk financing in 1990, down slightly from 52% in 1989.

And 28% of risk managers had supervisory/advisory authority for risk financing at this size company, unchanged from 1989.

At large companies—those with more than $7 billion in sales—46% of risk managers had direct, hands-on authority for risk financing, unchanged from the previous

Continued on next page

Risk managers' areas of responsibility

By company sales in millions of dollars

Legend: **Direct, hands-on responsibility** / Supervisory/advisory responsibility

	$0-200	$201-500	$501-1,000	$1,001-2,000	$2,001-4,000	$4,001-7,000	More than $7,000
Risk financing	51% 28%	75 20	63 17	82 10	57 19	81 8	46 11
Negotiation of coverage placement	58 28	61 24	78 14	76 13	69 14	58 17	36 11
Claims handling	45 38	60 27	73 24	50 39	43 55	31 44	14 29
Safety/fire loss engineering	57 34	68 22	43 25	41 40	24 60	31 52	14 39
Data security	50 27	19 54	15 43	8 39	7 40	8 48	11 11
Benefits administration	50 31	41 27	14 21	16 21	7 31	2 21	4 25
Pension/profit-sharing administration	27 38	33 35	13 10	12 12	5 22	4 10	4 18

Source: Logic Associates

GRAPHIC BY CYNTHIA WATSON



Continued from previous page
year. Only 11% of the risk managers at companies this size supervised risk financing last year, down from 20% in 1989.

Risk managers at midsized companies also assumed more direct responsibility for claims handling in 1990.

For example, 50% of risk managers at companies with $1 billion to $2 billion in sales had direct, hands-on responsibility for claims handling in 1990, up from 46% in 1989.

Risk managers at companies in this size category also held more supervisory/advisory responsibility for claims handling in 1990: 39% in 1990, up from 35% in 1989.

However, risk managers at small and large companies were less likely to have direct responsibility for claims handling, according to the survey.

Forty-five percent of risk managers at companies with less than $200 million in sales had direct, hands-on responsibility for claims handling in 1990, down from 56% in 1989. Risk managers at companies this size, however, held more supervisory/advisory responsibility for claims handling: 38% in 1990, up from 32% in 1989.

And at companies with sales exceeding $7 billion, only 14% of risk managers had direct, hands-on responsibility for claims handling during 1990, down from 29% the year before. The percentage of risk managers with supervisory responsibility for the task—29%—was up from 24% in 1989.

Another duty for which midsized risk managers appeared to be assuming more direct, hands-on responsibility was negotiation of property/casualty coverage placement.

Slightly more than three-quarters—76%—of risk managers at companies with $1 billion to $2 billion in annual sales held direct, hands-on responsibility for coverage placement in 1990, up from 71% the year before.

'Corporate America has realized it better get a (benefits) specialist,' says Barry Citron.

And only 13% of risk managers at companies in this size category had supervisory responsibility for coverage placement in 1990, down slightly from 14% in 1989.

Responsibility for coverage placement didn't change much for risk managers at smaller companies, the survey showed.

For example, 58% of risk managers at companies with less than $200 million in sales had direct, hands-on responsibility for negotiating coverage placement in 1990, down slightly from 59% the year before.

And 28% of small company risk managers had supervisory/advisory responsibility for coverage placement last year, up slightly from 27% in 1989.

At larger companies, the percentage of risk managers with direct, hands-on responsibility for coverage placement negotiations decreased, the survey showed. However, they did take on additional supervisory or advisory responsibility for negotiations.

Thirty-six percent of risk managers at companies with sales exceeding $7 billion had direct, hands-on responsibility for coverage placement in 1990, down from 46% in 1989. But 11% of these risk managers assumed a supervisory or advisory role in the task, up from 5% the year before.

While some risk managers were assuming more direct responsibility for certain tasks, fewer risk managers were involved in benefits or pension and profit-sharing administration last year, the survey found.

"The way benefit costs have been skyrocketing, corporate America has realized it better get a specialist" to administer them, according to Mr. Citron.

At companies with more than $7 billion in sales, only 4% of risk manager had direct, hands-on responsibility for benefits administration in 1990, down from 5% in 1989. And, only 25% of risk managers had supervisory/advisory responsibility for benefits administration last year, down from 27% in 1989.

Four percent of risk managers at larger companies also had direct, hands-on responsibility for pension/profit sharing administration in 1990, up from none in 1989. And 18% had supervisory responsibility over pension/profit-sharing administration in 1990, up from 15% the year before.

Risk managers at midsized companies also saw their responsibility for benefits administration decline somewhat in 1990.

For example, 16% of risk managers at companies with $1 billion to $2 billion in sales had direct, hands-on responsibility for benefits administration, down slightly from 17% the year before. And 21% had supervisory/responsibility for benefits administration in 1990, down from 22% in 1989.

Only 12% of risk managers at midsized companies had direct, hands-on responsibility for pension/profit-sharing administration in 1990, down from 15% the year before. And 12% also assumed supervisory or advisory responsibility for the task in 1990, down from 15% in 1989.

While risk managers at small companies saw their responsibility for pension and profit sharing administration decline somewhat, they still have about the same amount of responsibility for benefits administration, the survey showed.

For example, only 27% of risk managers at companies with sales below $200 million had direct, hands-on responsibility for pension and profit-sharing administration in 1990, down from 32% in 1989.

However, 50% of risk managers at these companies had direct, hands-on responsibility for benefits administration in 1990, unchanged from 1989.

Thirty-eight percent of small company risk managers had supervisory or advisory responsibility for pension and profit sharing administration during 1990, up slightly from 37% in 1989.

And 31% had supervisory/advisory responsibility for benefits administration, the same as in 1989.

Other survey findings included:

- Risk managers at large companies took on additional hands-on responsibility for data security during 1990.

Eleven percent of risk managers at companies with more than $7 billion in sales had direct, hands-on responsibility for data security in 1990, up from only 5% the year before.

Another 11% of risk managers at these companies had supervisory or advisory responsibility for data security in 1990, down from 15% in 1989.

- Risk managers at midsized companies were more likely to take direct, hands-on responsibility for safety and fire loss control engineering during 1990, the survey found.

For example, 41% of risk managers at companies with sales between $1 billion and $2 billion had direct, hands-on responsibility for the task in 1990, up from 36% in 1990.

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Copies of the 1990 survey are available for $60 each from Logic Associates Inc., 170 Broadway, Suite 814, New York, N.Y. 10038; 212-227-8000.



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STEAL THE SHOW, YOU CAN'T
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More women enter risk management

21% in top position in 1990, survey finds

More women are entering the risk management field—and reaching the top post, according to a new survey.

"We're seeing more of an influx of women coming into the field than ever before," said Bill Perry, president of Logic Associates Inc., the New York-based recruiting firm specializing in risk management that conducted the survey.

Although more women are entering the field, women currently are more likely to hold lower-level positions in risk management departments than the post of risk manager, Mr. Perry pointed out.

"At lower to intermediate levels, there are tremendously more women than ever before," according to Mr. Perry.

"Of course, it's going to take them some time to develop into the No. 1 position," but they're getting in the door, he said.

Women accounted for about 21%, or 236, of the 1,127 risk managers responding to Logic's 1990 survey, up from 19% the year before (*BI*, May 7, 1990).

In particular, women risk managers are becoming more prevalent in small to medium-sized firms, according to the Logic survey.

"The larger companies—those in the over $7 billion (in annual sales) range—are still lacking women as directors of risk management," Mr. Perry noted.

For example, only 2% of the risk managers at companies with more than $7 billion in annual sales were women, down from 3% in 1989.

However, at companies with less than $200 million in sales, nearly a quarter—24%—of the risk managers were women, up from 22% in 1989.

Other percentages of women in risk management, by company size, include:

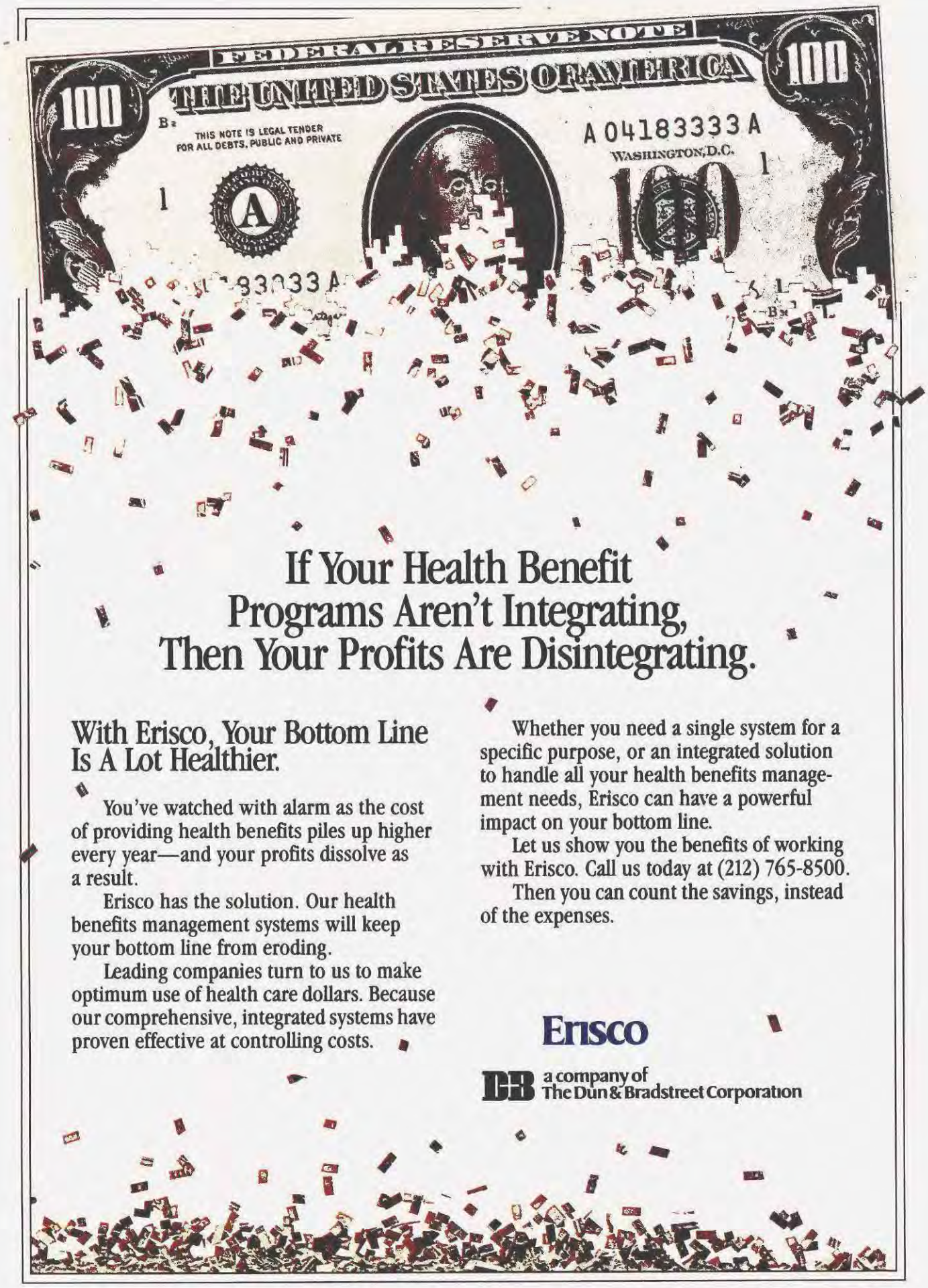
- 28% at companies with $201 million to $500 million in sales, up from 26% in 1989.
- 20% at companies with $501 million to $1 billion in sales, up from 19% in 1989.
- 16% at companies with $1 billion to $2 billion in sales, down from 17% in 1989.
- 13% at companies with $2 billion to $4 billion in sales, down from 14% in 1989.
- 9% at companies with $4 billion to $7 billion, down from 10% in 1989.

Logic Associates also concluded that women risk managers were most prevalent within the financial services industry.

For example, although women overall comprise a slight fraction of risk managers at the largest companies, at financial service firms with more than $7 billion in sales, nearly a third of the risk managers—31%—were women, compared with 26% in 1989, according to this year's Logic survey.

In addition, 66% of the risk managers responding to the survey from financial service firms with $501 million to $1 billion in sales were women, according to the 1990 Logic survey.

—By Joanne Wojcik



More ARMs, CPCUs at big firms, survey says

Risk managers at larger corporations are more likely to have earned professional designations than their counterparts at smaller companies, according to a new survey.

This may indicate that risk managers who further their education are more likely to move to better-paying positions at larger firms, the survey's authors say.

"The eagerness of risk managers to achieve these goals will help set them apart from other talented risk managers," observed Barry Citron, a vp at Logic Associates Inc., a New York-based recruiter specializing in risk management that conducted the survey.

Logic tracks risk managers' education as part of its annual salary survey (*BI*, April 29).

Risk managers at midsized and larger companies are more likely to have one of two designations, the survey found: the Associate in Risk Management designation awarded by the Insurance Institute of America; or the Chartered Property & Casualty Underwriter designation awarded by the American Institute for Property & Liability Underwriters. Both organizations are based in Malvern, Pa.

For example, at companies with $2 billion to $4 billion in annual sales, 42% of risk managers had an ARM designation while 31% had the CPCU designation.

And, at the largest companies—those with more than $7 billion in sales—34% of risk managers had an ARM designation while 26% had a CPCU.

In contrast, at the smallest companies—those with sales of less than $200 million—29% of risk managers had an ARM designation, but only 9% had a CPCU.

Following are the percentages of risk managers with professional designations at other-sized companies:

- At companies with $201 million to $500 million in sales, 28% had an ARM, while 12% had a CPCU.
- At companies with $501 million to $1 billion in sales, 38% had an ARM, while 19% had a CPCU.
- At companies with $1 billion to $2 billion in sales, 37% had an ARM, while 31% had a CPCU.
- At companies with $4 billion to $7 billion in sales, 38% had an ARM, while 16% had a CPCU.

—By Joanne Wojcik

Insider trading

Aon Corp.: Harvey N. Medvin, vp, disposed of by gift 800 shares of common stock at an unreported price per share on March 22, and indirectly acquired by gift 400 shares of common stock at an unreported price per share on that same day.

Mr. Medvin now directly and indirectly holds a total of 302,730 shares.

Aon stock was trading at $38.25 on April 26.

Arthur J. Gallagher & Co.: Peter J. Durkalski, vp, disposed of by gift 585 shares of common stock at an unreported price per share on Feb. 4, and indirectly acquired by gift 585 shares of common stock that same day.

Mr. Durkalski now directly and indirectly holds a total of 24,585 shares.

Gallagher stock was trading at $25.00 on April 26.

Hilb, Rogal & Hamilton Corp.: Andrew L. Rogal, officer and director, indirectly acquired by gift 5,400 shares of common stock at an unreported price per share on Nov. 19, 1990.

Mr. Rogal now directly and indirectly holds a total of 61,076 shares.

Hilb stock was trading at $15.75 on April 26.

Lincoln National Corp.: John P. Cole, officer of subsidiary, sold and disposed of by gift 436 shares of common stock between $52.06 and an unreported price per share on May 5, 1990.

Mr. Cole now directly and indirectly holds a total of 1,848 shares.

Lincoln National stock was trading at $51.13 on April 26.

Marsh & McLennan Cos. Inc.: John M. Regan, director, sold 10,000 shares of common stock at $83.63 per share on March 17.

Mr. Regan now directly and indirectly holds a total of 135,502 shares.

M&M stock was trading at $78.63 on April 26.

NAC Re Corp.: Donald Kramer, chairman, sold 116,500 shares of common stock at $36.75 per share on March 27, and now directly and indirectly holds 276,938 shares.

NAC Re stock was trading at $41.00 on April 26.

Sears, Roebuck & Co. (Allstate Insurance Group): Sears Savings & Profit Sharing Fund, beneficial owner, purchased 291,400 shares of common stock at between $30.94 and $35.37 per share from March 1 to March 6, and now directly holds 4,450,050 shares.

Sears stock was trading at $37.63 on April 26.

USF&G Corp.: John Maynard Hart, officer, purchased 10,000 shares of common stock at $9.38 per share on March 4, and now directly and indirectly holds 10,050 shares.

USF&G stock was trading at $12.00 on April 26.

U.S. Healthcare Inc.: Leonard Abramson, president, exercised an option for 29,630 shares of common stock at $5.63 per share on March 4, and now directly or indirectly holds 1,822,417 shares of common stock and 4,771,329 shares of class B common stock.

Hyman R. Kahn, vp, sold 10,000 shares of common stock at $41.25 per share on March 5, and now directly and indirectly holds holds 183,081 shares.

Costas C. Nicolaides, vp, exercised an option for 8,000 shares of common stock at $5.63 per share on March 5, and now directly and indirectly holds 28,000 shares.

Jay R. Rosan, vp, sold 3,000 shares of common stock at $46.63 per share on March 19, and now directly and indirectly holds 94,645 shares.

Marshall V. Rozzi, officer, exercised an option for 17,500 shares of common stock on March 4, and sold 4,000 shares of common stock at $13.75 per share on Dec. 22, 1989, and now directly and indirectly holds 33,500 shares.

Neil Schlackman, officer, exercised an option for 5,833 shares of common stock between $5.63 and $5.25 per share on March 1 and now directly holds 12,833 shares.

U.S. Healthcare stock was trading at $50.00 on April 26.

●

Insider Trading, compiled by Invest/Net Trading Group Inc. from reports filed with the Securities and Exchange Commission, tracks stock sales and purchased by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

Managers' work load increases

Many risk managers were forced to take on more responsibility last year due to recession-induced budget cuts, a new survey shows.

Most risk managers faced with budget cuts reduced their spending by curbing travel, which forced them to spend more time in the office attending to tasks they normally would delegate.

And some risk managers even made staff cuts, which further increased their workloads, the study conducted by Logic Associates Inc. showed.

When risk managers reduce their travel time while also reducing their support staff, they spend more time doing the things they normally would assign to someone else, pointed out Barry Citron, vp at Logic, a New York-based recruiting firm specializing in risk management.

Logic President Bill Perry agreed: "Many risk managers' duties increased because of the recession."

A total of 942 risk managers responded to Logic's "Recession" survey, which was included in its annual salary survey.

The recession also adversely affected risk managers' total compensation (see story, page 1).

Approximately 38% of risk managers responding to the recession survey indicated that their risk management budgets were reduced for 1990.

In addition, 42% of the risk managers responding to the survey indicated that their job responsibilities changed during 1990.

Of those whose responsibilities changed, 77% said they increased.

When Logic asked risk managers how they reduced their risk management budgets during 1990, the vast majority—78%—said they cut back on travel.

Other popular methods to absorb the cutbacks were:

- Reducing conference attendance, cited by 68%.
- Increasing deductibles or self-insured retentions, 37%.
- Changing insurers, 34%.
- Reducing staff, 31%.
- Reducing consulting work, 29%.

In addition, 11% of risk managers reduced their companies' insurance limits; 15% reduced spending on safety training; 8% cut back their safety equipment budgets; 19% delayed installation of a risk management information system; and 15% put off upgrading their RMIS.

—By Joanne Wojcik

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Guaranteed investment contracts

Executive Life Insurance Co. troubles top list of GIC industry concerns

By JUDY GREENWALD

PHOENIX—Executive Life Insurance Co.'s problems, the survival of book value accounting and pension plan sponsors' fiduciary liability are among the major issues the guaranteed investment contract industry faces, a major GIC manager says.

GIC

The Executive Life situation "hits us all," even plans that never purchased any GICs from the insurer, said Vernon S. Hodge, president of PRIMCO Capital Management Inc. of Louisville, Ky.

"If that's not a major issue today, then you've never been anywhere," Mr. Hodge said at a session called "How Far Beyond Today Do We Venture?" at GICs '91-The Fifth Anniversary Symposium, a conference sponsored by the New York-based Institute for International Research in Phoenix last month.

California regulators have placed First Executive Corp.'s largest unit, Executive Life Insurance Co. of California, into conservatorship, while New York regulators have placed Executive Life Insurance Co. of New York into rehabilitation (*BI*, April 29; April 22; April 15).

While Executive Life in California has commenced paying some death benefits and annuitants under a court order, the insurer has ceased paying holders of GICs.

"This really affects us all," Mr. Hodge said. The short-term advantage of not having been involved "won't help if the industry gets slayed," he said.

The solution to avoiding any future problems is simple, according to Mr. Hodge: "Quit buying anything risky."

Everyone who bought Executive Life GICs thought there was some risk there, but purchased them nevertheless because they provided a premium return.

However, plan participants simply do not care if they have a return of 8.65% as opposed to 8.85%, Mr. Hodge said. "They just don't care."

Mr. Hodge also noted that plan sponsors may be starting to consider guaranteeing GICs in the event of insurer insolvency. But, he advised against this, unless employers are also willing to report the GICs' value as a contingent liability on their balance sheets.

The biggest problem the GIC industry faces today, though, is the threat to book value accounting, according to Mr. Hodge.

Book value accounting allows employers to report to employees that their contracts are valued at the interest and principal due at maturity.

However, the Financial Standards Accounting Board last month preliminarily voted to require that GICs held by defined benefit pension plans be accounted for at market value.

At issue is whether this ruling will eventually be extended to defined contribution plans, like 401(k) plans.

That would force employers to report to employees the fluctuating values of their GIC investments. Plan sponsors fear this could cause employee anxiety and reduce the popularity of GICs (*BI*, March 11).

The problem is not with FASB, but with the industry's response to the threat, Mr. Hodge said. He criticized the industry for making only a "half-hearted" attempt to save book value accounting to date.

"I think we made a poor, misguided effort to protect" book value accounting and it has cost the industry credibility, he said. The industry should have taken a different approach, he said.

Mr. Hodge called for those in the industry to join forces on this issue.

He also said that employees must be encouraged to consider GICs, whatever FASB does. "Employees still want these things," he said. The challenge is finding a way to make them work.

Another big issue is the "G word": The "guaranteed" in guaranteed investment contract, according to Mr. Hodge.

This word "should go away," he said, adding that the industry would be a "whole lot better off" without it.

"The word 'guaranteed' has a terrible, terrible meaning," he said. The term confuses the participant, and the issue then becomes whether the plan sponsor tried to confuse the participant.

Better, less misleading terms would be "predictable return fund" or "protected return fund," he said.

These terms better convey the meaning of GICs: secure, systematic return funds that go up in value all the time, Mr. Hodge said.

The GIC industry also must begin helping plan sponsors assist participants in selecting their fund options.

"I believe we'll see some dramatic changes in what sponsors must tell about options," he said, referring to the latest proposed 404(c) rules from the Labor Department. Those proposed rules lay out the type of investment options employers must offer to participants of defined contribution plans, like 401(k) plans, to avoid fiduciary liability for participants' investment decisions (*BI*, Dec. 24, 1990).

He said he hopes that plan sponsors will be required to better inform participants about the riskiness and reward of each investment option.

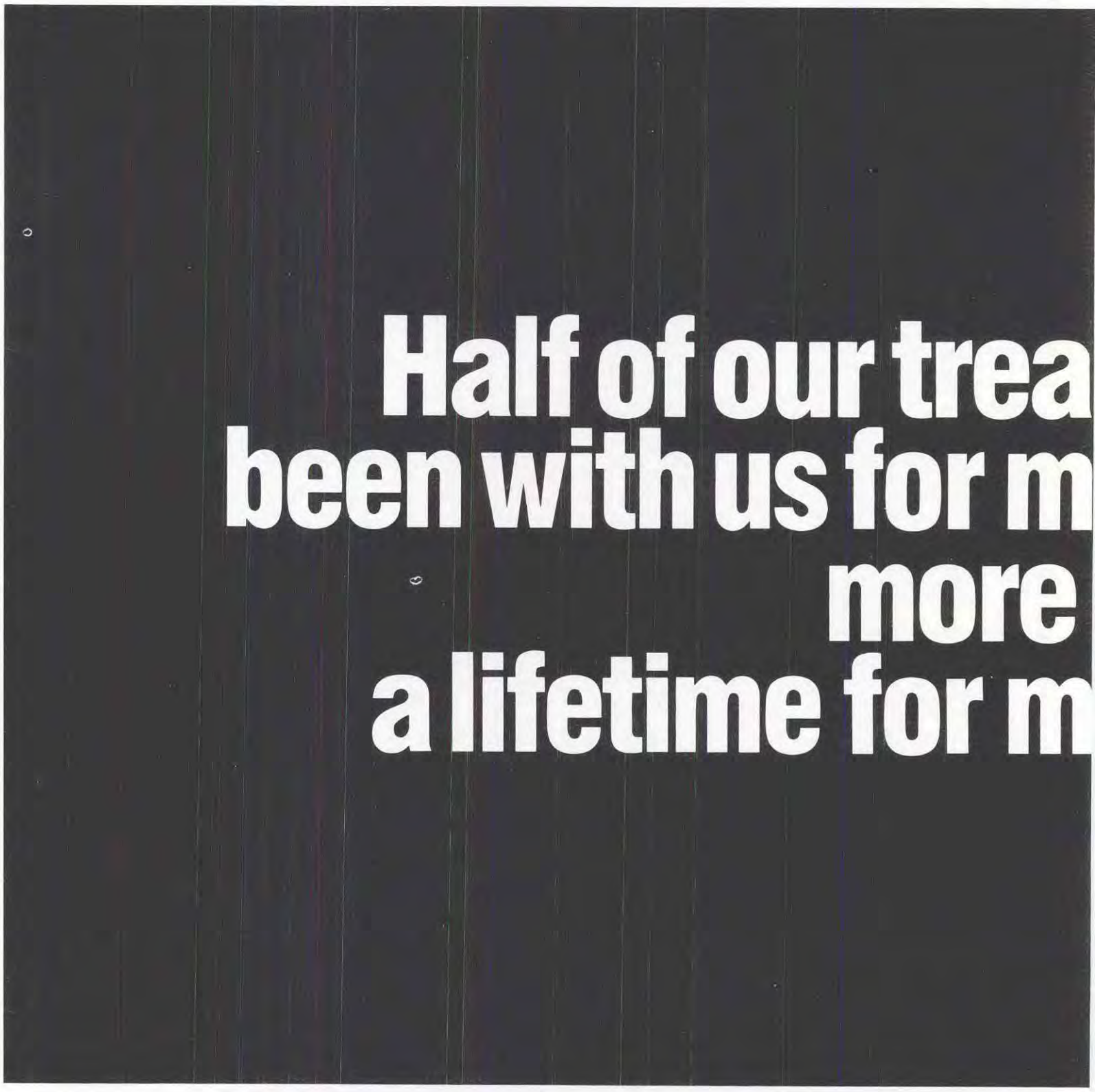
"You're going to see the need to have more efficient communication," he predicted.

He also believes that the use of software will be touted to model how assets should be invested.

Mr. Hodge said that some of the changes he has described are good, and some are not so good, and maybe the industry was responsible for the latter. But "the key issue is that change has occurred" and will continue to occur, he said.

GICs have grown up. The industry can either move in the right direction, or it can fight change. "Don't be left at the post," he advised the GIC market. "I urge you to be out in front leading the charge."

There was no moderator for the session. ■



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Public confidence in insurers slumps

By JUDY GREENWALD

PHOENIX—Employers must restore defined contribution plan participants' confidence in guaranteed investment contracts in the wake of the highly-publicized problems with two First Executive Corp. units and other negative publicity about the insurance industry, a GIC manager asserts.

GIC

"There's a substantial number of people who feel that the quality (of the insurance industry) has deteriorated drastically" and that insurance companies "are about to follow the savings and loans and the banks in their failure experience," said J. Thomas Morrow, an executive vp and director of research and development at Morley Capital Management Inc. of Oswego, Ore.

How did the public get this perception? Mr. Morrow asked at a session called "Coping with the 'Public Perception' of Risk in the GIC/BIC Market" at GICs '91-The Fifth Anniversary Symposium, a conference sponsored by the Institute for International Research in Phoenix last month.

"People were preconditioned by failures in the other financial areas of our economy," he said.

This situation was aggravated by an "irresponsible, sensationalist and uninformed media" that extrapolated data about a few weak insurers and applied it to the entire insurance industry, he said.

Ralph Nader and others then entered the fray following "their own agenda," he said.

Is the perception true? Mr. Morrow asked. Is the entire insurance industry "going to hell in a handbasket?"

No, it is not, he maintained.

There are some weak insurers that may fail, he acknowledged. But even Executive Life Insurance Co., First Executive's largest and most troubled unit, is still only in conservatorship, he pointed out.

Certainly, it is in the GIC industry's interest to present the high overall quality of GIC and bank investment contract issuers and to restore plan participants' confidence by giving them the "true story," Mr. Morrow said.

GICs should play a strong, continuing role in plan participants' investments, because they provide participants the security necessary to sleep at night, Mr. Morrow. As a result, "it's important to improve the perception of insurance companies and banks" among plan participants, he said.

Communications is an element in accomplishing this, Mr. Morrow said.

Morley Capital, for instance, responds to articles on the subject and also releases its own newsletter and other material, he said.

It also encourages its staff to contribute articles about areas in which they have expertise to various publications, Mr. Morrow said.

"We've been very successful in communicating to our constituencies," he said, adding that Morley Capital tries to provide them with timely, quality "well-thought out information."

As far as public perceptions of the GIC industry are concerned Coca Cola Enterprises Inc. "is very reluctant right now to take any chances on the credit quality of its GIC issuers," said Belinda A. Brady, pension fund manger for the Atlanta-based unit of The Coca-Cola Co.

The company has combined defined benefit and defined contribution plan assets of $400 million with a total of 12% of its defined benefit plan assets, or about $31 million, invested in GICs.

Coca Cola Enterprises does not envision adding to them, she said.

A total of 46.4% of its savings and investment plan assets, or about $63 million, is invested in fixed fund investments, much of it GICs, Ms. Brady said.

Other investments are in Coca Cola Enterprises and Coca Cola Co. stock, as well as a small loan account, Ms. Brady said.

The company is planning to add a stock index fund this year and is considering another fixed income fund as well, she said.

As of December 1990, the savings and investment plan had 9,800 participants, or about 63% of the eligible population, but the company would like to increase that number, Ms. Brady said.

The company's investment committees are "very concerned" about the quality of the insurers that issue its GIC contracts, Ms. Brady said. The committees ensure that only issuers with the highest credit ratings are used, she said, noting insurers must have an A+ rating from A.M. Best Co.

Even so, she said, no more than 15% of the GIC fund's assets can be invested with a single insurer, or up to 20% if the insurer also has top ratings from Standard & Poors Corp. and Moody's Investors Service Inc.

Ms. Brady said that as of Feb. 28, 57% of the company's fixed fund insurers had all three of these top ratings. And since the beginning of 1990, insurers with all three top ratings have accounted for 79% of the company's GIC placements, a total of $23 million.

Ms. Brady noted that the company is considering adding another fixed income account because of the possibility of capacity problems created as a result of using only top-rated insurers. One possibility is an actively-managed bond fund. It is also considering investing in bank investment contracts, she said.

Ms. Brady said Coca-Cola Enterprises has received only a few employee inquiries concerning the credit quality of its GIC issuers.

But, the company has decided not to give employees details about its fixed income investments, which "so far seems to be working," Ms. Brady said.

The company believes that employees should have faith in senior management on this issue.

"We don't see the need" to divulge additional information to plan participants, although "that could change in the future," she said.

In response to a question about whether this policy increases the company's potential liability, Ms. Brady said the company's attorneys are aware of its policy and "they don't see a problem with it."

Meanwhile, Larry A. Brossman, vp with Chicago-based Duff & Phelps Crediting Rating Co., said he does not understand how "people who have never spent any time in the business are coming up with solutions to its problems."

Mr. Brossman observed that he has been in the insurance industry 30 years and still does not completely understand it.

Discussing past insolvencies of

Continued on next page

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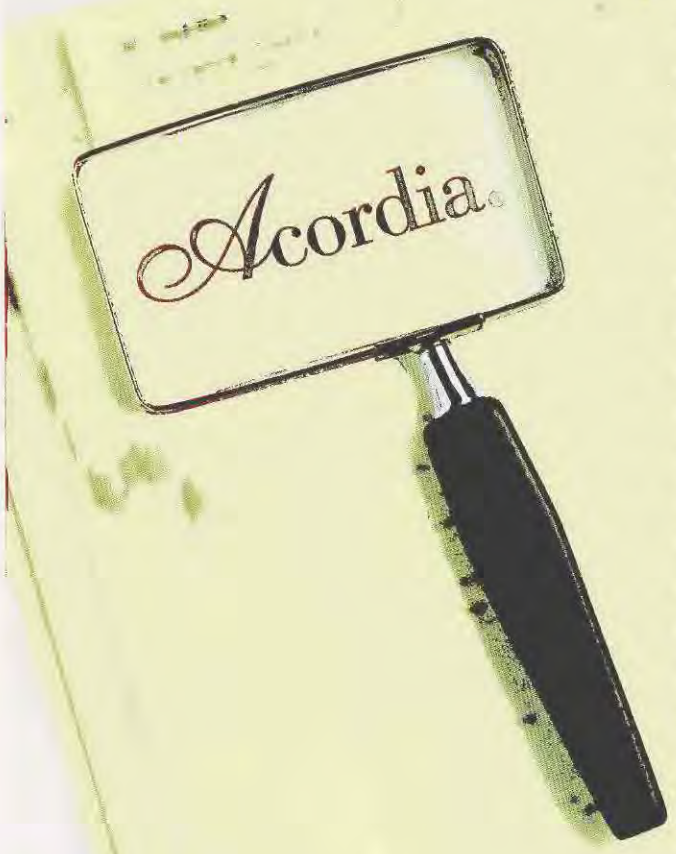
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Public confidence

Continued from previous page

several insurers, Mr. Brossman said it was the insolvencies of Baldwin-United Corp. units that gave rating agencies like Duff & Phelps the impetus to get into the business of monitoring insurance companies.

He also warned there are five or six insurers today, which he refused to identify, that "could have serious financial difficulties, and they are major companies."

Mr. Brossman said that rating agencies' responsibilities in this area are to, among other things:

- "Make sure your ratings are prospective in nature." Some insurers have the attitude that if they had a good year, they should get a good rating. But ratings should not be based on past performance. Ratings should be a "predictive tool for the future," he said.
- "Get the rating right the first time." If a company is properly rated the first time around, the rating will not jump up and down, which can be confusing, he said.
- "Provide timely information." Information obviously should be current and disseminated to people as soon as possible, Mr. Brossman said.
- "Produce reports that are useful and understandable."

Among rating agencies' responsibilities to insurers, Mr. Brossman said, are to:

- "Use methodology that can be explained."
- "Be worthy of the confidence of the rated company's management." The rating agency must have access to management to rate the company, Mr. Brossman said.
- "Be prompt in your ratings and reports."
- "Support your ratings with useable, understanding reports and have your analysts available" to an insurer's management to answer questions.

Mr. Brossman also delineated what he feels is the value of claims-paying ratings:

- It is a good methodology for evaluating insurance companies.
- The ratings are responsive to current changes.
- It provides a basis for cross-industry comparisons. GICs, for instance, can be compared with long-term certificate of deposit ratings.

However, there are certain things that rating agencies do not do, Mr. Brossman pointed out.

For example, they do not tell the public which company has the best product, either in terms of rate or features.

"Some of the highest-rated companies have the poorest products," Mr. Brossman observed.

A rating agency also does not inform the public which company has the best client service and support, he said.

"We are not 'Consumer Reports,' " he summed up.

Mr. Brossman said the insurance industry is strong in comparison to other financial institutions.

"It's a double-A industry," he said, adding that the possibility of an A-rated insurer going into default is "somewhat remote."

At the same time, however, "there are real differences among insurance companies in their financial strength, and these differences are widening," Mr. Brossman said.

Real estate and junk bonds continue to be a question mark in some insurers' investment portfolios, and there will continue to be opportunities in these investment areas and pressures to use them, Mr. Brossman said.

"There clearly is a perception of risk and what we need to do is deal with it," said John E. Milberg, vp-pension investment products for Pacific Mutual Life Insurance Co.

Pacific Mutual has a policy of educating the public about its financial integrity through a due diligence report it distributes that outlines information about, among other things, the company's organization; capital management strategy; investment portfolio and asset/liability management.

"We like to make as much information available as we can," Mr. Milberg said. "We pay a lot of attention to the due diligence process."

There was no moderator for the session. ■

Debate continues on use of outside GIC management

By JUDY GREENWALD

PHOENIX—Using an outside guaranteed investment manager rather than having staff place GIC contracts is worth the peace of mind it provides, according to a defined contribution plan sponsor.

GIC

"The basic question is a somewhat contentious topic," observed David K. McNiff, director of investment management for GenCorp Inc. of Fairlawn, Ohio, at a workshop called "Conducting a Management Search" at GICs '91-The Fifth Anniversary Symposium. The conference, held in Phoenix last month, was sponsored by the Institute for International Research.

Indeed, at last year's GIC seminar there was a heated debate on the pros and cons of using a GIC manager (*BI*, April 23, 1990).

"My own views have undergone a significant change over the past couple of years," Mr. McNiff said. He noted that when he joined GenCorp nearly two years ago, the firm was already in the process of selecting a GIC manager. "I would have said, 'Don't waste the money. We can do it all ourselves,' " he said.

But the firm nevertheless hired a manager.

And, "I'm very relieved we took that course," Mr. McNiff said, adding that he endorses this course for other firms as well.

A spate of press stories in recent years has suggested the impending collapse of insurance companies, he noted. So, the "relative peace of mind" that using an outside GIC manager provides alone makes the fees money well spent, he said.

Mr. McNiff said he does not know whether he would have purchased a contract from any First Executive Corp. unit if GenCorp had not hired a manager. But, the manager did impose tougher guidelines and criteria for selecting a GIC writer than GenCorp previously used. "So, we didn't have to face the problem," he said.

Mr. McNiff said he does not want to leave the impression that GIC management cannot be done in-house in a satisfactory and professional manner. But, he added, he now has greater respect and appreciation for outside firms that perform this function.

He noted that many defined contribution plan sponsors would have no qualms about using an outside manager to manage its indexed equity portfolio, even though it could

Continued on next page

Outside manager

Continued from previous page

be argued that this involves no management skills. The parallel is also true for GICs, Mr. McNiff asserted.

Mr. McNiff, who did not identify his firm's GIC manager, said that selecting the right manager was in some ways easier than picking an equity manager because there are fewer GIC managers.

Among the criteria GenCorp used in selecting a management firm was the size of assets under management; its experience; and the extent to which it had support from affiliated companies. Mr. McNiff explained that GenCorp thought there would be ancillary benefits in picking the subsidiary of a larger financial services organization because the manager's affiliates could provide advice on other plan investments.

GenCorp then selected a group of finalists and reached a consensus on a choice.

The final decision was reached by listening "to a small voice" that suggested a particular manager based on its investment philosophy and perhaps its personal style.

Mr. McNiff cautioned that no matter how skilled an outside consultant may be in helping select a GIC manager, "nobody knows you better than you." So the defined contribution plan sponsor must make the final decision itself, he said.

"We reached our own decision," Mr. McNiff said, though GenCorp used a consultant.

Among other reasons GenCorp uses an outside manager is the company's concern that its contracts be placed with issuers with strong credit quality.

Another major factor is the fiduciary liability issue. The Employee Retirement Income Security Act of 1974 states that employers can limit their fiduciary liability provided they prudently select an external manager.

The credit and fiduciary issues are "inextricably linked," Mr. McNiff said. A GIC manager must be a fiduciary and provide credit services as well, according to Mr. McNiff.

David C. Veeneman, a principal with William M. Mercer Asset Planning Inc. in Louisville, Ky., said that a GIC manager should provide the plan sponsor:

- Portfolio administration services.
- Assurance of a GIC writer's credit quality.
- Insulation from fiduciary liability.
- Portfolio engineering.
- Value-added management, or management that produces higher returns.

Mr. Veeneman also said that a GIC manager should be a "brand name" firm so plan participants feel confident that a well-known manager is handling their investments.

Mr. Veeneman noted that among the elements of risk to be considered in a GIC portfolio are credit risk, liquidity risk and maturity date risk—the risk that all contracts mature and funds must be reinvested at a time when interest rates are low.

But, while GIC managers are appropriate for some plans, "for others, it wouldn't work," Mr. Veeneman said.

Furthermore, all GIC management firms are not the same, Mr. Veeneman stressed. There are differences in how they are run and how their decisions will affect the plan sponsor's investment portfolio, which should be a major factor in selecting a manager.

Mr. Veeneman said there are two major styles of GIC management.

Under the index management philosophy, the manager structures the portfolio to minimize all elements of risk and to maximize return within the risk constraints.

The active GIC manager, however, takes a greater degree of investment risk to produce incremental returns, although the risk must be controllable and prudent to pass muster under ERISA. This manager would be expected to produce higher returns than the index manager.

To determine which approach is appropriate, a plan first must determine its objectives, Mr. Veeneman said. That decision, he added, can be based answers to several questions:

- What degree of risk is acceptable?
- What types of risk are acceptable?
- How will the risk will be measured?
- How will the value added by the GIC manager be measured?

Mr. Veeneman advises plans to determine the differences between managers, to match managers to plan objectives and to act accordingly.

For example, if a primary objective is being insulated from fiduciary liability but an active plan manager is selected, the plan sponsor may want to monitor the GIC manager more closely than it would an index manager to avoid fiduciary exposure.

If the plan sponsor's primary objective is portfolio administration, it would want to be sure that a GIC manager's fees are commensurate with the administrative services it provides.

Mr. Veeneman said other considerations in selecting a manager, include:

- Historical performance.
- Issuer quality research capabilities.
- Fees.
- Organization and staffing.
- Professional turnover.
- Capitalization.
- Client base.

Mr. Veeneman suggested that to measure performance after a GIC manager has been selected, plan sponsors should look at the absolute level of risk taken on and the level of return generated by that assumption of risk. The amount of risk should be in line with the plan's objectives.

Can a plan sponsor manage its portfolio in-house as well as an outside manager? Mr. Veeneman asked. "Yes," particularly if it adopts an index style of management, he replied.

However, there are other considerations, he said.

For example, an in-house manager may have competing priorities. And active managers can add value, he said.

And, even an outside index manager can be cost effective for the plan manager, he said.

There was no moderator for this session. ■

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Warn workers of low GIC returns: Experts

Proposal expands employers' duties

By JUDY GREENWALD

PHOENIX—Employers should warn their employees that guaranteed investment contracts generate a much lower return for their defined contribution plan investments than do stocks, two investment experts say.

GIC

With this information in hand, employees then can make their own informed decisions, the experts say.

"Just because they're popular doesn't mean they're good," said David T. Jack, a senior consultant in Pittsburgh with TPF&C, a benefit consulting unit of Towers, Perrin, Forster & Crosby Inc.

Under the Labor Department's proposed 404(c) regulation, the employer would be required to provide enough information to help the employee make an informed investment decision (*BI*, Dec. 24, 1990), Mr. Jack noted at a session called "Meeting the Investment Needs of Plan Participants: The Role of GICs in Defined Contribution Plans" at the GICS '91-The Fifth Anniversary Symposium in Phoenix last month. The conference was sponsored by the Institute for International Research.

Key characteristics that plan sponsors must inform participants of include the nature of their defined contribution holdings, the risk involved "in a way that the participant can digest," the return and the need for diversification.

Mr. Jack noted that according to the proposed 404(c) regulation, if the assets of the insurer issuing the GIC are diversified, then the GIC is diversified as well.

But Mr. Jack said he does not believe there is substance to that concept. GICs are, in fact, an undiversified investment, he said.

Among their other characteristics is a fixed, relatively low return, he said. "What's guaranteed is the low return," he observed.

GICs also normally do not have market value fluctuation and may have good liquidity.

Mr. Jack then compared GICs to stocks as an investment.

"Stocks have a relatively high return," he said, noting there is a total return of 11% for stocks, compared with just 8% for GICs. "The difference between eight and 11 over time is almost unbelievable," he said.

Mr. Jack noted that given a 4.5% inflation rate, stocks generate a real return of 6.5% while GICs generate just a 3.5% return.

The value of stocks grows faster than the rate of inflation, while GICs have "low returns relative to other asset classes, particularly relative to stocks."

Mr. Jack also discussed the difference in returns between equity and GIC investments over a 20-year period. "There's a dramatic, real, meaningful difference," he said.

"Everybody knows stocks are risky," he said. But, over a 25-year period, there is an 80% chance stocks will perform better than GICs in their returns, he said.

"When stocks do well, they do incredibly well," he said.

But, referring to the 20% chance that GICs will perform better than stocks, he said: "When GICs do better, they only do a little bit better."

For long-term investors, stock investments provide "a tremendous upside that makes a big difference when people retire," he said. However, defined contribution plan participants generally are very naive regarding investment risk and are extremely risk averse, he noted.

And plan design usually encourages low-risk investment classes like GICs. "There's a strong conservative bias in the design and communication of most of these plans," he said.

Education, said Mr. Jack, can change participant attitudes.

He noted, however, that plan sponsors will not provide personal investment advice, even though "there's no reason they couldn't or shouldn't."

GICs are a "good, stable asset class" and they are "useful as part of a diversified, low-risk fixed income investment option," Mr. Jack said.

Yet there are problems with the contracts. Among them: the difficulty of diversifying them; contract provisions often are misunderstood; and there is general confusion about the "G word"—guaranteed, he said, because GICs are only as good as the insurer that backs them.

In addition, they are not liquid in some circumstances, Mr. Jack said.

"It's not in the interest of plan sponsors to have people walk out the door with low account balances," he said.

But, "from the participant's point of view, the concept of risk can dominate" the investment decision, observed Michael G. Odlum, director of guarantee investment services at The Vanguard Group Inc. of Valley Forge, Pa., which offers GICs and a range of other investment options.

As a result, participants want to invest in GICs because of the short-term perceived benefit of safety and stay away from equities.

However, "what can get lost in the process" is that over the long run, GICs are likely to generate lower real returns than other investments, Mr. Odlum said.

As a result, participants "make long-term decisions on the basis of short-term fears."

"Our approach has been to educate the participant concerning the investment choice," Mr. Odlum said.

Vanguard presents the facts to participants in funds it manages, offers historical risk/return information, illustrates its information with sample investment mixes and extrapolates hypothetical real returns, he explained. "As long as this process occurs, we have done our job," he said.

Mr. Odlum said that in approaching participants, the factors that should be discussed are:

- Their investment objectives.

Mr. Odlum said participants should be led through a "logical thought process" to determine their goals.

- Their investment time frame.

This time frame could be long or short, depending on factors like age, amount of time until retirement and how much money they have invested so far.

- How they identify their risk tolerance.

Participants should be given a sense of the risk connected with fixed income investments like GICs and compare it with stocks and bonds. The rewards of these investments should be discussed as well, Mr. Odlum said.

- Possible other savings and in-

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vestments besides GICs.

"Plan sponsors owe it to participants to provide such information" without overwhelming them "to the point of confusion," he said.

But, even after plan participants' education process is completed, there are still a significant number of participants who decide to invest in GICs, "and it's appropriate for some of them."

Mr. Odlum said that GICs can play an important role in meeting plan participants' needs, "as long as it's within the framework of an overall investment approach."

Meeting plan participants' needs is the "most significant challenge" facing the GIC industry today," said Michael W. Neal, a financial adviser in the investment administration area of Eli Lily & Co., noting he was speaking as a plan sponsor, a GIC manager and plan participant.

The GIC market structure from a consumer marketing perspective has a pyramid shape, Mr. Neal observed. "At the top is the product, in our case, the GIC," Mr. Neal said. This also includes all products targeted to meet investment needs, he said.

This is followed, in descending order, by the GIC manager and the plan sponsor, with the plan participant at the pyramid's base, he said.

"The symbolism here is very important. The participant is the foundation of the market structure: the reason it exists," he explained.

Mr. Neal said that theory suggests young, well-informed consumers should be willing to accept higher levels of risk for higher levels of return. Therefore, a greater percentage of younger consumers than older consumers should participate in equity investments, he said.

But, while there is some trend in this direction, it is "not a significant one," he noted.

Narrower spreads and more risk threaten 'the very survival' of GICs, says Michael W. Neal.

GICs are the overwhelming choice for participants in all age groups.

In the past, GICs offered significant interest rate spreads over U.S. Treasury notes and there was little perception of risk, he said.

However, now that the spreads have narrowed and the perceived—if not actual—risk is greater, it is important that the participant believe that GICs add value, he said.

Without the ability to communicate this, "the very survival of the product is at risk," Mr. Neal warned.

This suggests, he said, that the GIC industry must:

- Protect the trust that has been established between the consumer and the GIC product.

The industry also must continue its efforts to strengthen its capital position and advisers and consultants must help build "sound, secure portfolios," he said.

- Be competitive.

"A competitive marketplace is probably the best mechanism to ensure participants receive fair value," Mr. Neal said.

- Be innovative.

Innovation "is the key to the future growth of the industry," he asserted. New products and techniques "can breathe new life into the industry."

Even if the industry loses the ability to account for GICs on a book value basis, the need for a safe and attractive investment will still remain.

For their part, plan sponsors should advise participants, he said.

Mr. Neal quoted a philosopher as saying: "Education should be as gradual as a moonrise: perceptible not in progress, but in result."

"This suggests a challenge to the plan sponsor to educate the participant," not in a manner that is easy and quick, but one that should produce results, Mr. Neal explained.

In the past, the GIC industry developed safe, secure investments with attractive returns, according to Mr. Neal.

But today, the industry faces hard issues, Mr. Neal said. He said he hopes "we keep our focus on the reason the industry exists—to meet the needs of the participant."

Marc Katz, vp in the New York office of Morley Capital moderated the session. ■

404(c) rules praised by GIC issuer

By JUDY GREENWALD

GIC

PHOENIX—The latest Department of Labor proposed guidelines on how employers can avoid fiduciary liability for investment decisions made by employees enrolled in defined contribution plans are meaningful, thoughtful standards, says a guaranteed investment contract writer.

The latest proposed 404(c) rules (*BI*, Dec. 24, 1990) are the third—and best—set of rules from the Labor Department in five years on the investment options employers must provide when offering defined contribution plans, like 401(k) plans, said Judith Markland, vp for group pension guaranteed product services for Boston-based John Hancock Mutual Life Insurance Co., a major GIC issuer.

"There's enormous progress here," Ms. Markland said at GICs '91-The Fifth Anniversary Symposium, which was sponsored by the Institute for International Research here earlier this month.

"I think these are workable regulations" that are well-intentioned, she said.

The comment period for the proposal ends May 13. If there are no substantial comments, the standards could be finalized shortly after that, said Ms. Markland.

Under provisions of the proposed 404(c) regulations:

- Employers would have to offer a "broad range of investment alternatives" for defined contribution plans, including at least three diversified investment categories, each with different risk and return characteristics.

The Labor Department wants sponsors to offer investment options that will perform differently in different economic environments, Ms. Markland explained.

She noted that many defined contribution benefit plans now offer a GIC option and two stock plans, like an index plan and a more aggressive stock fund. While a plan like that features different investment risk/return approaches, it would not meet the requirement for three diversified investment categories.

However, a plan that offered a GIC fund, a Standard & Poor's 500 fund and a real estate fund would meet the requirement, she said.

The proposal does not specify precisely what investment options should be offered, which permits innovation and flexibility, Ms. Markland said approvingly.

- Plan participants must be able to switch their investments at least once every quarter.

The proposal states that the investment's risk should determine

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404(c) rules

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the frequency of such transfers, and it lets the market establish those standards, according to Ms. Markland.

For example, plan participants investing in relatively volatile commodity futures should be permitted to transfer their funds more frequently than those invested in certificates of deposit or money market funds, she said.

- There should be meaningful participant control.

Participants must have the opportunity to diversify investments generally and within investment categories.

But, this provision does not require employers that offer a GIC to also offer a comparable competing fund, like a money market fund, Ms. Markland said.

The proposal does not permit "equity washes," she said. The intent of these requirements is to discourage transfers, she said.

Under an equity wash, for example, if a plan participant wishes to invest in a competing fund, like a money market fund, the participant's money must first be put in a non-competing fund, like an equity fund, for a specified period of time.

She also noted that under this proposal, employer stocks would not be considered a diversified investment but could be offered as a fourth investment alternative.

Employers would be immune from fiduciary liability for this investment option if the stock is publicly traded; the participant has voting rights; there is an independent fiduciary; and transactions are confidential.

Ms. Markland suggested employers review their plans and take the following steps:

- Compare the plan structure with the proposed 404(c) guidelines.
- Evaluate the cost/benefits of compliance for participants.
- Consult GIC issuers about changes early in the process. Ms. Markland noted that employers should bear in mind that adding plan options, changing transfer restrictions and similar moves can be considered a plan change about which issuers should be informed.

"Think about it and make your own decision," she said. ■

GIC meeting draws 275 to Phoenix

PHOENIX—About 275 people attended GICS '91-The Fifth Anniversary Symposium, which was sponsored by the New York-based Institute for International Research at the Arizona Biltmore in Phoenix April 22-24.

Those attending the seminar included plan sponsors, guaranteed investment contract issuers and bank investment contract issuers as well as consultants.

A major topic of discussion at the conference—though no session was exclusively devoted to it—was the recent troubles at First Executive Corp., a guaranteed investment contract issuer, and its possible negative impact on the industry.

California regulators have placed First Executive's largest unit, Executive Life Insurance Co., into conservatorship, while New York regulators have placed Executive Life Insurance Co. of New York into rehabilitation (*BI*, April 29; April 22; April 15).

However, the consensus of speakers during various sessions was that with a strong emphasis on credit quality and employee benefits communications, the industry could continue to do well and that employees will continue to be attracted to GICs as reasonably safe, secure, "sleep-well" investments for their 401(k) plans.

Next year's conference has been scheduled for April 27-29 at the Grand Floridian Hotel, which is on the grounds of Disney World in Orlando, Fla.

For further information, contact Lauren Schulman, Vp and Conference Director, Institute for International Research, 437 Madison Ave., 23rd Floor, New York, N.Y. 10022; 212-826-3340.

Reducing portfolio risk

Examine issuer quality before purchase: GIC manager

By JUDY GREENWALD

PHOENIX—Conducting an analysis of issuer quality is critical to managing a guaranteed investment contract portfolio, a GIC manager says.

GIC

A portfolio manager must go through an issuer quality analysis "so you know what you are buying," said Peter E. Bowles, president and chief investment officer at Fiduciary Capital Management, a GIC and bank investment contract investment manager based in Woodbury, Conn.

"It's very important to have a good judgment on the front end (of a contract) because you're going to be stuck with it, realistically," he said at a session titled "Update: Solvency, Capital Adequacy an Credit Issues for GIC/BIC Issuers" during GICs '91—The Fifth Anniversary Symposium in Phoenix last month. The conference was sponsored by the Institute for International Research.

Mr. Bowles pointed out that there are several reasons an analysis of issuer quality is so critical to GIC management.

Unlike conventional bond management, the GIC and bank investment contract market is highly inefficient, according to Mr. Bowles. A low rate of return does not necessarily mean a high quality issuer, nor do high rates necessarily indicate low quality, he explained.

In addition, if "quality" declines, the portfolio manager then cannot resell a "benefit responsive GIC," he said. A GIC is benefit responsive if plan participants can withdraw or transfer the full principal and accumulated interest.

Also important to keep in mind, is that "the participant is at risk," not the employer, Mr. Bowles said.

He said issuer quality analysis also is critical to:

- Assure that the plan purchases the level of quality GIC it sought.
- Control the risk of portfolio default.
- Assess investment risk/return characteristics of GIC quotes.
- Identify any deterioration in portfolio quality after a GIC is purchased.

In analyzing issuer quality, a plan should not rely heavily on any one rating agency, Mr. Bowles warned, noting that these agencies do not necessarily agree with one another.

He displayed a chart showing different rating agencies' evaluation of several unidentified insurers, noting that it reflected a "humongous" disparity of opinion.

Nor does any agency consistently rate issuers high or low, he said.

At this point, evaluating GICs is "more an art than a science," according to Mr. Bowles.

However, conducting an independent analysis of issuers without rating agency help would not result in any greater chance of success, he said.

The solution is that rating agencies' information "should complement what you do yourself," Mr. Bowles said.

One can then assimilate the resources and diversity of opinion represented among the various rating services, he said. A consensus view will be more balanced than any single assessment, he explained.

"It is important to have a disciplined process" in evaluating different opinions "and not to rely upon a single rating," Mr. Bowles said.

He suggested that portfolio managers go through the following process:

- Use both internal criteria and external rating service assessments to develop a consensus view of an issuer.
- Conduct face-to-face meetings with an issuer's investment, pricing, underwriting and management personnel.
- Assess on an ongoing basis any negative trends that possible cold lead to a downgrade of the issuer.

Mr. Bowles said that negative indicators that could lead to downgrades include:

- Very rapid growth.
- Risky product mix.
- A relatively undiversified product mix.
- Greater than appropriate use of investment risk, low quality investments or both. That was the case with First Executive Corp., according to Mr. Bowles.
- Negative trends in key financial ratios.
- The issuer's acquisition of a lower quality company.
- Unusually high turnover of key personnel.

This "can be indicative of a potential problem," Mr. Bowles said.

Although life insurers generally are strongly rated compared with other institutions, rating downgrades are likely to outnumber upgrades among life insurers this year, warned Mark Puccia, senior vp in charge of the life/health insurance ratings group at Standard & Poor's Corp. in New York.

He said the life insurance industry did not earn enough in the 1980s to support its growth. Many companies without the wherewithal to survive the new environment must withdraw from lines of business.

As insurers' capital is depleted and not replenished, their ratings will be lowered, he said.

Mr. Puccia said the philosophy of some in the life insurance industry has been "trust me." This "makes people nervous" and justifiably so, he said.

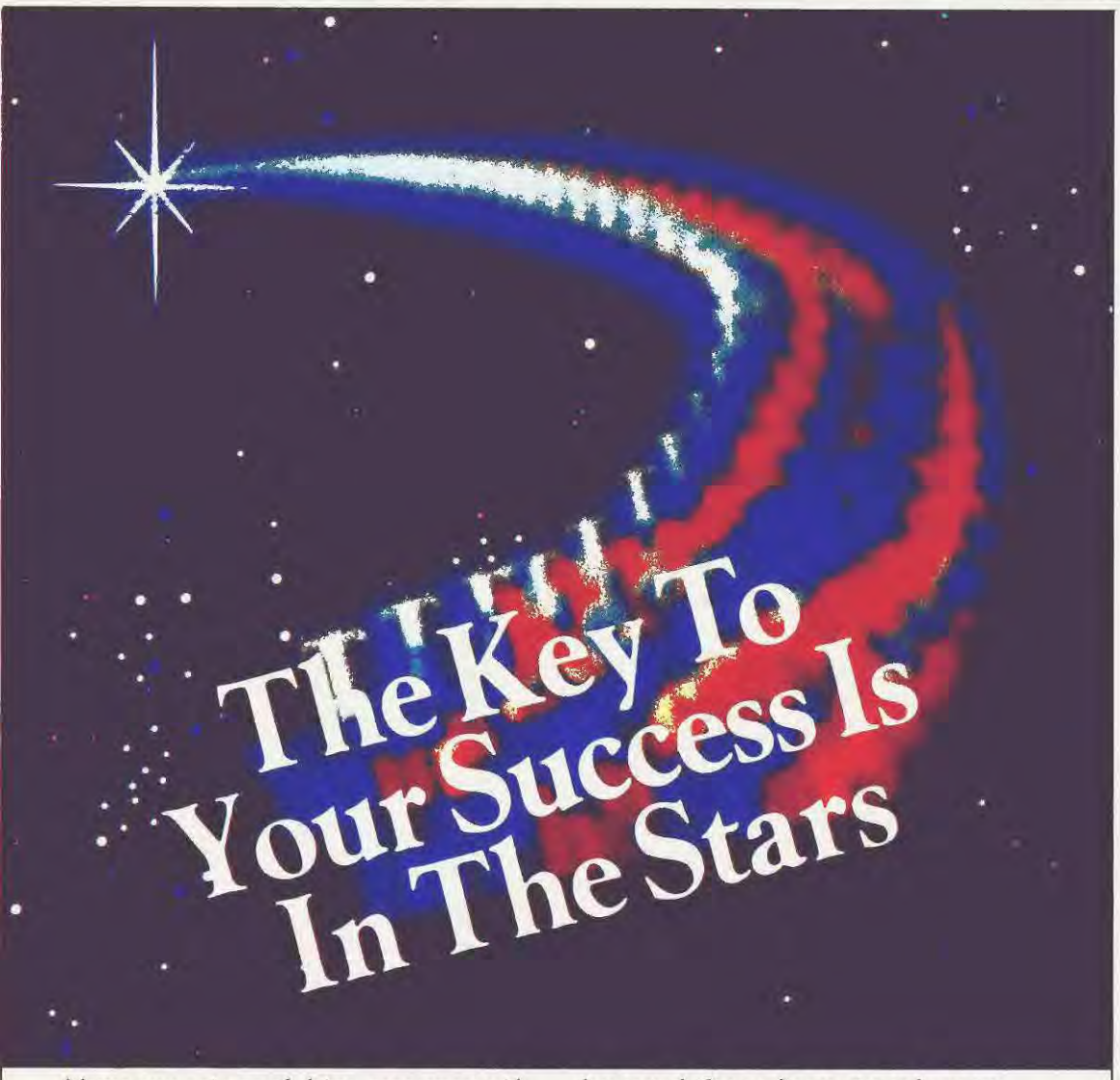
Overall, you can trust the life insurance "industry," Mr. Puccia said. However, "you don't buy policies from the industry—you buy them from companies," and they can go insolvent, he warned.

The life insurance industry needs to be consolidated, which will occur in the '90s, Mr. Puccia predicted.

However, the life insurance industry is now at a crossroads, and there have been fundamental improvements, Mr. Puccia said. Some companies are cutting back staff and taken other measures to help themselves, he noted.

Metropolitan Life Insurance Co. of New York, for instance, recently cut 1,000 positions in New York,

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GIC market value accounting blasted

By JUDY GREENWALD

PHOENIX—The guaranteed investment contract industry must help the Financial Accounting Standards Board find an accounting technique so that market value is equivalent to book value when evaluating GIC assets in defined contribution plans, a GIC consultant asserts.

GIC

The Financial Accounting Standards Board last month preliminarily voted to reverse an exception to a 1980 rule that allows defined benefit plans to value insurance contracts at a constant book value.

The vote also would affect bank investment contracts and similar instruments, according to Kim McCarrel, who is a consultant with Wyatt Asset Services of Portland, Ore.

Under the 1980 rule, known as FAS 35, other defined benefit plan assets must be listed at their current market value.

However, after the vote, FASB instructed staff members to further study the issue of book value accounting for both defined benefit and defined contribution plans.

Eliminating book value accounting for GICs in defined benefit plans would have little practical impact because their GIC holdings are relatively small.

But GICs account for a significant portion of defined contribution plans, like 401(k) plans.

Requiring defined contribution plans to account for their GIC holdings at market value would force employers to report to employees the contracts' fluctuating values, rather than the value of the contract at maturity, like plan sponsors report now.

Plan sponsors fear this could cause employee anxiety and reduce the popularity of GICs (*BI*, March 11).

FASB "apparently feels that all assets should be at market value," Ms. McCarrel said.

This means the industry must help FASB find an accounting technique that equates book value and market value for "benefit-responsive" contracts, Ms. McCarrel said.

Ms. McCarrel spoke at a session called "FASB: Update on Book Value Accounting Issues," at GICs '91-The Fifth Anniversary Symposium in Phoenix last month. The conference was sponsored by the New York-based Institute for International Research.

Ms. McCarrel said GICs cannot readily be accounted for at market value because:

- They are individually underwritten.
- There is no secondary market for them.
- They are not assignable or transferable.
- They are "benefit responsive," meaning participants can withdraw or transfer the full principal and accumulated interest.

FASB believes that GICs' market value on Form 5500—the annual statement filed with the federal government—must agree with participants' statements, Ms. McCarrel said.

However, FASB may not have jurisdiction over how the value of GICs are reported on benefit statements, she said.

If that is established, defined contribution plan sponsors then could continue to report GICs at book value to employees, Ms. McCarrel said.

But, if employers are required to report the same figures on both Form 5500 and employees' statements, employee relations problems could result, Ms. McCarrel said.

For example, if an employer has a GIC fund with a book value of $10,000 and interest rates rise, the contract's market value could drop to $9,000, she said.

If the employee then decides to transfer the GIC assets to an equity fund, how much should he be allowed to transfer? If he is given only $9,000, it could create a problem.

But, if interest rates fall, then the GIC's market value could increase to $11,000. If the employer then gives the employee the contract value of $10,000, the employee will be unhappy because he feels he is entitled to $11,000, she said.

Ms. McCarrel said she feels benefit responsiveness is the key to resolving this problem.

For example, in the case where the GIC's market value drops to $9,000, the value of benefit responsiveness could be set at $1,000 and used to increase the amount of transferred funds to $10,000.

Similarly, the value of benefit responsiveness would be used to subtract $1,000 in the case where the market value jumps to $11,000.

Ms. McCarrel said that FASB should announce a first exposure draft on this issue by the end of June. There will then be a 60-90 day public comment period.

The next step would be to issue a final statement, which she hopes would be by year-end, followed by a phase-in period.

Ms. McCarrel called on conference participants to express their views to FASB.

James A. Geyer, vp of Aetna Life Insurance Co. of Hartford, Conn., also spoke. ■

Portfolio risk

Continued from previous page

Mr. Puccia pointed out.

"The industry's taken some hard steps," he said. "We think there's a possibility of ratings improvements for some companies" because of the dramatic improvements they have made, Mr. Puccia said.

Other bright spots include progress in controlling expenses and weeding out unprofitable products, Mr. Puccia said.

But there are also investment issues to consider, including junk bonds, rising mortgage delinquencies and deteriorating real estate markets.

Discussing junk bonds, Mr. Puccia said about 8% of these defaulted in 1990. This year, S&P anticipates a 10% to 15% default rate, he said.

Focusing on the mortgage delinquencies, Mr. Puccia pointed out that "the vast majority of mortgages are fundamentally sound assets." He noted that S&P expects that 15% of all problem mortgages will be written off after a three-year period.

James J. McDermott, president and director of research of Keefe, Bruyette & Woods Inc. of New York, and John B. Kleiman, vp of Conning & Co. of Hartford, Conn., also spoke at the session.

Rita Fishman Auritt, vp-investment products for IDS Financial Services Inc. in Minneapolis moderated the session. ■



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National workers comp system looms

Low rates and high loss ratios weaken current system: Experts

By MICHAEL SCHACHNER

NEW YORK—A national workers compensation system would be needed by the turn of the century if the current system continues to deteriorate because of widespread rate inadequacy and the growing residual market, two workers comp experts contend.

If workers comp rates and insurer loss ratios continue to climb at their current pace, the federal government will be forced to step in and take corrective action within the next eight to 10 years, said Joseph C. Smetana, chairman and chief executive officer of New York-based AIG Risk Management Inc.

Mr. Smetana, one of three participants in a recent seminar on the workers comp crisis sponsored by Rollins Burdick Hunter of New York Inc., said key problems in the workers comp system are "everyone's problems, and it's unfair to point fingers."

The residual market's share of the total workers comp premium increased to an estimated 23% in 1990, up from 5.5% in 1984, according to the National Council on Compensation Insurance.

In addition, the accumulated residual market operating loss from 1985 through 1989 exceeds $6.5 billion, with more than $1.7 billion in losses in 1989 alone, the last year for which figures are available.

If rates "continue to become more inadequate, something will have to happen," agreed Stephen M. Wilder, director of corporate risk management for The Walt Disney Co. in Burbank, Calif.

"I think we could see government intervention in some states within the next five years," he predicted.

Mr. Wilder said one of the major reasons the workers comp system is failing is that attorneys have taken over the role of the claims adjuster.

"We just don't see that the expertise is there on the part of the claims adjuster. What is occurring is that the attorneys are coming in and running the cases, which is fine for the attorneys, but puts the claims adjuster out of the picture," Mr. Wilder said.

But Theodore Ronca, a Long Island-based attorney who specializes in representing employers and insurers in workers comp cases, said employers and insurers must assume some of the blame for the ailing system, because they do not understand the entire claims system and often appeal cases on the wrong grounds.

"Ninety percent of all workers comp appeals are made on medical grounds, while only 10% are made on legal grounds," Mr. Ronca said.

"What they don't realize is that a legal appeal has five times the chance of being upheld. Employers spend too much time and money for doctors to hold perjury contests."

Mr. Ronca also defended the claims adjustment industry, saying that it is working with one hand tied behind its back due to a turnover rate that is "staggering."

The workers comp system is faltering also because there is "too much opinion and not enough solid data regarding rates, rate increases and rate inadequacy," Mr. Ronca said.

He said the NCCI, employers and insurers have to do a better job of compiling solid data to help lawmakers pass sensible workers comp laws.

To reduce these costs, employers have to do a better job of preventing losses, the panelists said.

Mr. Wilder said employers are just beginning to realize the importance of loss control.

"In the past, we focused more on risk financing and forgot about loss control," he said.

"Now, loss control is the most important thing. If people never get into the system, you don't have to worry about the cost of the claim."

He noted that Disney is placing more emphasis on wellness and loss prevention than ever before.

"We're trying smoking cessation plans, exercise programs, and our employee cafeterias are serving better, healthier food. But it's still tough because we as an employer lack clout. We cannot manage costs ourselves. We need help from workers comp and health insurers," Mr. Wilder said.

But, the best employers can do is to try to prevent losses and handle them efficiently when they do occur, because employers will never be able to prevent all injuries, Mr. Ronca said.

"There will always be legitimate accidents, and certain people are accidents waiting to happen. You will always have your false and retaliatory claims, too," he said.

Mr. Wilder suggested that coordinating health, disability and workers comp benefits under one program would save most employers 7% to 9% of their combined workers comp and health care costs.

'I think we could see government intervention. . .within the next five years,' Mr. Wilder predicts.

But Mr. Smetana said that while coordination of benefits is a good idea in theory, it would be difficult to arrange.

"This would have to start at the corporate level," he said. "Now, most companies have these plans insured and administered by three or four different carriers."

Mr. Ronca noted that "package" plans are just now getting off the ground, although the idea is gaining in popularity.

Self-insurance is the only sure way for employers to get a grip on increasing rates, the panelists agreed.

However, "employers must have the employee base to support the administrative costs," Mr. Wilder pointed out.

Mr. Smetana said self-insurance is an employer's best option if the company is paying more than $1 million in annual workers comp premiums.

Garret A. Mathieson, executive vp with RBH in New York, moderated the seminar. ■

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Info

• A bimonthly flyer from the Labor Department features examples of how employers solved various **ergonomic workplace problems.** The one-page flyer, ErgoFacts, will draw on information from Occupational Safety and Health Administration inspections and consultations. Each bulletin will discuss a particular problem, highlight the ways employers reduced the risks and suggest other possible solutions. For a free copy, write ErgoFacts, OSHA Information and Consumer Affairs, Room N3647, Frances Perkins Building, 200 Constitution Ave. N.W., Washington, D.C., 20210. There is a limit of one copy per address.

• A book covering topics like public employee benefits law, Governmental Accounting Standards Board accounting standards for post-employment benefits, investment of public employee funds, and the use of laptop computer technology for benefits communication and data collection is available from the International Foundation of Employee Benefit Plans. Copies of **"Public Employee Benefit Plans-1990"** cost $19 for IFEBP members; $23 for nonmembers. Contact Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• The Hartford Steam Boiler Inspection & Insurance Co. is offering a **1991 Technical Training Catalog**. The catalog lists seminar and courses offered by the company. Listings include descriptions of content, locations, who should attend and registration information. For a free copy of the catalog, contact The Hartford Steam Boiler Inspection & Insurance Co. Engineering Services Division, 800-243-0090.

• The **"1990 Life Insurance Fact Book,"** published by the American Council of Life Insurance, gives a variety of statistical information on the life insurance business. Information on pension and retirement programs, benefit payments, reserves, assets, life expectancy and selection of risks is included, as is historical data and recent developments in the life insurance field. Single copies are free; each additional copy is $2. Contact Company Services Department, ACLI, 1001 Pennsylvania Ave. N.W., Washington, D.C. 20004-2599; 202-624-2372.

• Free Asian language translations of The California Workers Compensation Institute's pamphlets, **"Facts About Workers Compensation"** and **"Facts for Injured Workers,"** as well as the posting notice, **"If a Work Injury Occurs,"** are available for reproduction. Single copies of each publication are available in the form of camera-ready art, which may be reproduced as needed. In addition, printed copies of the CWCI pamphlets are available in English and Spanish. Contact CWCI, 120 Montgomery St., Suite 1300, San Francisco, Calif. 94104; 415-981-2107.

• A report summarizing the proceedings of the 1990 **Society of CPCU Annual Meeting**, "Today's Challenge—Tomorrow's Opportunity," is available from The Society of Chartered Property & Casualty Underwriters. The report summarizes the annual meeting held Oct. 7-10, 1990, in Washington, D.C. Seminars covered include: "Recovering from Catastrophes: A Three-Dimensional View"; "Who Takes the Risk, Locating Your Global Niche"; "Portraying an Industry: The Press Speaks Out" and "Reducing Expense Ratios Responsibly." The 104-page report is $20; $25 outside the United States. Contact The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2743.

• The Insurance Information Institute has published the 1991 edition of "Insurance Facts." The 132-page book contains information on occupational disease, workers compensation, government insurance programs and premiums for major lines of **property/casualty insurance.** A section of the book is devoted to automobile insurance. The book includes state-specific information as well, including a current list of state insurance commissioners. Copies are $18, plus $2.50 for postage and handling. Contact Insurance Information Institute, Publications Service Center, 110 William St., New York, N.Y. 10038; 800-331-9146.

• A booklet describing the responsibilities of various employee benefit occupations, **"Careers in Employee Benefits,"** has been published by the International Foundation of Employee Benefit Plans. The booklet also details education and salary guidelines. Single copies are $12; quantity discounts are available. Contact Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• The American Bar Assn.'s Standing Committee on Dispute Resolution has compiled a listing of federal and state initiatives dealing with **alternative dispute resolution techniques.** "Legislation on Dispute Resolution: Federal and State Laws and Initiatives Pertaining to ADR" also lists selected programs and task forces to show current trends in dispute resolution reform. The 288-page publication is available for $25, plus $3.95 for postage and handling. Contact ABA Order Fulfillment, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-5555.

• Retirement Advisors has published a booklet intended to make the **transition from active employment to retirement** easier. "Activities" offers suggestions on preparing for and enhancing leisure time activities. The 32-page booklet also lists sources of information on such topics as education, volunteer activities, government services and travel. Single copies are available free of charge if a request is written on an organization's letterhead; bulk rates are also available. Contact Retirement Advisors, 555 W. 57th St., 17th Floor, New York, N.Y. 10019.

• **"Workers Compensation in Maine: An Administrative Inventory"** has been published by the Workers Compensation Research Institute. The book studies the results of recent reform reducing benefits, enlarging the role of the Maine Workers' Compensation Commission and modifying the litigation process. The authors also discuss areas of the Maine system that may warrant further attention. Single copies are $20. Requests must be made in writing. Contact WCRI, Publication No. WC-90-5, 245 First St., Suite 1402, Cambridge, Mass. 02142; 617-494-1240.

• Employers needing help in understanding the Occupational Safety and Health Administration's requirements for preventing workplace exposure to the **hepatitis B virus and the human immunodeficiency virus** that causes AIDS can turn to a new OSHA publication. The booklet explains the procedures and the interpretation of the OSHA requirements that deal with workers who are exposed to blood or other potentially infectious materials. These standards will be replaced by a new OSHA bloodborne pathogens standard later this year. The

Continued on next page

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Continued from previous page
booklet tells how to establish an infection control program and discusses control methods like universal precautions, engineering controls, work practice controls and personal protective equipment. Post-exposure evaluation and follow-up also are covered, as well as infectious waste disposal, housekeeping practices and employee training and education. For a free copy of "Compliance Assistance Guidelines for the February 27, 1990 OSHA Instruction CPL 2-2.44B Enforcement Procedures for Occupational Exposure to Hepatitis B Virus and the Human Immunodeficiency Virus," send a self-addressed label to OSHA Publications Office, Room N-3101, U.S. Department of Labor, Washington, D.C. 20210.

• The New York Business Group on Health Inc. has issued a report assessing workplace AIDS education programs. **"AIDS Education in the Workplace: What Employees Think"** attempts to determine employee sources of AIDS information, how the employer is regarded as a source, the level of knowledge about AIDS transmission, attitudes about co-workers with AIDS and the employer's role toward those workers. Copies are available for $10 plus $2.50 postage and handling. Contact NYBGH, 622 Third Ave., 34th Floor, New York, N.Y. 10017-6763; 212-808-0550.

• **"A Pocket Guide to Automatic Sprinklers"** is a booklet from Factory Mutual Engineering & Research that explains how an automatic sprinkler system works and how firefighters can work with it. Topics include types of sprinklers, temperature ratings on the systems, alarms and sprinkler control valves. The guide is intended as a reference for fire department training, inspections and pre-fire planning. Copies are available for $1.25; for orders of 100 or more, the cost is $1 a copy. Contact Factory Mutual Engineering Corp., Order Processing, 1151 Boston-Providence Turnpike, P.O. Box 9102, Norwood, Mass. 02062; 617-762-4300, ext. 2151.

• **"Liability Prevention & You: What Nurses and Employers Need to Know,"** a new brochure published by the American Nurses Assn., is designed to educate nurses, nursing students, employers and risk managers about the liability confronting nurses. The brochure explains the difference between the National Practitioner Data Bank and ANA's National Nurses Claims Data Base. Single copies are available free of charge from ANA; sets of 25 can be purchased for $5 by state nursing association members or $6.50 by non-members. Contact the ANA at 800-274-4262.

• A catalog of publications is available from the **American Institute for Property & Liability Underwriters** in conjunction with the Insurance Institute of America. The catalog describes 48 textbooks published by the institutes under categories of insurance principles, insurance coverages, risk management, insurance operations and insurance in a business environment. Copies of the 43-page catalog are available free from the institutes' Field Services Department, 720 Providence Road, Malvern, Pa. 19355; 215-644-2100, ext. 7518.

• A guide to help consumers determine if they need to buy **long-term care insurance** is now available from the National Assn. of Insurance Commissioners. "The Shopper's Guide to Long-Term Care Insurance" helps individuals look at factors such as age, financial situation, health status and retirement objectives in order to determine if such a policy is necessary. It also compares available policies. The booklet is free from state insurance departments. For more information, contact Kevin Hennosy at 816-842-3600.

• The Occupational Safety and Health Administration has released a new booklet intended to help small businesses manage **safety and health protection programs.** The 56-page booklet, a revised version of the "OSHA Handbook for Small Businesses," informs employers of voluntary protection programs, compliance programs and their spin-offs. The booklet describes a four-point safety program including management commitment and employee involvement, worksite analysis, hazard prevention and control, and training for employees, supervisors and managers. Single copies of OSHA publication No. 2209 are free from the OSHA Publications Office, Room N-3101, Department of Labor, Washington, D.C. 20210, or from regional OSHA offices.

• Dun & Bradstreet Business Credit Services offers **"Business Failure Record,"** a booklet that gives a comparative statistical analysis of geographic and industry trends in business failures in the United States. The booklet shows the number of failures, liabilities and reasons for failure by state, region, industry and age of business. A free copy of the booklet can be obtained from Wendy J. Matheson, Product Manager-Insurance Information Services, Dun & Bradstreet Business Credit Services, 1 Diamond Hill Road, Murray Hill, N.J. 07974-0027.

• "1990-1991 Directory of Health Care Coalitions in the United States" is available from the National Business Coalition Forum on Health. The directory profiles 64 individual **health care coalitions,** including names and addresses of board and staff members, tax and corporate status and an analysis of corporate structure. A review of each coalition's health care management priorities is included. The directory also provides a membership list. Copies are available for $35 from the NBCFH. Contact Misshay White at 202-408-9320.

• **"A Guide to Catastrophe Preparedness"** is now available from the Independent Insurance Agents of America. The guide includes sections on contingency plans for alternate premises, claims handling, developing a referral list of contractors after a natural disaster and a public relations guide. Copies are available for $14.75. Contact the IIAA at 800-221-7917.

• A book covering topics like public employee benefits law, Governmental Accounting Standards Board accounting standards for post-employment benefits, investment of public employee funds, and the use of laptop computer technology for benefits communication and data collection is available from the International Foundation of Employee Benefit Plans. Copies of **"Public Employee Benefit Plans-1990"** cost $19 for IFEBP members; $23 for non-members. Contact Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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closing:	**May 8**	
demographic section:	Insurer Topics: Automation: Underwriting/Policy Management	
issue:	May 27	Bonus Distribution: NAIB
closing:	**May 14**	
conference report:	PRIMA	
ssue:	June 3	
closing:	**May 21**	
editorial feature:	Property Loss Control — Directory: Loss Control Consultants	
demographic section:	Agent/Broker Topics: Niche Marketing	
issue:	June 10	Bonus Distribution: NAIC
closing:	**May 29**	

		1	2	3	4	
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

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Advertiser Index

Issue of May 6

Advertiser	Page #
Acordia	56
Affiliated FM/Appalachian	18-19
A.I. Company	32-33
A.I. Credit/AIG	57
American Reinsurance	54-55
A.P.I.W.	80
Argonaut Insurance Company	9
Arkwright Mutual	62-63
Avesis	35
Blue Cross/Blue Shield-Assn.	14-15
Blue Cross/Blue Shield-CT	30C,30D
Brownyard Brothers	74
Business Insurance	69,73
Caremark	53
Chicago Board of Trade	68
CIGNA	13,46
Claims Overload Systems	56
CNA Insurance Co.	4
Conservco	20-23,39-41
Continental Loss Adjusting	66
Cost Care Inc.	38
Crawford & Company	12,44
Delta Dental Plan	16
Diversified Pharmaceutical	30
Employers Reinsurance Corp.	34
Environmental Compliance	43
Equipment Insurance Mgrs.	71
Erisco	52
Hannover Reinsurance	70
Health Chicago	30A,30B
Health Net	45
Health Risk Management Inc.	42
Hermitage Insurance Company	64
Industrial Risk Insurers	77
Insurance Software Packages	60
Intracorp	29
Lincoln Natl. Emp. Benefits	36-37
Magnus Software	6
Maryland Casualty	50-51
Metropolitan Life Ins. Co.	61
Northwestern National Life	11
Paige-Ruane, Inc.	75
PCS Incorporated	58-59
Provident Life & Accident	28
Prudential Insurance Co.	31
Reliance National	7
Resource Inform. Mgmt. Sys.	67
Healthcare Intl./San Marcos	24
SBPA Systems, Inc.	71
Seabury Smith	10
Swiss Life	72
Travelers Insurance Co.	25
Travis Software	42,44
Upjohn Healthcare Services	26-27
Utilization Management Syst.	74
Wausau Insurance Company	5
Zurich-American Insurance Co.	84

Business Insurance

INTERNATIONAL

Members seek to pierce Lloyd's immunity

By STACY SHAPIRO

LONDON—There may be a loophole in the Lloyd's Act, 1982 that would allow Lloyd's of London members to hold the Corporation of Lloyd's liable for losses by suing it for breach of contract, a members' lawyer argued in London's High Court last week.

The Lloyds Act, 1982, among other things, was designed to make Lloyd's of London immune from prosecution, a point that was fiercely debated at the time the legislation was wending through Parliament in 1981.

However, last week, during the second week of litigation against the Corporation of Lloyd's filed by members of defunct syndicates formerly managed by Oakeley Vaughan Underwriting Ltd., members' trial lawyer Michael Lyndon-Stanford suggested that the act's immunity clause does not include any reference to contracts.

This could mean that Lloyd's would be liable to members for breach of contract for losses they have suffered, he said.

If the Oakeley Vaughan members successfully pursue this point, thousands of other Lloyd's members who currently are litigating losses suffered after the act's immunity clause supposedly took effect could have some recourse against Lloyd's.

The 24 Oakeley Vaughan members are suing Lloyd's to recover more than 5 million pounds ($8.7 million at current exchange rates) of losses they incurred between 1981 and 1983.

The members filed suit under the Lloyd's Act, 1871 and the Lloyd's Act, 1911, neither of which included immunity clauses.

Nine more Oakeley Vaughan members have agreed to abide by the verdict of the court, though they are not represented in trial.

But, Lloyd's maintains that at the very least it should not be liable to Oakeley Vaughan members for any losses incurred after July 23, 1982, when Lloyd's Act, 1982 was passed into law.

However, Mr. Lyndon-Stanford argues that there may be a loophole in the 1982 law that will allow members to sue the corporation for losses incurred after the immunity clause took effect.

The act specifically states: "The society shall not be liable for damages whether for negligence or other tort, breach of duty or otherwise, in respect of any exercise of or omission to exercise any power, duty or function conferred or imposed by Lloyd's Acts 1871 to 1982 or any bylaw or regulation made thereunder. . .insofar as the underwriting business of any member of the society. . .Lloyd's brokers or underwriting agent may be affected."

Continued on page 71

Market expects Lloyd's to post big loss in 1988

By STACY SHAPIRO

LONDON—It looks more and more likely that Lloyd's of London will break even or post a minor overall loss when it reports its global results for 1988 on June 24.

"Highly spotty" is how sources in the market describe the 1988 underwriting year—which closed at year-end 1990 under Lloyd's three-year accounting system.

Those sources predict a "thumping great loss" in the marine market and at best a break-even situation in the non-marine market. Profits are expected in the smaller motor and aviation markets.

Major 1988 losses, plus increased claims reserves for U.S.-related pollution and asbestos bodily injury and property claims, are being blamed for the poor results.

The major losses to affect the 1988 underwriting year include the $1.4 billion Piper Alpha North Sea oil platform explosion which killed 67 people; Hurricane Gilbert which hit the Caribbean and Mexico; and the Pan American World Airways Boeing 747 explosion over Lockerbie, Scotland.

All of these losses affect the excess of loss reinsurance market, which at Lloyd's knows no bounds and can affect both non-marine and marine markets heavily.

Lloyd's has said that it expects an overall loss in 1989 but has not estimated the size. More than 40 syndicates are expected to make cash calls this year for 1988 and the 1989 and 1990 underwriting years.

Worst hit by the 1988 losses are marine syndicates, many of which have already told members to expect overall losses.

In particular, losses are projected for six of the top 10 marine syndicates in 1988, according to Oliver Carruthers of Lloyd's of London Digest News and other syndicate analysts (*BI*, April 29). These projections exclude up to 160 million pounds ($276.8 million at current exchange rates) in losses from syndicate accounting years prior to 1988 which have been left open, said Mr. Carruthers.

At syndicate 206, the second largest marine syndicate, 1988 overall losses were 32.9 million pounds ($63.5 million at appropriate exchange rates), or 14% of the syndicate's 235 million pound ($453.6 million) capacity for the year, confirmed Simon Edwards, managing director of Sturge Marine Syndicate Management Ltd., which manages syndicate 206.

Sturge's problems did not end there. In fact, five out of the six marine syndicates it managed lost money in 1988, Mr. Edwards con-

Continued on page 69

Environmental liability

U.K. risk manager sees trend in alternative financing of risk

By GAVIN SOUTER

BRUSSELS, Belgium—New risk financing methods guarding against the escalating costs of environmental pollution are the most exciting area of development for today's risk manager, a British risk manager says.

However, small and midsized companies still need the support of the insurance industry to cover all their pollution risks, said a London broker.

Through joint efforts with banks and reinsurers, risk managers are able to set up funding mechanisms to transfer risk and cover gradual pollution risks that the industry refuses to cover, said Geoffrey Saunders, a risk management adviser for RTZ Ltd., a British mining concern.

The purpose of insurance is to protect a company's balance sheet, and coverage for pollution risks should be viewed in the same way, Mr. Saunders argued at a recent conference on Environmental Liability Risk Management held in Brussels, Belgium, and sponsored by Management Centre Europe.

"Pollution is just a cost; there is nothing magic about it, and by insuring it we are trying to smooth the balance sheet," Mr. Saunders said.

If coverage cannot be obtained in the conventional insurance market, then companies should set up their own systems to spread the cost of pollution over several years, he said.

The RTZ solution is an "environmental endowment policy," he said. The policy covers gradual pollution risks for 30 years with no exclusions or cancellations, Mr. Saunders said.



Richard and Mary Magruder/Image Bank

Brussels was the site of a recent conference on environmental liability risk management.

RTZ contributes $15 million annually to a fund it established to cover pollution cleanup costs. To provide the element of risk transfer needed to obtain tax deductions, the company increases its contributions to the fund in the years that follow any payments, Mr. Saunders explained.

This method spreads the cost of pollution cleanup over the life of the policy by effectively renting a reinsurer's balance sheet, he said.

However, for the plan to gain in popularity, the companies will have to have the backing of major

Continued on next page

Bermuda proposals would aid regulators

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—The Bermuda government is considering proposals that would outline the records that insurers would have to keep in the domicile and would make it easier for authorities to intervene in troubled companies.

The proposed new record-keeping rules were described last week by Registrar of Companies Malcolm Butterfield as necessary to address a "gray area" of Bermuda's 1978 Insurance Act, which does not specify what information should be maintained on the island beyond statutory requirements.

That proposal was unveiled along with another proposed amendment to the law that would allow the minister of finance greater freedom to intervene in the affairs of insurers that are feared in danger of becoming insolvent.

Mr. Butterfield said that his department, which regulates the activities of more than 1,320 insurers, would be seeking Cabinet approval to issue an industry guideline on the minimum retention of records. The proposed guideline, which has already been approved by an advisory committee to the minister, is aimed at all Bermuda-domiciled insurers, especially those that are not managed

Continued on page 70

Pulbrook names win arbitration

By GAVIN SOUTER

LONDON

LONDON—Lloyd's of London members caught on troubled syndicate 90 managed by Pulbrook Underwriting Management Ltd. have been saved from a potential $40 million loss by an arbitration decision.

The arbitrator ruled that a nine-year-old runoff policy for syndicate 90 was valid and the runoff underwriters should meet their share of future asbestosis and pollution claims covered by the syndicate.

Consequently, syndicate 727, managed by S.A. Meacock & Co., which had disputed the validity of the runoff policy, will have to pay its 20% share of syndicate 90's losses, now an estimated $200 million.

Syndicate 90 members have already had to pay about $30.5 million for the open 1982 underwriting year, but if the decision had gone against Pulbrook Underwriting Management Ltd. the 400 members would have had to pay the Meacock share as well.

The disputed policy was underwritten in June 1982. Half the risk was covered by syndicate 317/661 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd.; 20% was covered by syndicate 727, managed by Meacock; and 30% was unplaced, said David Robson, director of Merrett Holdings P.L.C. which now owns Pulbrook.

Huge claims were made on the syndicate, which Pulbrook passed on to the runoff underwriters.

"During the 1940s, 1950s and 1960s Pulbrook was one of the biggest non-marine syndicates covering North American liability losses, so the impact of asbestosis and pollution losses on the syndicate has been catastrophic," Mr. Robson said.

Pulbrook and Outhwaite came to a compromise agreement in October 1989 that resulted in the $30.5 million payment by syndicate 90 members (*BI*, Nov. 13, 1989).

Meacock, however, alleged that Pulbrook had failed to disclose information and the case was arbitrated by Sir Michael Kerr.

Sir Michael ruled that the policy was valid and Meacock should pay its existing liabilities and 20% of any further liabilities. At year-end 1990, liabilities stood at $7.5 million.

Total liabilities for syndicate 90 will not be known for several years, but current estimates put them at $40 million, Mr. Robson said.

Some 323 Pulbrook members of syndicate 90 are currently suing Pulbrook and eight members' agents (*BI*, April 19, 1990). They allege that Pulbrook was negligent in the placing of the runoff contract and that the members' agents were negligent in placing them on the syndicate.

U.K. tranquilizer suit

British lawyers are being flooded

Continued on page 69

Pollution risks

Continued from previous page
banks to provide the funding mechanisms, Mr. Saunders said.

"We think it is workable, and we think it will be cradle-to-the-grave risk financing," he said.

RTZ has been advised by experts that the system will be tax-efficient, but the company will not know for sure until it has submitted its first audits to the tax authorities, he said.

However, insurers should not forget that the vast majority of companies in Europe are not large enough to set up alternative risk financing systems and depend on the insurance market for their pollution coverage, said Michael Jones, director of Bowring London Ltd., a unit of C.T. Bowring & Co. Ltd.

Unfortunately, there have been recent moves by insurers to restrict pollution coverage to sudden and accidental risks, leaving companies too small to set up alternatives without any gradual pollution coverage, said Mr. Jones.

Reasons Mr. Jones gave for insurers' move to restrict coverage are:

- The adverse loss experience of insurers and reinsurers in the United States.
- Occurrence-based coverage, which allows for different interpretations leading to disputes on coverage and potential stacking of limits.
- The inability of premiums charged years ago to take into account pollution discovered only recently.
- Insurers that have become wary of providing blanket coverage without adequate information on the risk or the exposure.

"It is my contention that gradual pollution liability coverage could continue to be provided to our clients. It is, however, important that a more balanced approach is taken allowing for an element of stability," Mr. Jones said.

Gradual pollution liability coverage should include the following, he said:

- An even balance between the premiums paid by the policyholder and the risk assumed by the insurer.
- A special extension in coverage for pollution.
- A coverage trigger date attached to the date of discovery of the pollution rather than the date of the damage.
- Coverage for any claims arising in the future from the occurrence to fall in one period.
- An aggregate limit applying to each annual period.
- A retroactive date which removes the risk of duplication of coverage with previous policies.
- Full risk information provided and additional premium charged.

However, these points must be used in conjunction with careful risk management by the policyholder, Mr. Jones said.

The technology and expertise needed to manage pollution risks can be brought in through independent consultants, he said.

Using independent consultants has several advantages, Mr. Jones said.

"Independent (consultants) can be more flexible, because the information they supply need not be restricted to insurance concerns. Also, if the work is done by an insurer, only that insurer will quote for the risk, and the information will not be available to other insurers," he said.

In addition to this, an independent consultant's report allows the policyholder to carry out any of the recommendations before the company approaches an insurer. The information also can be used to assess self-insurance potential, Mr. Jones said. Consequently, the policyholder, rather than the insurer, should pay the consultant's fee, he said.

"It is important that insurers in Europe do not follow the U.S. market and exclude all pollution liability coverage. Insurance should respond to at least sudden and accidental pollution, and I believe could also cover gradual pollution." ■

Extent of pollution risks leads to EIL pools

By GAVIN SOUTER

BRUSSELS, Belgium—Industrial companies will have to look to alternative risk financing mechanisms for pollution coverage since commercial insurers have abandoned this risk, a risk manager and a risk engineer say.

Worldwide concern about the effects of pollution has forced legislators and courts to punish industries that jeopardize the ecosystem. As a result, the costs of cleaning up years of pollution is too much for the insurance industry to bear, they say.

But alternative risk financing methods for gradual pollution exposures are in their infancy and need more industry support in order to succeed, the experts contend.

Although damage to the environment has been occurring for many years, society has only been concerned about the long-term effects for the past 10 years, said Dick Vlasblom, the risk manager for Dow Chemical Co.'s European operations.

Now, however, society has begun to realize that pollution has caused dangerous changes in the world climate and ecosystem, and that lifestyles may have to be changed to protect the environment, he said at a recent conference on Environmental Liability Risk Management held in Brussels, Belgium, and sponsored by Management Centre Europe.

An impending European Community directive on environmental liability is causing concern for all businesses.

"Environmental liability may be one of the biggest risk management challenges of the future," Mr. Vlasblom asserted.

Protection of the environment, he said, should hinge on two complementary approaches:

- Prevention of environmental damage.
- And cleanup of the damage that does occur.

According to Mr. Vlasblom, the precautionary approach should dominate.

Insurance against gradual pollution is not readily available in Europe, although limited facilities are available in some countries, he said.

For example, in several countries pollution insurance pools are available: Assurpol in France; Pool Inquinamento in Italy; and MAS in the Netherlands.

"As far as I have been able to ascertain, no gradual pollution liability insurance is available in other European countries," Mr. Vlasblom said. Sudden and accidental pollution coverage is still available in both the United States and Europe, but some companies find it difficult to obtain at high enough levels and at reasonable cost, he said.

In some cases, the difference between sudden and accidental pollution and gradual pollution are not clear-cut.

To illustrate, he cited some 1984 rulings in which U.S. courts held that pollution taking place over an extended period was considered sudden when the contaminated groundwater reached the plaintiffs' wells (*BI*, July 30, 1984).

"I would prefer pollution liability coverage which covered sudden and gradual pollution, because then you would not have arguments as to whether it was sudden or gradual," said Mr. Vlasblom.

However, he admits, there are no individual insurers either capable or willing to provide this coverage for large firms.

Major industrial firms may "have to band together and create an insurance pool of their own," he said.

About 30 industrial insurance pools have been set up in the United States, but the response in Europe has been lukewarm, he said.

In 1986, UNAT S.A. tried to set up an insurance facility in Luxembourg to cover general liability, whereby companies were expected to participate in risk-bearing capital of $5 million per company. That facility generated insufficient interest, said Mr. Vlasblom.

In 1990, the European Risk Management Assn. also canvassed industry on the possibility of a pollution liability pool. Risk managers said they were interested but were unwilling to pay for a feasibility study, he added.

"For the protection against gradual pollution liability. . .there is not sufficient capacity available at present, the more so since the picture is not quite clear as to the total amount of liability a certain company is exposed to for pollution that started a long time ago, which might still go on and could continue into the future," Mr. Vlasblom said.

Without sufficient capacity in the market, he said, companies are left with three options:

- Self-insurance for companies that are big enough and able to set aside reserves.
- Retentions for companies not big enough to self-insure, but large enough to sustain losses up to a certain level.
- A captive, as a way to combine self-insurance and retention.

Very high insurance costs may produce a curious result: Industry may find it less expensive to avoid pollution altogether than to buy insurance, said Mr. Vlasblom.

"There is still not a sufficient sense of urgency as far as the availability of insurance is concerned," he asserted.

Today's society is more concerned about the pollution of its environment than at any other time in its history, agreed Gungor Dincler, assistant vp in the risk engineering department at Zurich Insurance Co. of Zurich, Switzerland.

Currently, pollution coverage can be divided into that provided for North American risks and coverage for the rest of the world, Mr. Dincler said.

In North America, insurers "have an absolute pollution exclusion in their general liability coverage, an exclusion following from the continued tendency of the courts to disregard the difference between accidental and non-accidental pollution," he explained.

In the rest of the world, companies could generally cover about 80% of their pollution liabilities, and the only exclusions are for gradual pollution, dump sites and first-party cleanup costs, Mr. Dincler said.

But the increasing quantity and the more restrictive nature of incoming legislation could mean that existing coverages will fall farther behind the demands of industry, he warned.

"The biggest problem is contaminated land. If you take a building site as an example, the question is, 'how many layers of ground do you own?' " Mr. Dincler asked.

Another problem is determining safe limits of pollution, he said.

Ecotoxicology is a young science that is developing rapidly, so it is still difficult to assess risks accurately, Mr. Dincler added.

This problem is also linked to the problem of late claims, said Mr. Dincler.

"In such cases, at the time the policy was signed, the risk was classified as not harmful, while during the policy period the chemical substances were reclassified as harmful by the authorities, and stricter standards were introduced, necessitating further cleanup operations," he said.

Consequently, there are growing discrepancies between liability based on court judgments and legislation and the pollution coverages offered by the insurance industry, Mr. Dincler said.

Captives and structured insurance plans, which spread the risk between the policyholder and the insurer, are an alternative to traditional insurance and could be used to cover gradual pollution, Mr. Dincler said. ■

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INTERNATIONAL

Consumers force environmental awareness

By GAVIN SOUTER

BRUSSELS, Belgium—After years of lurking at the back of corporate consciences, environmental issues have leapt to the fore thanks largely to consumer pressure, say two leading risk managers.

Only within the last few years have companies started to look seriously at pollution issues, they say. And companies have found for the first time that commercial success requires them to be seen as concerned about the environment.

By setting up well-planned programs most companies can successfully deal with environmental problems, they said at a recent conference on Environmental Liability Risk Management in Brussels, Belgium.

Sweden has a long history of environmental protection but until recently it was the domain of specialists, said Jens-Jorgen Brunsvik, technical director at Stora Cell A.B., a large Swedish forestry products concern.

In the past, top managers at Stora did not discuss environmental problems. Nor did they let such concerns influence product details, said Mr. Brunsvik.

Gradually, the company began to deal with local problems and eventually it looked at global pollution, he said. But the discussions were still kept in-house.

That changed abruptly when dioxins were recently found in Stora products and public attention focused on the problem of "algae blooming," or unchecked algae growth caused by toxins in the water.

"From then on we had the public eye on us," Mr. Brunsvik said.

Soon Stora changed its approach to environmental problems to consumer-driven from company-driven, he said. "This was not just for our company but for the whole of the forestry industry."

A new policy stated Stora would:

- Manufacture products that are harmless to dispose of, use or recycle.
- Manufacture products in mills and with such processes that any discharges to air and water are harmless to the environment.
- Assist customers in manufacturing more environmentally compatible products.
- Continuously inform employees, customers and the public about the environmental impact of its products and manufacturing processes.

By adhering to this policy, Stora has improved its products, he asserted.

Consumers, in turn, realize that the company is now taking pollution seriously and acknowledge that solutions do not come quickly, said Mr. Brunsvik.

Environmental protection is also taken seriously at Johnson & Johnson Products Inc., said Derek Rochford, director of regulatory affairs in the international division.

Since 1979, the New Brunswick, N.J.-based health care products firm has included in its formal statement of company policy the phrase "protecting the environment and natural resources," Mr. Rochford said.

An environmental statement the company issued in 1987 bolstered that acknowledgment, he added.

The practical result of the statement was two corporate programs: environmental and regulatory affairs, which deals with the compliance and regulatory aspects of the group's environmental policies; and community environmental responsibility, which tries to ensure that plants, products and processes have a minimal effect on the environment.

At its 200 facilities in 54 countries, Johnson & Johnson has more than 83,000 employees, Mr. Rochford said. One of the group's two vice chairmen is directly responsible for environmental policy.

Through its environmental and regulatory affairs program, Johnson & Johnson carried out a third-party environmental assessment of its operations. That study led to an environmental practices manual that set out its basic environmental protection requirements, Mr. Rochford said.

The first policy instituted after the assessment dealt with storage tanks, he said.

"In support of this policy, Johnson & Johnson in 1988 initiated a five-year program to upgrade all its storage tanks to meet the Johnson & Johnson standards. The objective is to move all underground and on-ground tanks to above ground so that any leakage is easily observed," Mr. Rochford said.

Next came a biological waste policy. This required all biological waste to be rendered non-infectious and unrecognizable prior to disposal, he said.

Following this was a carcinogen policy, which required all Johnson & Johnson subsidiaries to find substitutes for any carcinogens they used, he said.

"If non-carcinogenic substitutes cannot be found, the policy requires the installation and operation of release control devices during 100% of the process operation time," Mr. Rochford said.

The company issued a chlorofluorocarbon policy in July 1989 that required the removal of all CFCs from Johnson & Johnson products and manufacturing processes by Jan. 1.

The group has achieved the goal in all of its operations except its sterilization operations and those processes and products that require government approval, Mr. Rochford said.

"Even in these processes we are committed to CFC elimination by Jan. 1, 1994," he asserted.

Johnson & Johnson's domestic hazardous waste treatment, storage and disposal facilities policy applies to all U.S. facilities, he said.

The policy requires all Johnson & Johnson domestic affiliates to only use off-site treatment, storage and disposal facilities on the group's approved list, he said.

"This policy was originally adopted because of the high liability associated with improper disposal of hazardous waste in the United States; however, this principle is being reflected in new environmental legislation being written throughout the world," Mr. Rochford said.

Johnson & Johnson then issued a product/process development policy that requires that an environmental impact assessment be performed on all research and development projects, he said.

The company's latest addition was a real estate acquisitions and divestitures policy that states that each Johnson & Johnson subsidiary must arrange a prepurchase or a divestiture environmental audit on all real estate to ensure that liabilities are defined, Mr. Rochford said.

The focus of the company's community and environmental responsibility program is "to foster employee and community trust in the environmentally responsible nature of our products, and to communicate environmental information in an effective manner to our employees and to the members of the community in which we operate," he said.

The program has four major phases, Mr. Rochford said:

- Phase One relates to training managers in crisis management and includes a three-day training program in environmental issues for all key managers.
- Phase Two concentrates on establishing leadership in employee/community communications and technical process technology, Mr. Rochford said.

"A key component of Phase Two is the development of a facility-specific environmental strategic plan whereby steps are taken to minimize the impact of various processes on the environment through continuous improvement," he added.

- Phase Three concentrates on making products environmentally neutral throughout their lives, Mr. Rochford said.

The major steps are removing heavy metal printing inks from packaging and using recycled materials whenever possible, he said.

- Phase Four concentrates on contributing to environmental initiatives outside the company and communicating with the public, he said.

The final phase "advocates facility involvement in community and professional organizations by encouraging facility personnel to invest their personal and professional expertise" in these groups and the community, Mr. Rochford said.

In setting up its environmental programs, the company learned that it takes time and corporate commitment to get results and that communications is the driving force behind the entire program, he said. ■

Environmental audits

Even the most well-planned can prove costly, time-consuming

By GAVIN SOUTER

BRUSSELS, Belgium—Environmental audits can help discover and deal with pollution, but managers should be aware of the cost and time involved, experts say.

To be effective, the audits should be carefully planned and run, they say. And the results should be used to help prevent future pollution, not just to clear up past mistakes.

Well-done audits can protect management from lawsuits, as well as protect the environment, according to speakers at a recent conference on Environmental Liability Risk Management held in Brussels, Belgium.

Gradual pollution is the worst kind of pollution to deal with, said Thierry Van Santen, director-risks and insurance for Valeo S.A., an auto parts manufacturer in Paris.

"It is there, but you don't know it. It is difficult to find, and it is difficult to deal with," he explained.

Mr. Van Santen recommended that companies follow three steps in dealing with gradual pollution, as well as accidental pollution, and that they comply with environmental regulations.

First comes investigation. All of a company's operations should be investigated, including research of past processes and post-operational and waste handling practices.

The investigation should include the process area, floor drains, storage vessels, tanks, waste streams, the geography of the area and its general hydro-geological conditions, Mr. Van Santen said.

Should potential problems arise, he said, proceed to the next step: sampling the air, soil, water and noise.

"The second phase is more costly, because it involves laboratories and it takes time," Mr. Van Santen warned.

Even this step, however, only indicates whether there are pollution problems. Alleviating them requires remediation—the often complex and costly third step.

Consequently, the first objective of the third stage is to estimate the cost of the cleanup, said Mr. Van Santen.

Once a company has assessed the degree of the problem, it can set up an investment plan to spread cleanup costs over several years.

"The final objective of all this is to provide local management with the means to deal with the problems," Mr. Van Santen said.

Environmental audits are tools for managers to determine if they are complying with regulations and to guard against lawsuits, said Turner Smith, managing partner with Hunton & Williams, a Brussels law firm.

These audits put managers in a much better position to defend themselves against pollution liability actions, Mr. Smith contended.

Conversely, audits do carry risks. They should not be done until managers have considered the possible results, warned Mr. Smith. "The person running the audit should be certain that his or her senior management understands what the audit means."

Managers may not be prepared to pay for cleaning up severe pollution if it is found, and they should be warned of that possibility beforehand, he cautioned.

Only multi-disciplinary teams should do the audits. "It takes an engineer to spot a physical risk, but you are also looking for legal liability, so you need a lawyer. Typically, the engineer and the lawyer working together come up with much better answers," he said.

An auditor's first tool, according to Mr. Smith, is a checklist that should

Continued on next page

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INTERNATIONAL

Pollution audit

Continued from previous page
include:

- A description of the company.
- Its operations.
- The location of hazardous waste, underground storage tanks, and other equipment that could give rise to potential environmental liability.
- The products manufactured and distribution areas.
- The age and condition of the facilities.
- The ownership of the property.
- The applicable laws and required permits.
- Previous environmental problems and how they have been corrected.
- The proximity to potential environmentally sensitive locations.

"But don't just use a checklist off the shelf. You must tailor it to your own situation," Mr. Smith said.

Another useful and simple approach is to list a facility's inputs and outputs, he said.

"You have what is going in and what is coming out, and if you can't find something that is going in on the way out, then you know that you have a problem," Mr. Smith remarked.

The audit should be viewed as a preventative exercise as well as a corrective one, and the report should be distributed among senior management and the departments of the company that are involved in monitoring environmental procedures, he said. ■

Australian risk management

Kloman predicts continued growth of alternative markets

By KATE McILWAINE

SYDNEY, Australia—Changes are afoot in risk management and risk financing, according to a consultant.

Risk managers need to adopt a different approach because of changes in the nature of risks, said H. Felix Kloman, principal and vp of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn.

"We focus on hazard-risk finance, which has traditionally been funded through insurance. The limitation is that insurance focuses on loss funding. Insurance companies have paid only lip service to loss prevention. They have not really put their heart into it," Mr. Kloman told Australian risk managers at a seminar in Sydney last month.

"There is a need for a new form of holistic risk management that focuses on broader areas of risk," he said.

Mr. Kloman said the traditional role of those involved in risk financing is changing as:

- Policyholders are buying less insurance and more services.
- Insurers are retaining larger net lines and entering service businesses.
- Reinsurers are writing less pure reinsurance and initiating direct contact with corporate buyers.
- And brokerages are selling less insurance and providing more services and advice.

Meanwhile, Mr. Kloman predicted continued growth in alternative risk financing techniques in the future. These alternative markets will flourish, he said, because of continuing insurance market volatility and financial instability; the unavailability of desired coverages; and inadequate loss prevention and claims management services.

"For major multinational organizations, more than 50% of total risk financing costs will be in self-insurance and alternative markets by 1995," he predicted.

Mr. Kloman said the favored alternative markets would include single-parent and group captives; risk retention groups; private insurers, like Bermuda-based ACE Ltd. and X.L. Insurance Co. Ltd.; pools and trusts; and financial reinsurance.

Problems facing the traditional insurance markets are a significant factor behind risk managers' embrace of alternative markets, Mr. Kloman said. He cited reduced security in the London and U.S. insurance markets, underwriting losses and high expense ratios as examples.

"Add to that the major earthquakes that will occur at some point in California or Missouri at an estimated cost to the insurance industry of $50 billion to $70 billion and environmental impairment claims being brought under all-risk policies," Mr. Kloman commented, predicting that EIL claims could cost underwriters $80 billion.

Despite the fact that there are no tax advantages for Australian companies owning captives, they have grown rapidly, and group captives are growing faster than single-parent captives, he said. A group captive offers substantially lower operating expense ratios and insurance at lower costs than the traditional markets.

"Throughout hard and soft markets, alternative risk financing has continued to grow, reflecting a massive loss of confidence in the system," he said.

Mr. Kloman suggested that companies create captives as mutuals with substantial capitalization of between $25 million and $100 million and allow them to retain substantial net lines from between $5 million and $20 million.

"The subsidiaries become policyholders and serve on the board or committees. They then come to think of the captive as their company and it is run for the benefit of the operating units," he said.

"A corporate captive can never be a profit center, but it is a tool to support sound risk management programs."

While many will flock to alternative markets, Mr. Kloman said some insurers and policyholders would probably prefer long-term relationships. Risk managers that do so should start making 10-year agreements with reinsurers and insurers that include mutual noncancellation clauses, except in cases of bankruptcy or non-payment of premium, Mr. Kloman commented.

"The insurance company should take a net line without reinsurance of at least as much as the corporation," Mr. Kloman suggested. Premium ratings might be averaged across 10 years, and costs could be stabilized, he said. The arrangement would permit an underwriter to offer broader coverage, he said.

In response to a question from the audience on insurer solvency, Mr. Kloman acknowledged that risk managers opting for these long-term relationships would need to pick their potential insurer partners very carefully.

Mr. Kloman said if Australian regulations discouraged such partnerships, risk managers should get together and approach the Insurance and Superannuation Commission to make regulators aware that their regulations would hinder "prudent decision making." ■

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Risk managers need management support

By KATE McILWAINE

SYDNEY, Australia—Risk management is often seen as a financial irritation and an impediment to more important corporate objectives, a risk management professor contends.

Corporate acceptance of risk management often is the most difficult problem facing the risk manager, said Gordon C.A. Dickson, professor of risk management at Glasgow College in Glasgow, Scotland, during a seminar for Australian risk managers in Sydney last month.

"For many years, insurance was seen as the answer to problems posed by risk," Mr. Dickson commented.

"In many countries, there was a general insure-all philosophy. Reaction was more prevalent than pro-action; steps to minimize risk were not taken until after the disaster struck. The 'it-won't-happen-to-me syndrome' was prevalent," he said.

Mr. Dickson said "financial fat" in many corporations contributed to this approach, noting that when profits were easy to acquire, there was little incentive to look at risk as a major cost. And, he said, risk managers were not skilled in educating people to better understand risk.

But many factors have made risk management a more important facet of a business's financial management, Mr. Dickson said.

They include:

- Legislation that makes it increasingly clear that companies have corporate responsibility for managing risk.
- Market forces that cause fluctuations in insurance pricing, making it less attractive as a risk-transfer mechanism and creating capacity problems for some coverages.
- Increasing consumerism.

Mr. Dickson advised Australian risk managers to win the support of senior managers to ensure that risk managers have "clout." But, risk management often conflicts with other corporate objectives, like production and cost and time savings, he said.

Meanwhile, Mr. Dickson said managing risk involves more than simply relying on good practice in the past and the creation of safety systems.

He cited examples of disasters in which the key elements of risk management had not been present —personnel with responsibility for risk identification and sufficient procedures to ensure risks were identified.

Mr. Dickson warned that the risk management profession was in danger of being marginalized and risk managers relegated to insurance buyers unless the profession assumes overall control for hazard analysis.

Shaun W.L. Wilkinson, group risk and insurance manager for Auckland, New Zealand-based Fletcher Challenge Ltd., a forest, paper and building materials company, agreed that risk managers tend to be reactive rather than pro-active.

Mr. Wilkinson also agreed that risk managers place too much emphasis on insurance. "Insurance merely provides some money to offset part of the effects of loss resulting from risk," he said.

"Most risk managers in Australasia have worked in the insurance industry, and it is perhaps only natural that they have a tendency to cling to their mother's skirts," he said.

However, Mr. Wilkinson acknowledged that insurance is an important risk financing tool and in some cases is the only way a firm can handle the consequences of being exposed to some forms of risk. ■

Syndicate losses

Continued from page 65

firmed.

The others are:

- Lloyd's ninth-largest syndicate, syndicate 209, which produced a loss of 4 million pounds ($7.7 million) or 4% of its 1988 capacity of 103 million pounds ($198.8 million).
- Syndicate 288, with a loss of 14.8 million pounds ($28.6 million), or 34% of its 1988 capacity of 43.5 million pounds ($84 million).
- Syndicate 203, with a 1.6 million pound loss ($3.1 million), or 8% of its 1988 capacity of 20.5 million pounds ($39.6 million).
- Syndicate 207, with a loss of 508,000 pounds ($980,000), or 4% of its 1988 capacity of 12.7 million pounds ($24.5 million).

Mr. Edwards generally attributes the poor results to "a combination" of 1988 losses plus the "deterioration in back-year losses." Pollution losses may have increased for some syndicates, but this was not the primary reason for the dismal results, he said.

"Ours aren't the only five marine syndicates to make losses in 1988," Mr. Edwards added. "A lot of marine syndicates will show losses in 1988. Very few marine syndicates will have a profit this year."

Major overall losses have also been announced at another two of the 10 largest marine syndicates, both managed by Wellington Underwriting Agencies Ltd.

'Very few marine syndicates will have a profit this year,' says Mr. Edwards.

Syndicate 448, the fifth-largest, has an overall loss of 34.8 million pounds ($67.2 million). And Lloyd's eighth-largest marine syndicate, syndicate 406, had a loss of 69.3 million pounds ($133.7 million)—the largest loss of the top 10.

"The result is of great concern to us; it is a cause of both embarrassment and regret that our names should have to shoulder such a heavy burden of loss against the background of many stable and profitable years," said John Prentice, the chairman of Wellington, and Ian Agnew, syndicate 406 underwriter, in a letter to members.

Outstanding pollution losses rose 41% to 18 million pounds ($34.7 million) from 12.7 million pounds ($20.4 million) in 1987. And outstanding asbestos claims increased about 13% to 8 million pounds ($15.4 million) from 7.1 million pounds ($11.4 million) in 1987.

Altogether, the reinsurance premium to close the 1988 syndicate just for asbestos and pollution claims has increased threefold to 91.2 million pounds ($176 million) at Dec. 31, 1990, from 31.9 million pounds ($51.4 million) at the end of 1989, said the letter from Messrs. Agnew and Prentice. A time and distance reinsurance policy, however, will reduce syndicate 406's gross loss by 33.7 million pounds ($65 million), says the letter.

Last week, in a meeting with 80 to 90 members' agents, Mr. Prentice explained that the overcapacity in the marine market has been "dwarfed" by the "significant increase in outstanding pollution and asbestos losses which occurred during recent months." These new notifications "outstripped" any reasonable projections that were made at the time of closing the 1987 account last year, Mr. Prentice said.

The pollution liabilities dating back as far as 40 years ago have arisen as a result of U.S. litigation that could not have been foreseen at the time the policies were written, Wellington's executives also say.

As a result, members on Wellington syndicate 406 have been asked to pay a cash call amounting to 58.7% of their written premium income; and members on syndicate 448 have been asked to pay 25.3%.

Other Lloyd's marine syndicates with 1988 overall losses, according to syndicate analysts, are:

- The third-largest, syndicate 932, managed by Janson Green Ltd., with an estimated loss of 32.6 million pounds ($62.9 million), or 20% of its capacity of 163 million pounds ($314.6 million).
- The fourth-largest, syndicate 367, managed by FLP Secretan & Co. Ltd. with an overall loss of 44.7 million pounds ($86.3 million), or 30% of its capacity of 149 million pounds ($287.6 million). ■

London

Continued from page 65

with inquiries from potential claimants in what could prove to be the nation's biggest ever product liability suit.

The number of people lining up to sue Roche Products Ltd. and John Wyeth & Brother Ltd. has nearly doubled to 6,000 since the action against the drug companies started in the British High Court earlier this year (*BI*, March 18).

The companies allegedly failed to warn doctors of the addictive qualities of benzodiazepine, a tranquilizer sold under various names.

Damages could run into many millions of pounds if the suits are successful as some of the plaintiffs are suing for over 10,000 pounds ($17,300).

Some 5,500 potential plaintiffs are seeking to sue Roche, which produces Valium, and Wyeth, which produces Ativan, said Paul Balen, a partner at Nottingham solicitors Freeth Cartwright. He is also head of the Benzodiazepine Solicitors Group, which is coordinating the action.

There are now 960 English law firms involved—from 620 in March.

The judge, Justice Ian Kennedy, also authorized adding Librium and Sernid to the list of drugs that can be cited in the action.

In a separate action in Scotland, lawyers have received 586 inquiries from potential plaintiffs and 500 will proceed with the case, said Kenneth Hogg, partner at Caesar Howie and chairman of the group coordinating the Scottish litigation.

The lawyers have lodged summonses for over 280 plaintiffs—up from 200 in March. Lawyers are now assessing the claims to determine what damages each plaintiff will seek.

Under Scottish law, the figure for each damage claim is inserted into the summons and any subsequent award may not exceed that amount. However, plaintiffs can adjust the amount claimed during the court case.

The highest amount entered in a summons so far is 20,000 pounds ($34,600), Mr. Hogg said.

In Northern Ireland, plaintiffs are still waiting to follow the lead of the English action, said Cormac Fitzpatrick, a partner with Vincent P. Fitzpatrick and secretary to the plaintiffs' lawyers group in Northern Ireland.

The group now has around 300 potential plaintiffs, which is about 50 more than in March, Mr. Fitzpatrick said.

Continued on next page

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INTERNATIONAL

LONDON

Movie claim possible

The producers of what was to be Sir David Lean's last film are insured against incompletion of the film in the event of the legendary director's death.

Although underwriters and brokers in London are stingy with the details, there could be an 11 million pound ($19 million) claim in the market following Sir David's death late last month.

At the time of his death Sir David was making a film version of Joseph Conrad's novel "Nostromo."

Shooting had not started, though sets had been built and other preparatory work done.

The film is believed to have had a $45 million budget and was to be filmed in a variety of locations in Europe and South America.

Sir David had been ill for some time, however, and Victoria Film Productions organized an insurance package "to indemnify the company in the event of the abandonment of 'Nostromo' due to the death or illness of David Lean," said an underwriter with a small line on the slip.

The risk is led by Lloyd's, the underwriter said. C.E. Heath & Co. (Insurance Broking) Ltd., which placed the coverage, would not comment.

However, it is not clear whether a claim will be made as the policy is understood to contain several clauses imposed by the underwriters because of Sir David's fragile health.

Also, the producers have not yet revealed whether they will abandon the project or find a replacement director. ■

BERMUDA

Continued from page 65

from within the jurisdiction.

"We are increasingly seeing efforts to decrease the costs of doing business here and, in some cases, this has meant that a company ends up being run by an absentee manager who maintains records overseas," Mr. Butterfield said. "There are also other instances where companies in Bermuda may have elected, under the IRS code, to be treated as U.S. companies for tax purposes. Companies in these situations will often do quite a lot of their business and record-keeping onshore," he said.

Though absentee managers are by no means illegal in Bermuda, regulators have found that problems can arise when a company's "principal representative" has difficulty performing his statutory duties due to a lack of information. Under the Insurance Act, every insurer must have a principal representative in Bermuda whose most important legal obligation is to provide authorities with an early warning of likely insolvencies.

"It has always been a gray area as to just what records are to be kept here in order for the principal representative to discharge his responsibilities. The guideline removes any uncertainty about what constitutes adequate records. It makes the position clear and is likely to be welcomed by absentee managers," Mr. Butterfield said.

The proposed new rule would directly affect "probably less than 100 companies" run from outside Bermuda, he said. Most companies that have a physical presence on the island or are managed from within the domicile are considered likely to already maintain adequate records, he said.

The recommendation proposes that minimum records kept on the island should include: financial statements; minutes of board and shareholder meetings; general and cash ledgers; details of reinsurers; premium and loss registers; and underwriting details of the programs being written. These would be in addition to statutory financial statement required to be kept on the island.

"Since the aim is to make sure the principal representative can perform his duties under the Insurance Act, it will be up to him to make sure these records are maintained here," Mr. Butterfield said.

Another proposed amendment to the Insurance Act would involve changing section 32 of the act, which governs the actions the minister of finance is permitted to take when "it appears. . .that the business of an insurer is being so conducted that there is a risk of the insurer becoming insolvent."

In these circumstances, the minister may "direct the insurer" to either cease underwriting, halt investment activities, maintain assets in Bermuda or avoid varying insurance contracts when the effect would be to increase the company's liabilities.

However, the act stipulates that before the minister issues a "direction," he shall "give notice to the insurer of his intention to give the direction and take any representations made by the insurer into account."

According to Mr. Butterfield, "the amendment being put to Cabinet proposes allowing the minister to serve a direction on an insurer without serving a prior notice. The idea is also that the minister would not be compelled to wait for a response. This would avoid the minister being effectively prevented from taking any action in cases where a response is not forthcoming. The proposed amendment would also require an insurer in these circumstances to submit details of its plans for corrective action.

"Amending section 32 in this way would make the section easier to administer and permit the regulatory authorities to respond more effectively to the problems of insurance companies," Mr. Butterfield said.

"Companies are usually more inclined to cooperate with the authorities in Bermuda than try to abuse the system," he added.

The proposals are expected to be well-received by Bermuda's liquidators, who have long complained that the law should be clearer, particularly on the subject of maintaining adequate records within the domicile.

Insolvency specialist David Lines, who was recently elected liquidator of Focus Insurance Co. Ltd. (*BI*, April 29) and has been liquidating Cambridge Reinsurance Ltd. since its collapse in 1985, said he is "delighted" with the proposed changes.

"All too often, many of the records are simply not here but in other countries," he said. The best example of this, according to Mr. Lines, was River Plate Reinsurance Co., which he was appointed to liquidate.

"We were never able to obtain River Plate's records. They just weren't here," he said.

Argus profits up

Bermuda-based Argus Insurance Co. Ltd., whose Somers Isles Insurance Co. Ltd. subsidiary is the island's largest domestic provider of group health insurance, announced profits of $7.2 million for 1990.

In addition, Argus unveiled plans for an insurance management office to be opened in Dublin,

Continued on next page



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INTERNATIONAL

BERMUDA

Continued from previous page
Ireland, and for a new rent-a-captive facility to be formed in Bermuda.

President Thaddeus Trott said net earnings rose 3% last year, with most of the gain due to non-underwriting activities like commissions and management fees.

"Underwriting results and investment income were little changed" from 1989 levels, he said.

Gross premium income increased to over $23 million, more than $21.2 million of which came from Argus' general and health insurance book. Investment income, commissions and management fees combined brought in an additional $31.4 million. And, shareholders equity rose almost $6 million to $38.3 million.

Commenting on the figures in the Argus annual report, Mr. Trott said that increases in the use of health care and medical services in Bermuda had exceeded projections.

However, while Argus health premiums were up 6%, claims grew by 14%, he noted. Mr. Trott blamed the sharply higher claims figure on increased services provided by the island's medical profession.

And, he called for the setting up of a controlling body to monitor health costs in Bermuda, arguing that such a move was necessary to prevent "the unrestrained provision of services with accompanying spiraling costs to the ultimate detriment of the public."

Argus, which also writes a small number of financial reinsurance contracts, additionally operates a brokerage that exclusively handles submissions to ACE Ltd., X.L. Insurance Co. Ltd. and Corporate Officers & Directors Assurance Ltd.

Argus also manages approximately 30 insurance companies and captives through its Argus International Management Ltd. subsidiary. And, it hopes to open a captive management office in Dublin, Ireland in June.

The company said this expansion recognizes "the importance of captive insurance developments in Europe and will be supported by two major clients," although it declined to name them.

Argus expansion plans in Bermuda include the formation of The Stuart Insurance Group Ltd. as a new rent-a-captive facility. Argus is Stuart's majority shareholder, while Liberty Mutual Insurance Co. of Boston has an 18% stake and Winterthur Swiss Insurance Co. Ltd. of Winterthur, Switzerland, holds a small stake.

Robert Barrese, a Liberty Mutual vp, said the new facility will be marketed in the United States as the Stuart Premium Investment Plan. It will be sold to family-owned business and property/casualty accounts generating less than $1 million in annual premium.

"Liberty Mutual has a large base of mid-sized customers that have limited financial options," Mr. Barrese said. Stuart "is one way they can obtain some investment returns on their premium dollars."

He said Argus already is operating a rent-a-captive in Bermuda for Liberty Mutual known as Liberty Mutual Bermuda. "Our latest research identified a niche for this product, but it is one in which we needed to simplify the product and market it to a larger sector."

For the future, Argus' Mr. Trott predicts that although Bermuda's recession will affect "the implementation by employers of new employee benefits," the company is predicting "slow growth" in all areas of its business. ■

Oakeley Vaughan lawsuit

Continued from page 65
Nowhere in the clause is the word "contract" mentioned, which could mean Lloyd's can be held liable for breach of contract with a Lloyd's member, Mr. Lyndon-Stanford said.

This argument evidently caught Lloyd's attorney and the judge by surprise.

Lloyd's trial lawyer David Johnson said that he had not been told before the trial that this point would be raised.

Justice Gatehouse—who is very familiar with the acts of 1871, 1911 and 1982—also seemed surprised at this argument. "Are you suggesting that Lloyd's is liable for breach of contract?" he asked.

Mr. Lyndon-Stanford answered only that it was strange that breach of contract is not mentioned in the immunity clause.

"Well, I'd be surprised if there was a great big hole in Lloyd's immunity," Justice Gatehouse said. "It can't have been intended, surely."

The court then examined a 1980 report issued by Sir Henry Fisher that became the framework for the 1982 law. The report suggested that it would be "disastrous" if the Lloyd's Council were deterred from forming bylaws under the act for fear of litigation by members later.

Sir Henry therefore recommended some alternatives to protect the council from liability, from which Parliament was to select one. The alternatives included that the council would buy insurance, which would be paid for by Lloyd's brokers and agents, and that the council would be immune from liability.

"The question of (Lloyd's liability to members under) contract was clearly before Parliament," Mr. Lyndon-Stanford argued. "If (Lloyd's) has contracts with members, why shouldn't (Lloyd's) be sued?"

But, Justice Gatehouse pointed out that if the immunity clause does not include contractual liability, then Lloyd's would have had to require all members to sign a new members agreement that included a clause granting it immunity from contractual liability.

Existing members might have refused this waiver, the judge said.

"So I would have thought that statutory immunity in the act was the only alternative."

However, Mr. Lyndon-Stanford stressed again that the question of Lloyd's liability for breach of contract is not specifically addressed in the 1982 act.

Mr. Johnson, the attorney for Lloyd's, then complained that Mr. Lyndon-Stanford should not have brought up such a "serious" matter during the second week of a trial, especially since he had ample time before trial to consider this argument and file it in the plaintiffs' pleadings.

"If this is a point, you must tell me and Mr. Johnson," Justice Gatehouse agreed. "You may or may not want to pursue this point," the judge added.

Mr. Lyndon-Stanford contended that he had in fact included the point in his pleading and later pointed it out to the court.

The members' attorney also continued to present a chronology of events that he said shows that Lloyd's covered up its concerns over the management of Oakeley Vaughan between 1981 and the end of 1982.

The Oakeley Vaughan members accuse Lloyd's of negligence for keeping them "in the dark" about the reasons it imposed penalties on certain Oakeley Vaughan directors in 1981; for not telling them at the time that the syndicates were overwriting by as much as 300%; and that it was taking other actions against Oakeley Vaughan, including demanding that Chairman Charles St. George step down and not hold more than 10% of the voting rights of the underwriting agency (*BI*, April 29).

The chronology of events included meetings regarding Oakeley Vaughan involving Lloyd's underwriter and committee member Stephen Merrett; former Lloyd's employee Kenneth Randall, now managing director of Merrett Holdings P.L.C.; former Lloyd's Chairmen Peter Green; and former Chairman Murray Lawrence in his capacity as a Lloyd's committee member.

At the time Lloyd's was trying to sort out the Oakeley Vaughan situation, Parliament—which was being lobbied by former Lloyd's Chairman Peter Miller—was acting on the Lloyd's Act, 1982, according to Mr. Lyndon-Stanford.

The members contend that Lloyd's tried to cover up the Oakeley Vaughan situation so members of Parliament would not raise any questions and hold up passage of the act, he said.

All these former Lloyd's chairmen are expected to be called as witnesses during the trial, which is expected to last nine weeks.

But, Justice Gatehouse pointed out that the members should have known of the "severe" penalties on the Oakeley Vaughan directors because they were posted in the underwriting room at Lloyd's.

In addition, letters about the penalties were sent to members.

But, Mr. Lyndon-Stanford argued that those letters were insufficient because they did not include the reasons for the penalties. Mr. St. George made it seem that the penalties were merely for misconduct in "technical" procedures and nothing more, Mr. Lyndon-Stanford contended.

"Let's be realistic," Justice Gatehouse replied. Members should have realized that "if it was a technical matter it wouldn't have attracted this sort of penalty," he said.

"What should Lloyd's have done other than what they did do?" the judge asked. "Are you saying that Lloyd's should have reported to members individually? I would have thought it realistic (for Lloyd's) to leave it to the underwriting agency to tell names. . . .Why shouldn't Lloyd's leave it to the (members') agency?"

Lloyd's should have evaluated any Oakeley Vaughan Underwriting letters for accuracy and to make sure that the letters actually reached names, Mr. Lyndon-Stanford argued.

What happened "was seriously wrong" and "called for correction," he said. ■

Late captive manager listings

The following captive management companies' questionnaires were not submitted in time to be alphabetized in the April 29 directory.

Bain Clarkson Management Services (Isle of Man) Ltd.

Derby House, Athol Street, Douglas, Isle of Man; 0624 624141; fax: 0624 622500

Founded: 1986.
Parent company: Inchcape Group.
Frequent services: Subcontracts for captive management services with Isle of Man Insurance Management Ltd.
Compensation: Annual fee, $38,000 minimum.
Principal officers: E.G. Thomas, C. Crowther and B.M. Vick, directors.

Isle of Man Insurance Management Ltd.

Derby House, Athol Street, Douglas, Isle of Man; 0624 624141; fax: 0624 622500

Founded: 1979.
Parent company: Isle of Man Assurance Ltd.
Frequent services: Captive feasibility studies, captive formation, government reporting, accounting, computerized accounting, manual claims processing, claims reserves analysis, underwriting and ratemaking for captives.
Occasional services: Loss forecasting, reinsurance brokered for captives.
Staff: 10, seven professionals. Professional designations held include one FCII.
Clients: 10 active captives managed at year-end 1990.
Current business: 10 active captives, one inactive captive.
Subsidiaries: Dublin Independent Risk Management Ltd.
Compensation: Annual fee, $38,000 minimum.
Principal officers: R.N.S. Bigland, C. Crowther, P.M. Vick and T.E. Osborne, directors.

Sedgwick Group Management Services (Barbados) Ltd.

P.O. Box 1262, Musson Building, Hincks Street, Bridgetown, Barbados, W.I.; 809-436-7635; fax: 809-436-7871

Founded: 1984.
Parent company: Sedgwick Group, Lynch Insurance Brokers and Insurance Group of Barbados.
Frequent services: Captive formation, government reporting, accounting, computerized accounting, manual claims processing, claims reserves analysis, loss forecasting.
Staff: Four, one professional who is a chartered accountant.
Clients: 15 captives managed at year-end 1990.
Principal officers: Peter Walford, chief executive officer; Alex Dowell. ■

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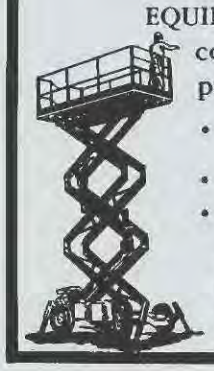
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Eastern moves toward liquidation

Bankrupt airline seeks relief from retiree health obligation

By STACY ADLER

MIAMI—Some 14,000 retirees say they will fight attempts by bankrupt Eastern Air Lines Inc. to avoid paying for their health care benefits.

Eastern, which filed for bankruptcy under Chapter 11 of the Federal Bankruptcy Act in 1989, has asked a federal bankruptcy judge to relieve the airline of its obligation to retirees.

Providing health insurance, at an estimated $400 per retiree monthly, has become prohibitively expensive since Eastern stopped flying Jan. 18, the Miami-based airline claims.

However, retirees—half of whom are under 65 and do not qualify for Medicare—say they cannot afford to pay the cost of health care coverage.

Eastern now pays the full cost of the plan.

Because no previous cases have addressed these questions, the Eastern litigation "will create new law," said William Bell.

Mr. Bell is a former senior vp and general counsel for the airline, who is now representing a large group of retirees.

Employee benefit consultant Henry Saveth agreed: "This case will set a precedent."

In addition, this case could lead to new legislation to protect retirees' health care benefits, said Mr. Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"If this turns out badly for retirees, in that they are left practically without coverage, we would likely see some legislation," he said.

Attorneys for Eastern could not be reached for comment.

Eastern estimates that the present value of its obligation under the retiree health care plan is $353.3 million.

Retirees, however, put the present value of the obligation at $450 million, according to Mr. Bell.

The Eastern retiree health litigation 'will create new law,' says plaintiffs attorney William Bell.

That discrepancy is due to differing estimates of future increases in health care costs, Mr. Bell explained.

Eastern has asked U.S. Bankruptcy Judge Burton R. Lifland in New York to allow it to set up a trust fund to pay for the retiree medical coverage. The airline wants to provide an initial $1.5 million and have retirees pay the remainder.

"A mere $1.5 million would be little better than no contribution at all," said Mr. Bell. To make the coverage affordable for retirees, he estimates that Eastern would have to contribute $200 million to $300 million.

A hearing scheduled for May 8 has been postponed as retirees try to negotiate a compromise under which the airline would contribute enough money to make the coverage affordable for retirees, he said.

"We are trying to determine just how much contribution is necessary by Eastern so that retirees can afford this coverage," said Mr. Bell.

Retirees with health care benefits at companies that file for bankruptcy under Chapter 11 of the Federal Bankruptcy Code have some protection under the Retiree Benefits Bankruptcy Protection Act (*BI*, June 6, 1988).

That 1988 law was passed shortly after LTV Corp. attempted to cancel its retiree health care coverage in 1987, explained Nel Hennessey, a benefits attorney with Wilkie, Farr & Gallagher in Washington, D.C.

Under this act, a company that is in bankruptcy cannot modify retiree health care benefits or reduce its obligation to provide these benefits without proving to a bankruptcy judge that such measures are necessary to avoid going into liquidation.

The problem with applying this law to the Eastern bankruptcy is that Eastern says it is liquidating. It is possible for companies to move toward liquidation under Chapter 11, attorneys say.

Moving to Chapter 7, which provides for liquidation, would raise costs substantially, leaving less for retirees and all other creditors.

"Eastern is just using Chapter 7 as a threat," said Mr. Bell, the lawyer for the retirees.

"No one wants to go into Chapter 7," Mr. Bell said.

As a result, the airline is arguing that the Retiree Benefits Bankruptcy Protection Act does not apply while retirees are countering that it does.

Furthermore, the retirees argue that even if Eastern moves under Chapter 7, the law should still be applied.

Mr. Bell also said he is pushing for Congress to amend the Retiree Benefits Bankruptcy Protection Act so that it expressly applies to Chapter 7 liquidations.

Eastern retirees have one other measure of protection: Under the Consolidated Omnibus Budget Reconciliation Act, the retirees can purchase continued health care coverage through Eastern at a maximum cost of 102% of the plan premium if the coverage is canceled by Eastern, explained Mr. Saveth.

However, COBRA coverage would only be available if Eastern is not liquidated.

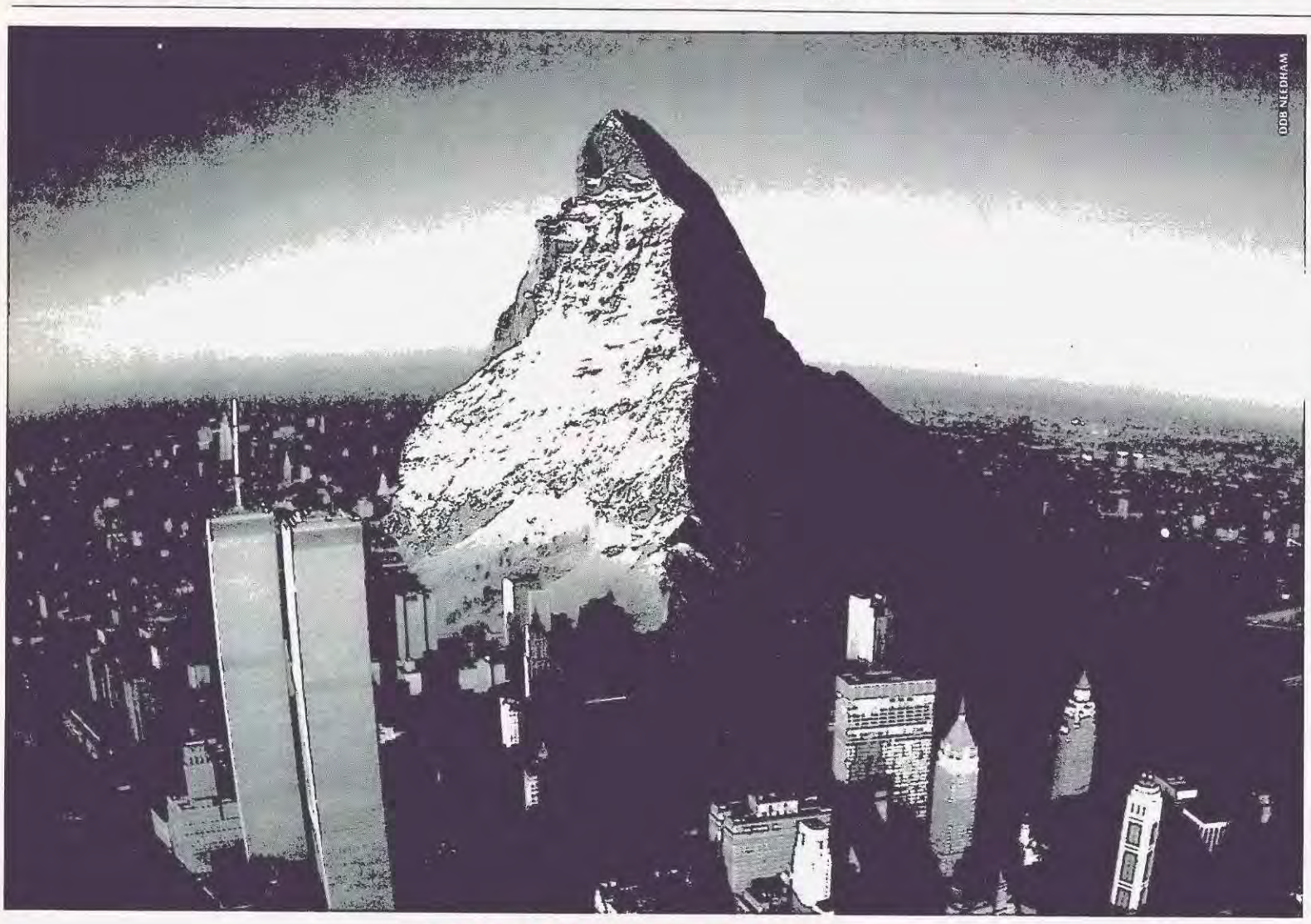
And most Eastern retirees, however, would find the cost of COBRA coverage prohibitive, said Mr. Bell. "The cost of the medical policy would in most cases be more than what the retirees receive in retirement pay," he said.

In addition, many retirees have pre-existing conditions that would bar them from purchasing health insurance, Mr. Bell said.

Until this problem is resolved, Mr. Bell is proposing that the benefits under the retiree health care plan be scaled back and retirees begin contributing to the plan.

Eastern has not yet responded to this proposal, said Mr. Bell.

Should the employees lose their health insurance plan, no guaranty fund would step in, explained Ms. Hennessey. ■



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McDonald's seeks retrial of 'fatigue' suit

Employer liability questioned for car crash

By DEBORAH SHALOWITZ

PORTLAND, Oregon—A McDonald's Corp. franchise is seeking a new trial after a jury ordered it to pay a $400,000 negligence award to a man severely injured in a car wreck caused by a fatigued employee driving home from work.

The verdict, though, raises questions among some insurance experts about whether employers are insured for such damages under any commercial policies.

A Multnomah County Circuit Court jury in Portland, Ore., last month ordered McDonald's Restaurants of Oregon Inc. to pay the award to Frederic M. Faverty, who was severely injured in a car accident caused by an 18-year-old McDonald's worker on his way home from work.

The worker, Matthew Theurer, who was killed in the April 5, 1988, accident, had attended high school the day before and then worked from 3:30 p.m. to 7:30 p.m. at a McDonald's restaurant in Clackamas, Oregon. He then returned to work at midnight that night and worked until approximately 8:20 a.m.

Before leaving work, Mr. Theurer asked his manager to assign another worker to work his next shift, which was arranged, according to court papers.

Within 20 minutes after leaving work, while driving to his home 19 miles away from the restaurant, Mr. Theurer fell asleep at the wheel. His car drifted across the center of the road and hit the auto driven by Mr. Faverty head-on.

Among many other injuries, Mr. Faverty sustained multiple fractures in his left hip and leg.

Because of his injuries and the many surgeries that resulted, Mr. Faverty, who shoes horses for a living, could not work for approximately nine months.

McDonald's "was negligent in working (Mr.) Theurer more hours than was reasonable under the circumstances when (the company) knew, or in the exercise of reasonable care should have known, that (Mr.) Theurer would operate a motor vehicle and be a hazard to himself and to others," his lawsuit claimed.

McDonald's has filed a motion for a new trial in the case.

A $10 million lawsuit filed against McDonald's by the worker's estate still is pending.

McDonald's officials and its attorney would not comment on the case or the franchise's insurance.

However, Janet Bachman, vp-claims administration for the American Insurance Assn. in Washington, D.C., blasted the decision. 'They're expecting an employer to be responsible for a circumstance he cannot control or predict. How can you tell how tired someone is unless they fall asleep while you're talking to them?"

And, an individual is responsible for deciding whether he or she is too tired to drive, she said.

There is "no one, clean, national answer to" the question of insurance for this kind of loss, Ms. Bachman said.

"It would be a novel question of coverage," she said.

However, "by and large, most insurance contracts do not anticipate this problem," she said.

But, two brokers disagree.

Andrew Rogal, executive vp with broker Hilb, Rogal & Hamilton Co. said that courts have looked at employer's liability "very broadly."

"The general trend of courts has been to extend liability to the employer," said Mr. Rogal, who is also chief executive officer of the broker's Pittsburgh operations.

And, if an employer were held liable, it is likely that there would be coverage, he said.

But, the primary source of coverage for third-party claims would be the deceased employee's automobile policy, he said.

If the employee was uninsured or the limits were insufficient, the company's commercial general liability policy would then be tapped, Mr. Rogal speculated.

Neil Huson, senior vp of Jardine Insurance Services Inc. in Portland, Ore., agrees that the primary source of coverage to pay any claim probably would be the deceased employee's own automobile policy.

But, am employer's general liability policy would almost never respond to such a case because a typical policy excludes auto-related claims, he said.

Another popular exclusion in general liability policies denies coverage if an accident occurs when a worker is "not operating on behalf of the corporation," Ms. Bachman noted.

Even without those exclusions, the policy would have to be written to cover off-premises hazards, she noted.

The company's umbrella or excess layer possibly could be tapped, Ms. Bachman, Mr. Huson and Mr. Rogal agreed.

Umbrella or excess liability policies "tend to be very liberally worded," Ms. Bachman pointed out.

These policies "anticipate and generally provide for instances where the primary contract doesn't respond," she said.

Ms. Bachman also noted that an employer would be covered under its commercial automobile liability insurance if the employee were driving a company vehicle while on business.

But, Mr. Huson said that commercial auto liability coverage also typically covers damages caused by employees when driving non-owned vehicles. The policy would respond after the employee's auto liability coverage, he said. She also pointed out that each state has its own "going and coming rule," which addresses whether injuries that employees sustain while traveling to and from work are covered by workers comp.

But, in Oregon, employees are not covered by workers comp when they are commuting to and from work, according to an official of the state's workers compensation administration.

Employers' liability coverage, which protects employers against liability for worker injuries not covered by the workers comp law would not respond in a case like the one in Oregon because the employee was not working when the accident occurred, Ms. Bachman noted.

In litigation like the McDonald's case, it would be important for employers to determine how the lawsuit presents "the basis for the liability of the corporation," Ms. Bachman said.

"That will go a long way" toward determining how an insurance company would respond, she said.

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Associate Editor Meg Fletcher in Chicago contributed to this report.

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Buffett outlook

Continued from previous page
tle difference, Mr. Buffett said.

Without naming names, he also observed of some failed insurers "that if they had a 20-foot neon sign flashing, 'Fraud, fraud, fraud,' it couldn't have been any clearer."

Mr. Munger disagreed: "The sign you would see more often is, 'Stupid megalomania.' "

Flawed regulation was the focus of a report last year by the House Oversight & Investigations Subcommittee, which has since floated a proposal for a federal role in insurance regulation.

"Maybe they will come up with something better," Mr. Buffett said of the subcommittee proposal.

For the second year in a row, Berkshire held its annual meeting at the Orpheum after the 1,000-seat Joslyn Art Museum auditorium proved too small for the growing crowds of Berkshire shareholders.

Shareholders' questions at the meeting reflected Berkshire's diversity: Its insurance operations—a key source of cash for investments—are largely capitalized with its huge holdings in Capital Cities/ABC Inc., The Coca-Cola Co., GEICO Corp., The Washington Post Co., Wells Fargo Co., Salomon Inc., USAir Group Inc., Champion International Corp., and Gillette Co.

Berkshire is also a major shareholder of the Federal Home Loan Mortgage Corp., and a major holder of RJR Nabisco Inc. junk bonds and bonds issued by the Washington Public Power Supply System.

In addition, the company holds controlling interests in See's, a California candy maker; Borsheim's, an Omaha jewelry store; the Omaha-based Nebraska Furniture Mart; World Book, the encyclopedia publisher; Fechheimers, a uniform manufacturer and retailer; and The Buffalo News, a Buffalo, N.Y., newspaper.

The highest-priced stock listed on the New York Stock Exchange, Berkshire shares closed at $8,125 on April 29, the day of the meeting.

Along with his wife, Mr. Buffett—who received $100,000 in cash compensation last year—owns 45% of Berkshire's outstanding stock, worth roughly $4.2 billion.

Formal business typically takes only minutes at the annual meeting. This year, it included the election of Mr. Buffett's wife, Susan T. Buffett, to the board.

The real business then begins: a roughly three-hour question-and-answer session—in which Mr. Buffett and Mr. Munger field queries ranging from their strategic plans to pleas for stock tips.

The first question this year was from a 10-year-old boy who said he owned 10 shares and complained that his age was misstated as 11 in a previous Berkshire annual report.

Given this, he wondered, how reliable were other numbers in the report?

"That's a very good question," Mr. Buffett said when the laughter died down.

The garrulous, folksy Mr. Buffett and the reserved, trenchantly funny Mr. Munger made an odd pair onstage.

Mr. Munger's penchant for letting his long-time partner do most of the talking became a running joke. At one point, Mr. Buffett delivered a lengthy answer to a question about abusive executive pay practices at some companies, then turned to Mr. Munger. "Charlie, do you want to say anything?" he asked.

"I have nothing to add," Mr. Munger said with finality.

"That's what he's here for," Mr. Buffett told the chuckling audience.

The same relaxed spirit is evident in Berkshire's 1990 annual report, which includes a letter to shareholders from Mr. Buffett on Berkshire's operations and a separate letter from Mr. Munger on the operations of Wesco Financial Corp., a Berkshire subsidiary.

Mr. Buffett reported in a footnote that "a few small sections" of Mr. Munger's letter had been excised.

"When Berkshire's report exceeds 72 pages, we have problems in binding it," Mr. Buffett explained. "Either Charlie's letter or mine had to be cut and I decided a coin flip was appropriate. In fact—as things turned out—I finally decided nine flips were appropriate."

Along with an entertaining annual meeting, Berkshire management has provided above-average returns, an increasingly difficult task in most areas of its insurance segment.

The Berkshire insurance group consists of a dozen companies—principal among them National Indemnity Co.—with total year-end 1990 statutory surplus of $6.3 billion, according to the annual report.

'We believe Berkshire to be the largest U.S. writer of super-cat business,' writes Mr. Buffett.

Total premium earned by Berkshire's insurance operations was $591.5 million last year, up 50% from $394.3 million in 1989, largely because of a huge increase in assumed reinsurance volume, the statement said.

Berkshire's direct insurance operations continued to shrink last year, producing earned premiums of $154 million, down 18.5% from $188.9 million in 1988. The 1990 direct premiums included:

- $94 million in auto and general liability coverages, down from $113 million in 1989, $168 million in 1988 and $268 million in 1987.
- $18 million in commercial casualty, professional liability and specialty risk premiums earned through Berkshire's New York-based commercial underwriting office. These premiums were down from $20 million in 1989, $54 million in 1988 and $93 million in 1987.
- $42 million in premiums written by Berkshire's "homestate" insurance units writing only in Colorado, Kansas and Nebraska; and California workers compensation business written by Cypress Insurance Co. Combined volume from these units was down from $56 million in 1989, $70 million in 1988 and $80 million in 1987.

Business written by these operations has declined after hitting a peak in 1986, because Berkshire underwriters have been encouraged to reject underpriced risks, the annual report says.

Meanwhile, assumed reinsurance volume exploded last year, with earned premiums more than doubling to $437.4 million from $205.4 million in 1989.

This was despite the complete absence last year of premiums assumed by National Indemnity under a quota share reinsurance treaty with Fireman's Fund Insurance Cos.

This treaty—which ran from September 1985 to August 1989 and called for National Indemnity to assume 7% of Fireman's Fund's business—had accounted for the bulk of the group's reinsurance volume in recent years, generating earned premiums of $130.6 million in 1989 and $215.5 million in 1988.

The August 1989 expiration of the treaty allowed National Indemnity to escape losses from Hurricane Hugo and the San Francisco earthquake.

More than making up for the loss of this business, though, Berkshire last year wrote $378 million in financial reinsurance products covering ceding insurers against adverse development of their own loss reserves, the annual report said.

In his letter to shareholders, Mr. Buffett also reported that the insurance group is pursuing an "unusually volatile" form of coverage: "super-catastrophe" retrocessional coverage.

Such coverage has a dual trigger, requiring both the ceding reinsurer's and the total industry's losses to exceed defined levels in a given catastrophe.

For example, he said, Berkshire might write a policy with a $10 million limit covering a reinsurer if the reinsurer's losses in a catastrophe exceeded a defined amount and the total industry's losses exceeded $5 billion.

"Note that we are not spreading risk as insurers typically do; we are concentrating it," Mr. Buffet said. "Therefore, our yearly combined ratio on this business will almost never fall within the industry range of 100%—120%, but will instead be close to either zero or 300%."

"We believe that Berkshire shareholders, if properly informed, can handle unusual volatility in profits so long as the swings carry with them the prospects of superior long-term results. Charlie and I always have preferred a lumpy 15% return to a smooth 12%," Mr. Buffett wrote.

"At the moment, we believe Berkshire to be the largest U.S. writer of super-cat business. So when a major quake occurs in an urban area or a winter storm rages across Europe, light a candle for us," he said.

With the $591.5 million in premiums earned last year, Berkshire reported losses and loss expenses of $534.2 million and underwriting expenses of $83.9 million, leaving the group with a pre-tax underwriting loss of $26.6 million.

This was a slight deterioration from the $24.4 million underwriting loss reported in 1989, according to the annual report.

After net investment income of $327 million and other investment gains and taxes, the insurance group finished the year with net earnings of $279.1 million, down 19.6% from $347.2 million in 1989.

Assessing the industry's outlook, Mr. Buffett observed in his letter that he expects industrywide incurred losses to grow at an average annual rate of about 10%.

If growth in written premiums lags behind, the result will be widening underwriting losses, "though the industry's tendency to underreserve when business turns bad may obscure their size for a time."

Citing figures from A.M. Best Co., he noted that written premiums grew an estimated 4.5% in 1990 and 3.2% in 1989, while incurred losses expanded an estimated 5.0% and 7.7%, respectively.

The industrywide combined ratio grew to 109.8% last year from 109.2% in 1989, and the deterioration was somewhat masked by the inclusion of losses from Hurricane Hugo in the 1989 figure, he noted.

This downward trend will continue, and the industrywide combined ratio will probably rise another two percentage points for 1991, Mr. Buffett predicted.

Posing the problem of how to evaluate an insurer's profitability, Mr. Buffett proposed what he described as the "loss/float ratio" as a better measure than the traditional combined ratio.

The loss/float ratio compares a company's underwriting loss to its "float"—or the funds it has available for investment—defined as the total of loss reserves, loss adjustment expense reserves and unearned premium reserves, minus agents' balances, prepaid acquisition costs and deferred charges applicable to assumed reinsurance.

The ratio is intended to show the cost to the insurer in losses of the funds it takes in to invest.

Berkshire's annual report includes a table calculating the group's loss/float ratio for each year from 1967 to 1990.

For example, the figure hit a peak in 1984, when Berkshire produced an underwriting loss of $48.1 million on an average float of $253.2 million, producing a loss/float ratio—or average cost of funds—of 18.98%. This compared unfavorably with the 11.58% year-end yield on long-term government bonds, the table shows.

In 1990, though, Berkshire produced an underwriting loss of $26.6 million on an average float of $1.62 billion, resulting in a loss/float ratio of 1.65%, representing a cost of funds far lower than the 8.24% year-end yield on long term government bonds.

Like any insurance statistic, Mr. Buffett noted, this one is meaningless over a short period of time.

"The fat lady has yet to gargle, let alone sing, and we won't know our true 1967-1990 cost of funds until all losses from this period have been settled many decades from now," he wrote.

So far, though, Berkshire has generally kept its cost of funds low, enhancing the company's value to shareholders, he observed.

Many widely-known insurers, on the other hand, have not, he added.

"Unless these companies can materially improve their underwriting performance—and history indicates that is an almost impossible task—their shareholders will experience results similar to those borne by the owners of a bank that pays a higher rate of interest on deposits than it receives on loans," he concluded. ■

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MAY 13-15. Regional Environmental Regulation Conference in Chicago, sponsored by Executive Enterprises Inc.; $1,045. **Also June 3-5** in Boston; **June 10-12** in St. Louis and San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 13-15. Reinsurance Accounting and Auditing seminar in New York City, sponsored by The College of Insurance; $895 for college sponsors; $995 for non-sponsors; less $100 for second person from same organization registering on same date. **Also Sept. 11-12** in Chicago, **Nov. 13-15** in San Francisco. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 13-16. Federal Income Taxation—Life seminar in Hartford, Conn., sponsored by Booke & Co.; $1,295. **Also June 11-14** in Winston-Salem, N.C. Booke & Co., Insurance Co. Services, 919-748-1120.

MAY 13-17. Aviation Insurance Course in London, sponsored by DYP Insurance and Reinsurance Group Ltd.; 895 pounds ($1,720). DYP Insurance, Bridge House, 181 Queen Victoria St., London EC4V 4DD; 71-236-2175.

MAY 13-17. Fundamentals of Employee Benefits Management training course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $1,050 for International Foundation members; $1,175 for non-members. **Also June 10-14, July 22-26, Aug. 12-16, Sept. 23-27** in Brookfield, Wis. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MAY 14. Workers Comp—Issues for the 90s seminar in Sioux Falls, S.D., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the The South Dakota Underwriters Assn.; $75. Charles White, program coordinator, 605-361-1866.

MAY 14. A Course in Business Income Exposures and Their Treatment in Plainview, N.Y., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Long Island Chapter; $100; $20 exam fee. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2735.

MAY 14. American Institute of Marine Underwriters seminar in New York City, sponsored by the AIMU; $150 for AIMU members; $175 for non-members. AIMU, 14 Wall St., New York, N.Y. 10005; 212-233-0550.

MAY 14. EPA workshop in Chicago, sponsored by the Illinois State Chamber of Commerce; $120 for chamber members; $180 for non-members. Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

MAY 14. Benefit Recordkeeping Strategies for the 1990s and Beyond seminar in Detroit, sponsored by GENESYS Software Systems Inc.; no charge. **Also May 15** in Cleveland; **May 22** in New York City. Maureen Paradis, GENESYS, 508-685-5400, ext. 3055.

MAY 14-15. Two Day Advanced Captive Workshop in London, sponsored by the Risk & Insurance Research Group Ltd.; 575 pounds ($1,121). Risk & Insurance Group Ltd., 4 Henrietta St., London, England WC2E 8PS; 071-836-0614.

MAY 14-15. Health Care Cost Containment workshop in Milwaukee, sponsored by the Health Research Institute; $595. **Also Sept. 17-18** in San Francisco; **Oct. 15-16** in Boston; **Nov. 12-13** in New York. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 14-15. Labor Management Health Care Cost Containment workshop in Milwaukee, sponsored by the Health Research Institute; $595. **Also Oct. 15-16** in Boston; **Nov. 12-13** in New York; **Dec. 10-11** in Chicago. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 15. Human Factors in Loss Control seminar in New York City, sponsored by The College of Insurance; $225 for college sponsors; $275 for non-sponsors. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 15. Pollution Liability—The Law and Available Insurance seminar in Fort Wayne, Ind., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Northern Indiana Chapter; $135 for society members; $155 for non-members. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, Kahler Hall, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2735.

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MAY 15-18. 1991 Annual Meeting of The Physician Insurers Assn. of America in Nashville, Tenn., sponsored by the PIAA; $375 for PIAA members; $500 for non-members. Joyce Harbourt, Administrative Manager, PIAA, 65 S. Main St., Building D, Pennington, N.J. 08534-2827; 609-737-7193.

MAY 16. Halon in the '90s seminar in Newark, N.J., sponsored by the New York City and New Jersey Society of Fire Protection Engineers; $80; $100 after May 9. John Crawford, Johnson & Higgins, 6 Century Drive, Parsippany, N.J. 07054; 201-292-5245.

MAY 16. Mission Possible—And You Though You Had Problems conference in Memphis, Tenn., sponsored by Business Emergency Preparedness Council; $129 for BEPC members; $149 for non-members. Don Batchelor, P.O. Box 387, Memphis, Tenn. 38147; 901-523-6345.

MAY 16. National Health Proposals workshop in Milwaukee, sponsored by the Health Research Institute; $295. **Also June 27** in Honolulu. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 16. Workers Comp Office of Benefit Assistance & Enforcement Audit Program in Sacramento, Calif., sponsored by the Insurance Educational Assn.; $140 for IEA members; $165 for non-members. Maggie Rodee, IEA, 415-986-6356.

MAY 16. Advanced Cost Containment workshop in Milwaukee, sponsored by the Health Research Institute; $295. **Also Sept. 19** in San Francisco; **Oct. 17** in Boston; **Nov. 14** in New York; **Dec. 12** in Chicago. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

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MAY 16. 83rd Annual Meeting of the Surety Assn. of America in New York City, sponsored by the SAA; no charge. Cary Schneider, 212-669-9200.

MAY 16. Employers Council on Flexible Compensation Regional Conference in Morristown, N.J., sponsored by the ECFC; $185 for ECFC members; $195 for non-members. ECFC Conference Center, Department 5063, Washington, D.C. 20061-5063.

MAY 16. Fleet Driver Improvement Program in Charlotte, N.C., sponsored by Consolidated Service Corp.; $88; discounts for additional participants from same company. **Also May 21** in Boston; **June 4** in St. Louis; **June 6** in Kansas City, Mo.; **June 11** in Denver; **June 18** in Sioux Falls, S.D.; **June 20** in Detroit. Ron Starr, CSC, 2500 Devon Ave., Elk Grove Village, Ill. 60007; 708-640-2666.

MAY 16. How to Identify, Evaluate and Reduce the Risks of Special Events in Parsippany, N.J., sponsored by Event Risk Management; $235; $135 for manual or seminar only. **Also May 17** in Boston; **May 21** in Rochester, N.Y.; **May 23** in Norfolk, Va.; **May 24** in Baltimore; **May 28** in Philadelphia; **May 29** in New York City; **June 10** in Phoenix, Ariz.; **June 12** in Albuquerque, N.M.; **June 14** in Oklahoma City; **June 17** in Memphis, Tenn.; **June 18** Atlanta; **June 20** in Greenboro, S.C.; **June 21** in Huntington, W. Va; **June 24** in Cleveland; **June 25** in Chicago; **June 27** in Des Moines, Iowa; **June 28** in Kansas City, Mo.; **July 1** in Denver. Event Risk Management, 34052 La Plaza Drive, Suite 103-314, Dana Pointe, Calif. 92629; 714-493-0529.

MAY 16-17. Brief Reinsurance seminar in New York City, sponsored by The College of Insurance; $215 for college sponsors; $265 for non-sponsors. **Also June 6** in Chicago, **September 12** in New York City, **November 7-8** in New York City. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 16-17. Coverage Disputes in Catastrophic Events in Coronado, Calif., co-sponsored by the American Bar Assn. Division for Professional Education, the ABA Section of Tort and Insurance Practice and the San Diego County Bar Assn.; $395 for TIPS members; $345 for young lawyers; $425 for ABA members; $75 for law students; $450 for non-members. ABA, Division for Professional Education, 541 N. Fairbanks Court, Chicago, Ill. 60611-3314.

MAY 16-17. Reinsurance Claims Management seminar in New York City, sponsored by The College of Insurance; $695 for college sponsors; $795 for non-sponsors; less $100 for second person from same organization registering on the same date. **Also Nov. 11-12** in San Francisco. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 16-17. Managed Health Care Strategies for the 90s conference in San Jose, Calif., sponsored by the National Assn. of Employers on Health Care Action; $545 for members; $645 for non-members. NAEHCA, P.O. Box 220, Key Biscayne, Fla. 33149; 305-361-2810.

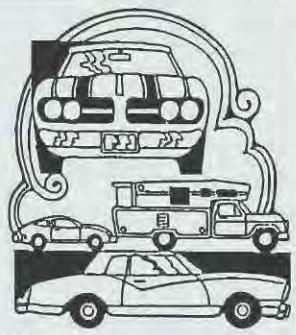
MAY 16-17. Medical Malpractice Seminar in Washington, D.C., sponsored by the Defense Research Institute Inc.; $370 for DRI members; $395 for non-members. DRI, Medical Malpractice Seminar, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MAY 16-17. Successful Strategies for Winning Approval of rate and Form Filings conference in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 16-17. Environmental Due Diligence conference in San Francisco, sponsored by Executive Enterprises Inc.; $1,045. **Also May 22-23** in New York City. Executive Enter-

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Continued from previous page
prises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 16-17. Insurance Law seminar in Coronado, Calif., sponsored by the American Bar Assn.; $425 for ABA members; $450 for non-members. ABA, Division for Professional Education, 312-988-6200.

MAY 19-22. Casualty Actuarial Society Spring meeting in Palm Desert, Calif., sponsored by the CAS; $375 for CAS members; $425 for non-members. Kathy Spicer, CAS, One Penn Plaza, New York, N.Y. 10119; 516-352-8453.

MAY 19-22. 95th Annual Meeting in Boston, sponsored by the National Fire Protection Assn., $260 for members; $335 for non-members; add $35 for Monday night gala. Michelle Perrault, NFPA, One Batterymarch Park, P.O. Box 9101, Quincy, Mass. 02269-9101; 617-984-7275.

MAY 20-21. Preparing for Market Conduct Examinations of Insurance Cos. in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 20-21. Responding to the New Hazardous Waste Initiatives: Land Disposal, TCLP and Corrective Action Programs conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,045. **Also June 10-11** in San Francisco, **June 24-25** in Chicago. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 20-22. Corporate Benefits Management Conferences in Philadelphia, sponsored by the International Foundation of Employee Benefit Plans; $645 for IFEBP members; $690 for non-members; add $75 less than 45 days prior to conference. **Also July 22-24** in San Francisco. IFEBP, Registration Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MAY 20-23. Annual Statement Preparation-Property & Casualty seminar in Winston-Salem, N.C., sponsored by Booke & Co.; $1,295. **Also June 25-28** in Milwaukee; **Aug. 5-8** in Newport Beach, Calif.; **Aug. 26-29** in Winston-Salem. Booke & Co., Insurance Co. Services, 919-748-1120.

MAY 20-24. Annual Statement Preparation—Life seminar in Winston-Salem, N.C., sponsored by Booke & Co.; $1,495. **Also June 24-28** in Milwaukee; **Aug. 5-9** in Newport Beach, Calif. Booke & Co., Insurance Co. Services, 919-748-1120.

MAY 21. Pollution Liability—The Law and Available Insurance seminar in Brookfield, Wis., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Greater Milwaukee Chapter; $120 for society members; $140 for non-members. Add $15 after May 14. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2735.

MAY 21-22. Annual Meeting in Washington, D.C., sponsored by the Assn. of Private Pension and Welfare Plans; $575 for APPWP members; $650 for non-members. Ellen L. Goldstein, APPWP, 1212 New York Ave., N.W., Suite 1250, Washington, D.C. 20005; 202-289-6700.

MAY 21-22. State Filings—A Practical Workshop program in Chicago, sponsored by the National Assn. of Mutual Insurance Cos.; $299. **Also June 19-20** in Minneapolis; **July 30-31** in Harrisburg, Pa.; **Aug. 7-8** in Albany, N.Y. Tonya J. Berkley, NAMIC, 3707 Woodview Trace, P.O. Box 68700, Indianapolis, Ind. 46268; 317-875-5250.

MAY 21-22. Process Safety Excellence Course in Syracuse, N.Y., co-sponsored by the National Safety Council and DuPont; $850 for NSC members; $1,050 for non-members. **Also June 25-26** in Chicago. Registrar, Safety Training Institute, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, ext. 5105.

MAY 22. ERISA Basics: A Primer on ERISA Issues in Chicago, sponsored by the American Bar Assn; the Sections of Business Law, Labor and Employment Law, Real Property, Probate and Trust Law, Taxation, Tort and Insurance Practice; and the Division for Professional Education; $450 for sponsoring section members; $475 for ABA members; $500 for non-members. **Also June 12-14** in Los Angeles. ABA, Division for Professional Education, Department NI625/624/626, 541 N. Fairbanks, Chicago, Ill. 60611-3314; 312-988-6200.

MAY 22. Workers Compensation seminar in New York City, sponsored by The College of Insurance; $225 for college sponsors; $275 for non-sponsors. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 22. Ninth Annual Ohio Health Care Conference in Columbus, Ohio, sponsored by The Ohio Manufacturers' Assn.; $130 OMA members; $155 non-members. Mark W. Uher, Jana Lilly or Lisa Cramer, Ohio Manufacturers Assn., 33 N. High St., Columbus, Ohio 43215; 614-224-1722.

MAY 22. Workers Compensation: Crisis Resolution videoconference at 57 locations, sponsored by The Society of Chartered Property & Casualty Underwriters; $125. The Society of CPCU, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2763.

MAY 22-23. First Party Property Pollution Contamination Coverage Claims and Litigation Issues conference in New York City, sponsored by the Defense Research Institute Inc.; $370 for DRI members; $395 for non-members; discounts available for additional registrants from the same company. Defense Research Institute, First Party Property Pollution Seminar, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MAY 22-23. Banks and Insurance Update conference in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MAY 22-23. Managed Care & Workers Compensation seminar in Chicago, sponsored by Infoline Inc.; $895; $695 for three or more attendees from the same company. Also **June 6-7** in Dallas; **June 10-11** in Atlanta. Infoline Inc., 633 Third Ave., Suite 2227, New York, N.Y. 10017; 212-557-3400.

MAY 22-24. Techniques of Loss Control course in New York City, sponsored by the Risk & Insurance Management Society Inc.; $495 for RIMS members; $595 for non-members; less than six weeks prior to course add $45. **Also Oct. 23-25** in Denver. Education Department, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MAY 23. Introduction to Risk Management seminar in New York City, sponsored by The College of Insurance; $225 for college sponsors; $275 for non-sponsors. **Also Sept. 26** and **Nov. 13**. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

MAY 25-29. Second International Conference on the Global Insurance Market meeting in Tucker's Town, Bermuda, co-sponsored by The Society of Chartered Property & Casualty Underwriters and The Bermuda Insurance Institute; $800. Mina MacFarlane, CPCU Bermuda Conference, 212-677-7762 or Ian Linnegan, 809-295-1596.

MAY 28-30. Health Benefits in the 90s—The Struggle for Survival in the Lean Years conference in Saratoga Springs, N.Y., sponsored by the New York State Public Sector Coalition on Health Benefits; $150 for members; $200 for non-members. N.Y. State Public Sector Coalition on Health Benefits, P.O. Box 15, Albany, N.Y. 12260.

MAY 28-31. Reinsurance Accounting and Finance seminar in Ossining, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,595 including lodging and books. Robert W. Strain Seminars Inc., Box 1000, Wingdale, N.Y. 12594; 914-832-9384; 212-677-5974.

MAY 29. High Tech Inventory Management for the 90's seminar in Boston, sponsored by Uniform Printing; No charge, seating is limited. **Also June 5** in Chicago; **June 11** in San Francisco; **June 13** in Los Angeles. Deirdre Fleck, 617-431-0770.

JULY

JULY 1-3. 1991 World Insurance Congress in London, sponsored by *Business Insurance* and Lloyd's of London Press Ltd.; 650 pounds ($1,125 at current exchange rates) plus 97.5 pounds ($169) value-added tax; 585 pounds ($1,012) plus 87.75 pounds ($152) value-added tax for additional registrations from same company; 275 pounds ($476) plus 41.25 pounds ($71) value-added tax for spouses. 1991 World Insurance Congress, *Business Insurance,* 220 E. 42nd St., New York, N.Y. 10017; phone: 212-210-0299; fax: 212-210-0704.

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The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Industry support of education seen lacking

By ADRIENNE C. LOCKE

PHILADELPHIA—Insurers and other insurance professionals must provide more money and advice to colleges and universities with insurance and risk management curriculums if they expect colleges to produce capable workers, say Temple University officials and alumni.

"You must encourage, cooperate and support" insurance and risk management education if colleges are to successfully educate student about the field, H. Wayne Snider, a professor at Temple, told insurers and professional associations representing risk managers, underwriters and actuaries.

Insurance and risk management instructors, for their part, must move away from "esoteric" research and instruction toward coursework that is applicable in the working world, he added.

Mr. Snider and others spoke recently at Temple's Third Annual Awards for Excellence ceremony, where Mr. Snider was honored for his contribution to risk management and insurance.

The event, which also showcases some of the best and brightest college students who plan on an insurance or risk management career, is sponsored by the university's risk management, insurance and actuarial science department, the Gamma Iota Sigma insurance fraternity, and many large corporations, including several property/casualty insurers.

While Temple—which offers undergraduate and graduate insurance and risk management programs—has enjoyed much support from the insurance industry, the university is "absolutely unique in this regard," said M. Moshe Porat, chairman of the risk management, insurance and actuarial science department.

Supporting university insurance programs benefits both the industry and the schools, Mr. Porat said.

"When you take an insurance major, you have taken a person who has voluntarily agreed to enter into that field," Mr. Porat said.

An insurance or risk management major does not need six months of training for companies or insurers "to get a return, and that's a plus," said Kevin Junod, an account executive at Alexander & Alexander Inc. in Philadelphia and a Temple alumnus.

And, the employer is more likely to get an employee who is going to stay, he said.

But, "there has not been much concern about recruiting insurance majors. Insurer representatives would come to campus and recruit from any department," he said.

Mr. Porat said insurers and risk management departments that recruit from the general student body then must train the recruits, an appealing prospect to a student. However, many recruits end up leaving the industry after they discover that it is not suitable for them, he said.

As a result, insurers and risk management departments either go through the expense of training new employees or hire skilled staff away from others, he said.

Mr. Snider said the academic excellence at Temple is proof of the difference industry involvement makes.

"We have been able to achieve the things that we've done here and are represented by the students that you've met today because of the support of the (insurance) industry," Mr. Snider said.

'There has not been much concern about recruiting insurance majors,' says A&A's Mr. Junod.

A lack of support at other schools, though, has meant that academic studies in insurance and risk management have not kept pace with changes in the industry, Mr. Snider said.

Although the insurance industry has been slow in adopting change, "revitalization is coming from the industry, not from academia. We have had a failure of academia," he said.

While Temple was growing, insurance and risk management programs at other universities were either diminishing or disappearing, he said.

"The deans and the faculty members didn't know about the (insurance) area and thought only of the teaching of the standard fire policy as the role of a program," Mr. Snider said.

These universities "lost their programs—seldom with the recognition of their demise by the industry—for they have no impact on the industry for a significant period of time," Mr. Snider said.

Mr. Snider also said that the number of research papers on risk management and insurance for academic and business journals has steadily declined since its peak in 1967.

"Some (studies) are a simple exercise in symbolic logic and are irrelevant," he added. Some of the research has "real value," but has not reached a corporate audience, he said.

Mr. Snider noted that at the beginning of his teaching career, he followed the standard insurance and risk management curriculum, which he now says must be updated to reflect current insurance industry issues.

"Originally, when I began teaching, I taught what was in the textbooks and what had been taught to me," he said.

"We are living in revolutionary times. If we are to meet and prepare for the future, we must recognize change, and it must be reflected in our teachings," he said.

Mr. Snider said that he and the Temple faculty have worked hard to keep the curriculum at pace with the insurance industry.

For example, Temple was the first university to have a department of insurance and risk management and to offer actuarial science as a major in the business school rather than as a major through the math department.

The university also was the first to offer courses in employee benefits, he said.

"There were schools that have courses in group life insurance, group health insurance and pensions. But the concept of employee benefits as such was first recognized in terms of our thinking here at Temple," Mr. Snider said.

The university also offers exceptional students internships with insurers and corporate risk management departments, which often lead to full-time and permanent positions.

Mr. Porat said it has been a battle over the years to persuade Temple to maintain the risk management and insurance curriculum.

And, he credits Mr. Snider with the foresight that laid out the groundwork for the department as it exists today. "He envisioned the importance of risk management education and convinced the School of Business to incorporate core courses into the core curriculum of the school."

Mr. Snider, who is retiring this year, was chairman of the department at Temple from its inception during the mid-1960s through the 1970s.

Mr. Snider also has taught at the University of Pennsylvania's Wharton School of Business in Philadelphia and at Northwestern University in Evanston, Ill. ■

III activities

Continued from page 2

operates within society, said Mr. Stewart.

As an example of the first tier, Mr. Stewart pointed to the National Insurance Consumer Helpline, which was launched by a group of life, health and property/casualty insurance industry trade groups early last year. During its first year, operators answered about 100,000 questions on all aspects of insurance, he said.

"The good news is it's up and it works," he said. The service has received publicity in consumer affairs publications and public interest television shows, he said.

But the service also costs money, he noted. "The more successful it becomes, the more it costs to operate," he said.

On the other end of the spectrum, Mr. Stewart wants to reach people "capable of altering their opinions" of the insurance industry if presented with adequate information. He said that even sophisticated public policymakers tend to base their views of insurance either on bad personal experiences or, simply, see it as yet another example of a greedy, heartless industry.

Reaching these decision makers is particularly important "because the insurance industry is being hauled into the center of the debate" about individual rights and responsibilities vs. government rights and responsibilities over such matters as health care, workers compensation and personal automobile insurance, he said.

"The social contract of the United States is perhaps the least defined of any serious country in the world," he said. If insurers do not effectively present their concerns to opinion makers, they may find the social contract being redefined in a matter not to their liking, he said.

Mr. Stewart hopes that the proposed III Press will reach this group. Discussions are already planned with scholars in a variety of disciplines to commission research about the insurance industry, which would then be published and distributed to key opinion makers by the III Press, he explained.

"Let's try to create some excitement in the intellectual community" that insurance presents interesting questions about public policy and the social contract, he said.

Mr. Stewart stressed that the III Press would not be a propaganda mill for the insurance industry. "It will stand or fall on the quality of the work. The choice of who will be asked to write will be up to the editorial board," he said.

The incoming III president pointed out that the insurance industry itself shares "many characteristics of the government," which is one reason it suffers from a poor public image.

"You have to pay" for insurance, "whether you use it or not," Mr. Stewart explained. Public resentment of the insurance industry is typical of "any large compulsory institution," he said.

The third prong of Mr. Stewart's strategy, midway between the broad reach of the consumer hot line and the carefully targeted strategy of the III Press, is the organization's continuing informational efforts conducted through local offices.

"I don't plan to close any offices" in the foreseeable future, Mr. Stewart said.

He stressed that the information provided by the III through all of its operations has to be objective. "If you're really honest about it and put out decent information, that becomes something people will respond to," he said.

"Because insurance is different across the country," each regional office will take a somewhat different approach to local concerns and problems, Mr. Stewart said.

The localized approach also will extend to the III's internal operations and management, he said.

He admitted that "probably some degree" of belief exists among insurers that the III is an East Coast-dominated group. To show that this is not the case, at least one of the group's five annual board meetings will take place outside of New York. This fall's meeting is to be held in Los Angeles.

Meanwhile, the III's financial situation "is not as immediately bad as it might seem," Mr. Stewart said, referring to the recent withdrawal of five national insurers. For example, Allstate announced that it was withdrawing from the institute effective June 30, though it would continue its financial support through 1991.

"We'll be smaller in 1992 than we were in 1991," Mr. Stewart said. He said that the III's staff, currently about 80, will shrink through attrition rather than mass layoffs.

Mr. Stewart said that he is attempting to convince insurers to either join the III or to work jointly with it on projects of mutual interest. He said he realizes that companies often find that they have interests that don't also coincide with that of the entire industry, and that they would want to promote those interests in their own way. "What I'm really asking companies is to accept the notion that what you do has to be directed toward your standing as an industry" to a certain degree, he said.

Allstate became the fifth major insurer to quit the institute since the middle of last year. The others are Philadelphia-based CIGNA Corp.; Home Insurance Co. of New York; Long Grove, Ill.-based Kemper National Insurance Cos.; and Travelers Corp. of Hartford, Conn. (*BI*, April 1). Each of the companies cited market conditions rather than philosophical differences or doubts about the institute's effectiveness as the reason for quitting.

A spokesman for Allstate, the nation's second-largest property/casualty insurer in terms of premium volume, said: "This decision is the result of an ongoing review of major expense areas which indicate that membership in the institute is not a priority at the present time. This should in no way be considered a criticism of the Insurance Information Institute.

"Allstate has had a long and beneficial relationship with the Insurance Information Institute. They've done a good job of representing the property/casualty industry and of providing good information to a variety of audiences," he added. ■

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Award appealed in salmonella suit

Horse feed firm insured

By MICHAEL BRADFORD

CARLISLE, Pa.—A supplier of allegedly tainted animal feed blamed for a salmonella outbreak that killed five racehorses is appealing an $8.6 million jury award to several horse owners.

A Court of Common Pleas jury in Cumberland County, Pa., found Pennfield Corp. negligent in producing the feed that allegedly killed the five horses and made several others ill.

The standard bred horses were boarded at a Carlisle Springs, Pa., farm owned by Nelson Wert, a veterinarian who lost two of his own horses to the salmonella poisoning.

Mr. Wert was awarded $6.9 million, and six other plaintiffs who boarded horses at his Stone Manor Farm were awarded a total of $1.7 million.

The Lancaster, Pa.-based feed company is appealing the verdict before the Court of Common Pleas. Under Pennsylvania law, if the appeal is rejected, it then can be filed with state Superior Court.

Pennfield is "extremely disappointed by this ruling" and is "confident of the quality of its products," said its president, Donald E. Horn.

Mr. Horn declined to comment further on the case.

Plaintiffs' attorney Neal Rovner also declined to comment because of the appeal.

Court papers show that Pennfield believes it has adequate insurance to cover the award.

The papers state that The PMA Group of Philadelphia, which consists of the underwriting subsidiaries of the Pennsylvania Manufacturers Corp., provided Pennfield with $500,000 in general liability coverage and $5 million in umbrella limits.

The papers also show that International Insurance Co., a Chicago-based unit of Crum & Forster Inc., provides a $5 million excess layer.

Mr. Wert and the other horse owners filed lawsuits in 1988 and 1989, which were later consolidated.

The suits charged that the salmonella poisoning occurred after the horses ingested feed pellets from two shipments from Pennfield in 1987.

Laboratory tests performed on the remaining feed pellets showed they contained salmonella bacteria, according to court papers.

However, defense attorneys argued that the salmonella could have spread to the feed from a chicken house at the horse farm or from a horse already infected when it arrived at Stone Manor.

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Risk/Employee Benefits:
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Sub-total 24,591

Associations 488
Government, unions and Educational Institutions 1,275

Commercial Consumers

Sub-total 26,354

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Others Allied to the Field 1,365

TOTAL 50,176

★ Source Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

Bill would cap non-economic damages

By ADRIENNE C. LOCKE

Washington

WASHINGTON—Non-economic awards in medical malpractice cases would be capped at $250,000 under legislation recently introduced in the House and Senate.

The bill, S. 489, introduced by Sen. Orrin Hatch, R-Utah—and its companion bill, H.R. 1004, introduced by Rep. Nancy Johnson, R-Conn.—would also set limits on attorneys' contingency fees and would generally establish a two-year statute of limitations for the filing of medical malpractice lawsuits.

They would also require states to improve their methods for uncovering poor practice patterns that may lead to patient injuries.

"This legislation restores the balance between the rights of citizens and the improvement of health care," said Sen. Hatch. "The time for medical reform is now."

"Our bill is a dramatic step toward a more accessible and efficient system that guarantees justice for everyone, not just the select few who can afford a high-priced lawyer," said Rep. Johnson. "This bill will make it easier and cheaper to resolve malpractice claims, while at the same time discourage frivolous suits."

Both measures also would:

- Require economic and non-economic damages exceeding $100,000 to be paid periodically.
- Require mandatory offsets of awards for collateral sources of recovery, like workers compensation benefits.

In addition, both S. 489 and H.R. 1004 would encourage the development of alternative dispute resolution systems for medical malpractice cases.

Grants would be provided to states as an incentive to develop mechanisms like:

- "Fault-based Administration Systems."

A state would develop an administrative agency that would have exclusive jurisdiction to review medical liability claims. The process would provide for expedited examination of claims, an investigation and hearing, and appellate review by an agency panel.

Any judicial review of final administrative decisions would be limited in scope.

- "Defined Catastrophic Injury Compensation Systems."

A state would establish a fund that would compensate all individuals who were injured while receiving health care services, regardless of negligence by the doctor or hospital. However, those receiving compensation would be prohibited from seeking damages in court.

Claims could be filed by claimants with or without legal counsel, and would be resolved within six months.

- "Early Offering and Recovery Mechanisms."

Under such systems, a health care provider would offer to compensate a claimant for all economic losses before a medical malpractice suit is filed. Disputes about the value of economic losses would be resolved by arbitration.

If the claimant rejects the offer and pursues a court action, non-economic damages could be capped at a level below the $250,000 cap proposed by the bill. The claimant may also be required to meet a more stringent standard of proof in a subsequent trial.

- Binding arbitration.

A state would establish a voluntary or mandatory system in which a three-member panel would arbitrate any claims of medical negligence. The health care provider and the patient would each select one arbitrator and jointly agree on the third.

Decisions by the panel would be subject to limited review in the state courts.

States could also use any other alternative dispute resolution systems they develop, pending approval by the secretary of health and human services.

The legislation also would mandate new "patient protection" measures. States would be required to comply with these requirements as a condition to receiving funds under the federal Public Health Services Act.

Under H.R. 1004 and S. 489:

- Health care providers operating in a state must institute "early warning systems" for practices which may result in patient injury.
- Liability insurers doing business in a state would have to require providers to establish patient safety programs as a condition of maintaining insurance.
- Licensing fees collected from health care professionals would be allocated exclusively to those state agencies responsible for licensing and disciplinary activities.
- States would be required to authorize the "appropriate participation" of state and local medical societies in the process of reviewing the practice patterns of individuals who may be endangering patient safety.

Finally, the legislation would make $10 million in research grants available to states and local non-profit organizations in the next three years to study the prevention and compensation for injuries from health care negligence.

Superfund study

Resources for the Future, an environmental and natural resources think tank in Washington, D.C., is studying possible financing alternatives that could be used under the Superfund act.

"Throughout the (Superfund's) history, there has been a tension between using fund money to get sites cleaned up quickly and using (the Environmental Protection Agency's) broad enforcement powers to encourage or compel private parties to clean up sites," said Katherine N. Probst and Paul R. Portney, authors of the study, in a brief on its preliminary framework.

"Since its inception, questions about the speed of cleanup and the efficacy and efficiency of an enforcement-based system have plagued the (Comprehensive Environmental Responsibility and Compensation Liability) Act," they noted.

The study will focus on how to allocate cleanup costs among parties with a stake in a waste site. However, "since this cannot be separated from the assignment of liability, we will deal with it as well," the authors said.

The study has already identified specific criteria that the authors believe should be used to evaluate the existing system and any proposed alternatives. They are:

- Speed of cleanups.
- The quality and cost of the current system.
- Voluntary cleanups at non-Superfund sites.

Some of the alternative systems the study will examine include:

- Preserving the current system, but tying its funding more closely to past sources of pollution, like a broader corporate tax.
- No-fault liability.
- Preserving the existing liability system with increased funding.

The study, "Financing Superfund Cleanups: A Search for a Better Mechanism," is expected to be completed by the end of the year.

PBGC advisory group

The Pension Benefit Guaranty Corp. has appointed three new members and has reappointed two others to its seven-member advisory board.

Entering into their first terms are:

- W. Gordon Binns Jr., vp and chief investment funds officer at General Motors Corp. in New York. His term expires in February 1992.
- Kenneth K. Keene, a retired partner of Johnson & Higgins of New York. Mr. Keene was head o the firm's benefits consulting division. His term expires in February 1992.
- Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C. His term expires in February 1994.

Re-appointed to new terms are:

- Myron J. Mintz, senior partner and chairman of the tax department at Dickstein, Shapiro & Morin in Washington, D.C. His new term expires in February 1993.
- Richard M. Prosten, director of bargaining and research in the industrial union department at the AFL-CIO in Washington, D.C. His new term expires in February 1993.

Two other appointments are awaiting advisory board approval, the PBGC said. The panel advises the pension agency on policies and procedures of agency investments trusteeship, among other things. ■

Massachusetts

Continued from page 1

Act of 1974—employers have been required for years to provide health care coverage to employees working 20 hours per week or more (see story, page 1).

Even business groups, long opposed to government involvement in the employee benefit arena, said the Massachusetts approach was preferable to proposals by Sen. Edward Kennedy, D-Mass., the congressional champion of expanded health care coverage, that specified the design of employer-provided plans.

But the Massachusetts model, conceived during a robust economic era, now may never get off the ground.

Repeal of the law now is likely, because of a slumping state economy, a changed political climate and stiff opposition from small business.

"Realistically, repeal probably is in the offing. Support for the law has largely evaporated because of the economic situation," said State Rep. John McDonough, D-Boston, a key supporter of the law.

"The employer mandate likely will go. Many legislators already have written off the law," said Stephen Caulfield, a managing director with William M. Mercer Inc. in Boston.

"At this point I would bet on repeal," said Rhonda Davis, a consultant in the Boston office of Hewitt Associates.

Other state health care observers say that if the law is not repealed, then it definitely will be delayed from its scheduled Jan. 1 effective date.

"I don't think there is a prayer this law will be implemented next year," said Alan Sager, an associate professor at Boston University's School of Public Health.

The repeal drive could begin as soon as this month when Massachusetts legislators take up new budget legislation. Political observers there expect repeal amendments to be inserted in the budget proposals.

Earlier this year, the Legislature, as a compromise between those who favor keeping the law and those backing repeal, agreed in another budget proposal to delay the employer health care tax to 1994 from 1992.

'The issue has become will or will not the law be repealed,' says Mr. Tringale.

But, the state's new governor, conservative Republican William Weld, vetoed that proposal, saying that the best course of action is repeal, not delay.

Legislators, including Rep. McDonough, say it is unlikely that any moves will be made to try to override or sustain Gov. Weld's veto. Instead, the political battle will be on whether the law should be repealed.

"The issue has become will or will not the law be repealed," said Steven Tringale, vp-public affairs at Blue Cross/Blue Shield of Massachusetts in Boston.

Benefit observers say the problems with the Massachusetts health care statute have implications beyond the Bay State.

Supporters of the law say a repeal of the law would discourage other states or Congress from acting on similar proposals.

If the Massachusetts law is repealed, opponents of similar health care access proposals will say: 'Look what happened in Massachusetts.' That is unfortunate," Rep. McDonough said.

Indeed, U.S. Department of Health and Human Services Secretary Dr. Louis Sullivan last month told the House Ways and Means Committee that the problems the Massachusetts law has encountered is an example of why Congress should not adopt a "play or pay approach."

"If this idea is not working in one small Northeastern state, it seems foolhardy to impose this on our vast and varied nation of 250 million people," Dr. Sullivan told the House panel, which is now grappling with the access issue.

The growing opposition to the Massachusetts statute "makes very explicit the political problems of 'play or pay,' " said Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington think tank.

"States' legislatures will be reluctant to take on the seemingly intractable problem of a lack of health access through a mandate-type approach because of what has happened here," predicted Mercer's Mr. Caulfield.

Others point out that the political firestorm that has erupted over the Massachusetts health care law is a dramatic example that only federal action—rather than state action—can solve the access problem.

"One state alone cannot do it. A state-by-state approach is never going to work without federal help," asserted Alain Enthoven, a professor at Stanford University's Graduate School of Business in Stanford, Calif.

The controversy over the Massachusetts health care law also provides more evidence that there are no simple answers to improving access for the 34 million Americans not covered by employer health care plans, health care experts say.

"We are nowhere near a solution. There is no silver bullet for solving the access problem," said Stuart J. Brahs, vp-federal government rela-

Continued on next page

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Massachusetts

Continued from previous page

tions in the Washington, D.C., office of the Principal Financial Group, a diversified financial services company.

"There is a consensus that something must be done to improve access. But there is no consensus on what that something should be," agreed Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans, an employer-supported benefits lobbying group in Washington, D.C.

While supporters of the Massachusetts health care law concede that repeal appears likely, they say the drive to improve health care access for the nation's uninsured—now about 16% of the population—will not end.

"If this law is repealed, the crisis for the uninsured has not ended. It is one just one battle. No matter what, you will see more proposals," predicted Robert Restuccia, executive director of Health Care for All, a consumer advocacy group in Boston.

In fact, some benefit observers believe the problems in Massachusetts and the lack of a congressional consensus only are a temporary delay in the search for answers to improve health care access.

"The mistake would be to confuse what is a short-term impasse with permanent inaction," observed Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

The current drive to repeal the employer health care mandate would have been difficult to imagine three years ago when the proposal cleared the Massachusetts Legislature and was signed by Gov. Dukakis.

But as EBRI's Mr. Salisbury notes, much can happen between the time a law is passed and the time it is ready to go into effect.

In the case of Massachusetts, what changed the most was a rapid and steep turnover in the economic climate.

In early 1988, Massachusetts's unemployment rate was in the 3% range, among the lowest in the nation, leading some to describe the state economy as "The Massachusetts Miracle."

In those heady economic times, there was little concern that a health care tax could hurt employers, benefit experts recalled.

"Everyone was feeling the glow from the boom years. There was a feeling in some quarters of, 'So what if employers have to kick in more?' " Hewitt's Ms. Davis said.

But Massachusetts' bright economy began to dim last year as one-time state strengths—real estate and the financial service industries—developed major problems.

The state's unemployment rate in March, the most recent month for which statistics are available, was 9.7%.

And some observers believe the unemployment rate will rise even higher.

In this deteriorating economic climate, support for a statute that would impose a tax on employers of as much as $1,680 per employee began to evaporate, explained Mr. McDonough, the Boston Democratic representative.

"A feeling developed that it would be tough enough for small employers to survive, let alone pay a new tax or provide health care coverage," said Barbara Kalfin, a consultant with The Wyatt Co. in Boston.

The change in governors also has contributed to the loss of support for the statute's requirement that employers be taxed unless they offer health care coverage, observers say.

While Mr. Dukakis was an enthusiastic supporter of the employer mandate, citing it during his 1988 presidential campaign as a model for the nation, his successor, Gov. Weld, has opposed the mandate from the time he took office earlier this year.

"We had a new Republican administration with a very different set of priorities," said Mercer's Mr. Caulfield.

"Gov. Weld feels the mandate would hurt small business. It is a burden that employers in these times can ill afford," a spokeswoman for the governor explained.

Without gubernatorial support, it becomes very difficult to implement a law of this type, Rep. McDonough said.

Rising opposition from small business also has weakened support for the employer mandate, many Massachusetts observers say.

Groups like the National Federation of Independent Business and the Massachusetts Restaurant Assn. have intensified their efforts to repeal the employer mandate.

The mandate "is a quick fix that places the burden exclusively on employers. This is something many of our members—with low profit margins—cannot afford," said Cindy Eid, director of government affairs for the Massachusetts Restaurant Assn. in Westboro, Mass.

"For many employers, the problem is just staying in business and paying other mandated costs, like workers compensation," said Carolyn Bovierd, state director of the NFIB in Boston.

"I think legislators now realize that access to health care is a bigger problem than just trying to make employers pay for it. It was a naive approach," Ms. Bovierd said.

But, Mr. Restuccia of the consumer advocacy group Health Care for All, says that just as there is a minimum wage requirement there also should be a minimum health care benefit requirement.

"The law is not a panacea, but it is a good step forward," he said. ■

Law levies tax penalties on firms without coverage

BOSTON—At the heart of Massachusetts' 1988 universal health care law are steep tax penalties for employers that fail to offer their employees health insurance.

Starting in 1992—unless the law is repealed or delayed—employers with more than five employees who are Massachusetts' residents will be liable for a "medical security tax" equal to 12% of the first $14,000 of each employee's wages, up to a maximum of $1,680 per employee.

This tax would be offset by the per-employee amount an employer spends on its health care plan.

For example, if an employer's health care plan costs $1,480 per employee, the per-employee tax would be $200.

If the plan costs at least $1,680 per employee—as do most plans offered by large and medium-sized employers—the employer would be exempt from the tax.

However, the law does not make clear whether pretax contributions made by employees in flexible benefit plans would be considered an employer contribution for determining the employer cost of a plan.

Under federal tax law, employees' pretax contributions in flexible benefit plans are treated as employer contributions.

In determining the size of its workforce when calculating the tax, an employer would include employees who:

- Work at least 30 hours a week and who have been employed for at least 90 days.
- Are heads of households with dependent children, work at least 20 hours a week and have been employed at least 90 days.
- Have worked more than 20 hours a week for the employer during the prior six months.

Employees that can be excluded include:

- Those covered by another employer's health plan. However, prior to hiring an employee, an employer could not ask whether he or she is covered under another company's health care plan.
- Those hired to work on a temporary basis for less than five months.
- Seasonal agricultural employees.

The law also requires employers with more than five employees to pay an unemployment health insurance tax equal to 0.12% of the first $14,000 of each employee's wages, up to an annual per employee maximum of $16.80. This tax went into effect in January 1990.

Revenues generated by this tax, which has not aroused significant objections, are used to fund a state health care plan for the poor and unemployed. The plan, which is administered by John Hancock Mutual Life Insurance Co. of Boston on an administrative services-only basis, now covers about 7,700 unemployed workers and their dependents.

—By Jerry Geisel

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Dukakis proposes alternate plan

BOSTON—The future of the Massachusetts universal health care law may be in doubt, but the law's key proponent has not lost interest in improving access to health care.

Michael Dukakis, who described the program—enacted while he was governor—as a model for other states to help achieve universal coverage, is now developing a new access proposal.

Mr. Dukakis, who left office last year and now is a visiting professor at the University of Hawaii, soon plans to publish a detailed proposal that he hopes will make a major contribution to the debate on improving coverage for the uninsured.

The public is unhappy with the current health care delivery system because it "can't provide comprehensive health care for all of its citizens but is charging the highest prices in the world," he said.

Under the new Dukakis plan, which the Democratic candidate for president in 1988 recently outlined:

- All employers would be required to provide basic health care coverage to employees who work at least 20 hours a week. To qualify for coverage, an employee would have to work at least four continuous months.

Employers also would have to extend the coverage for at least four months after a worker's employment is terminated.

- The basic health plan provided by employers could impose on workers: a maximum 20% premium contribution requirement for both individual and family coverage; maximum annual deductibles of $250 for individual coverage and $500 for family coverage; a maximum 20% coinsurance requirement; and a maximum $3,000 annual out-of-pocket requirement.

These benefit levels and premium requirements are a significant departure from the Massachusetts law, which does not set design or cost sharing requirements. Under that law, an employer's only obligation to avoid paying special state taxes is to provide health care coverage that costs an average of $1,680 per employee.

Mr. Dukakis envisions that his new proposal would be phased in gradually.

The mandate to provide health insurance would become effective during the first year after enactment for employers with at least 100 employees. The program would apply to companies with at least 50 employees in the second year, those with at least 25 employees in the third year, employers with at least five employees in the fourth year and to all employers—regardless of their size—in the fifth year.

In addition, a new public plan would be established in the sixth year for those without employer-provided coverage. That plan would be funded in part by individual premiums, based on an individual's ability to pay, as well as by a special assessment on the health insurance premiums employers pay for workers.

Mr. Dukakis said funds generated by the special assessment on employer-sponsored plan premiums would equal the amount that employers would save on health care because—with universal coverage—hospitals would no longer have to shift the cost of treating charity patients to those with insurance.

"In short, our calculations show that we can provide universal coverage without creating additional burdens on the federal Treasury and without imposing new federal or state taxes," Mr. Dukakis said.

His plan also would impose unspecified caps on medical malpractice awards for pain and suffering and limit contingency fees for plaintiffs' attorneys in medical malpractice cases.

"If we are serious about bringing down the cost of health care and encouraging the practice of good, cost-effective medicine, then we should be willing to take this step as part of a national reform effort," Mr. Dukakis said.

—By Jerry Geisel

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Hawaii law

Continued from page 1

programs, have prompted the Hawaii Legislature to form a blue-ribbon panel charged with studying the state's health care system and proposing necessary changes to the universal health care law. The panel consists of 21 leaders from business, labor, health care providers, health care insurers, government and the University of Hawaii.

But, the panel's charge promises to be no easy task, because modifying the law would require obtaining a broader exemption from the Employee Retirement Income Security Act of 1974. ERISA generally prohibits state interference with employee benefit plans.

"An unfortunate consequence of the limited exemption is that (the PHCA) has been frozen in time, with no amendments or changes allowed other than those that would enhance 'effective administration,' " said State Sen. Daniel K. Akaka, D-Honolulu.

"There remains an urgent need to allow the state statute to include changes which better reflect the needs of today's population and their employers," he said.

Hawaii's Prepaid Health Care Act of 1974 is the only state statute in the nation that requires employers to offer a minimum health care plan—through either an insured or self-funded program. Although the law was successfully challenged in court, President Reagan in 1983 signed federal legislation that exempted the PHCA from ERISA pre-emption (see related story).

But few—if any—employers stopped providing the state-mandated coverage when the law was being challenged or was suspended between 1981 and 1983, noted Dr. John Lewin, director of health for the state of Hawaii.

The PHCA requires employers to provide a generous package of health care benefits to employees working 20 hours a week or more, though employers are not required to offer dependent coverage.

Employer health plans must cover hospital stays of at least 120 days annually as well as surgical, medical, diagnostic, outpatient, emergency and maternity benefits.

An employer can meet the minimum required standards by adopting one of two model plans. One is offered by the Hawaii Medical Service Assn., the state's Blue Cross/Blue Shield organization. The other plan is offered through Kaiser Foundation Health Plan Inc.

If an employer wishes to offer a plan other than the HMSA or Kaiser plans, it must be approved by the state. If an employer's plan does not match or exceed the coverage provided in the model plans, the employer must pay half the cost of dependent coverage.

A state-subsidized basic health insurance program enacted in 1989 extends coverage to Hawaiians who are not covered by the PHCA. The two laws extend health insurance coverage to virtually all Hawaiians.

In 1974, before the PHCA was enacted, 17% of Hawaiians did not have health care coverage. But in 1975, only 3% were uninsured, and that "gap group" is slowly obtaining coverage, according to Dr. Lewin.

State officials claim that health care costs in Hawaii have been lagging behind those on the mainland because Hawaiians are healthier, thanks to better access to primary care.

Dr. Lewin notes that in the Centers for Disease Control's ratings of states, "Hawaii rates below 35th in lifestyle factors such as high cholesterol and cigarette smoking. Hawaii's people are not the healthiest by choice." But, because of easy access to primary care, "Hawaii's people have the lowest rates of early deaths from heart disease, cancer, emphysema and (they enjoy) the highest longevity in the nation," Dr. Lewin asserted.

Other factors—most notably the dominant position of the HMSA, which has the ability to negotiate fees with more than nine out of 10 physicians and major hospitals in the state—also contribute to the lower health care costs in the state, consultants and employers say.

Strong utilization review also plays a key role, HMSA spokesman Christopher Pablo said.

In 1989, the latest year for which figures are available, there were 85 hospital admissions per 1,000 Hawaiians, compared with the U.S. average of 136 per 1,000, according to the HMSA. And there were 58 surgical operations per 1,000 Hawaiians that year, compared with the U.S. average of 90 per 1,000 people.

The result is that group health insurance premiums in Hawaii are lower than in other states, the HMSA spokesman said. Monthly premiums for single coverage offered by HMFA averaged $94 in 1990, compared with $140 in Arizona, $217 in Massachusetts and $282 in Kansas, he said.

And, average rate increases for community-rated groups have slowed to 9.9% in 1991 from 16.2% in 1986, according to HMSA data.

Indeed, medical cost increases in Hawaii, as measured by trend factors, have been "holding steady at about 15% for a few years now," as opposed to about 22% currently on the mainland, said Russ Robertson, vp at The Alexander Consulting Group Inc. in Honolulu, a unit of Alexander & Alexander Services Inc.

"Health care costs in Hawaii are rising rapidly, though they're probably eight to 10 years behind the rest of the country," observed M.H. "Joe" Tripp, senior consultant at The Wyatt Co. in Honolulu.

"From the standpoint of providing the benefits that we provide here vs. the mainland, we are well ahead," observed Bill Brown, vp of human resources at Outrigger Hotels Hawaii, one of the state's largest employers.

"It would cost a lot more to do this if we picked up and moved to any other state to provide the benefits," said Mr. Brown, who is also a member of the Prepaid Health Care Advisory Board. The board reviews medical plans proposed by employers and advises the State Department of Labor on which plans are acceptable under the law.

"If you compare us with other locations, our health care costs are quite modest," agreed Richard Dahl, vice chairman of Bank of Hawaii and a member of the blue ribbon panel studying the state's health care system. "We're not walking into this with a major problem on our hands. Something is working right."

Still, escalating health care costs make employers in Hawaii "angry and extremely concerned," Mr. Brown said.

'Part of the problem is the mandated benefit is too generous. The employer cannot offer a lesser plan and charge a lesser amount, although the employee might choose that if he could,' says Bradley Oliver of Marsh & McLennan.

Because goods and services in Hawaii generally cost so much more than they do on the mainland, rising health care costs place employers in "a very difficult situation," Mr. Dahl explained.

One change that employers want in the PHCA is to be able to require employees to pick up a greater share of the cost of their health care.

"There needs to be a fair apportionment of cost," Dr. Lewin agreed.

For example, he asked: "Why should the employer have to pay a major part of premium costs for people in higher income levels?"

Most employers—facing a labor shortage—have been paying 100% of premiums and many pay the cost of covering dependents to attract employees, consultants say.

But as premiums have skyrocketed, some employers have begun shifting more of the premium costs to employees.

However, the PHCA does not provide much flexibility for employers that want to introduce cost containment provisions in their plans or that want to offer employees benefits that are suited to their individual needs.

Employers under the law are required to pay at least 50% of employee premiums, and employees cannot be required to contribute more than 1.5% of wages toward the cost of health care.

In addition, an employer in Hawaii does not have the flexibility of raising deductibles to keep up with increasing costs "because the plan will no longer be generous enough to meet minimum standards," explained Bradley Oliver, senior vp at Marsh & McLennan Cos. Inc. in Honolulu.

Though the model plan contains a $250 deductible, a $250 deductible in a different plan proposed by an employer "would be challenged" by the advisory board that reviews plans that do not conform to the model, said M&M's Mr. Oliver.

"The employer would have to show that he'll pay a high percentage of the premium and is offering dental coverage and doing other things that aren't required" before a high deductible would win approval, he said.

"I'm not aware of any $400 to $500 deductibles (in plans approved in Hawaii). They would fail universally," he said.

"They don't always let you have a deductible higher than $200," agreed Selina Cheng, a consultant with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in Los Angeles.

The biggest complaints come from small businesses, which make up the bulk of the state's firms. "Ninety-nine percent of the 26,000 businesses in the state have 100 employees or less and are classified as small businesses," said Sam Slom, president and executive director of Small Business Hawaii Inc. in Honolulu, an association of 3,000 small firms, 75% of which have fewer than five employees.

The PHCA and other mandates imposed on insured health care plans in the state have "not really" provided optimal coverage or optimal choice for either employers or employees. Because the cost of the basic medical coverage has become so high, it rules out options," he explained.

For example, because of the labor shortage in Hawaii, small businesses must recruit older workers and retirees, who would rather have long-term care benefits than coverage for in vitro fertilization, which is mandated by the PHCA. But small employers, saddled with the cost of the mandated benefits, can't afford to offer options.

"Part of the problem is the mandated benefit is too generous. The employer cannot offer a lesser plan and charge a lesser amount, although the employee might choose that if he could," said M&M's Mr. Oliver.

But though there's "very little choice for small business, if you are a larger employer with more cash flow, you have the ability to negotiate (with insurers) and provide" added benefits, Mr. Slom said.

"Larger employers tend to be more sophisticated buyers and they may be working more aggressively to get HMSA to offer alternatives or to get an alternative approved," M&M's Mr. Oliver agreed.

One such large employer is Hawaiian Electric Co., which has 3,500 employees. "We provide a choice of five different (health) plans" as part of a cafeteria benefit program, said Julie Price, the company's director of benefits. "We haven't had a problem in that area," she said.

With Hawaii's roots in a plantation culture, "a lot of the companies that originated here are used to providing very generous benefits," Ms. Price observed. So, the PHCA "is not a very big problem for employers like us who have been here forever," she said.

Other large employers, like Outrigger Hotels and Bank of Hawaii, also have succeeded in offering a variety of plans as well as preferred provider organizations to their employees.

But Bank of Hawaii's Mr. Dahl admits: "To date we have found ways to make the situation work for both ourselves and our employee base, though a smaller employer would not have as many options. That's something the panel needs to address. Not all employers are created equal. How can we assist the smaller employer to have the advantages enjoyed by the larger employer?" Mr. Dahl asked.

The PHCA's inflexibility also is frustrating for mainland employers that offer generous health care plans to workers in other states but cannot get those plans approved for a small number of their employees in Hawaii.

"Most of the hassle for us was not being able to take our own plan, which we consider a very good plan, and just provide it to our two employees in Hawaii," said Deborah Leddon, director of personnel at Viking Freight Systems Inc. in San Jose, Calif. Viking, which self-funds its health care benefits in other states, purchased an HMSA plan for its two Hawaiian employees.

Consultants also complain that they have little to work with in designing plans for Hawaiian employers.

"I have very few medical plans to offer an employer. I talk to my counterparts on the mainland, and they have a long list of companies they can get quotes from," said

Continued on next page

Hawaii law survives challenges

HONOLULU—Hawaii's Prepaid Health Care Act was enacted in 1974 but had to survive a legal challenge that eventually involved the U.S. Supreme Court, Congress and President Reagan.

The law requires employers in the state to offer nearly all employees who work 20 hours or more per week a broad range of benefits, and it limits cost shifting to workers (see story, page 1).

But, when Hawaii legislators amended the law in 1976 to require employers to also provide coverage for substance abuse treatment, Standard Oil Co. of California—now Chevron Corp.—sued the state claiming that the Employee Retirement Income and Security Act of 1974 pre-empted the PHCA.

A federal district court ruled in favor of Standard Oil in 1976, and the 9th U.S. Circuit Court of Appeals upheld the decision.

The state appealed to the U.S. Supreme Court, which in 1981 let stand the lower court's decision.

Hawaii then sought an exemption from ERISA pre-emption of the PHCA.

Congress approved the exemption, and President Reagan on March 1, 1983, signed a law that grants the PHCA a limited exemption from the ERISA pre-emption as long as no substantive changes are made to the 1974 measure.

Hawaii legislators, though, have amended the state insurance code to mandate that all insured benefit plans cover the cost of additional benefits, including substance abuse and mental health treatment, well-baby care, mammograms and in vitro fertilization.

Few, if any, employers stopped providing the state-mandated coverage when the law was being challenged or was suspended between 1981 and 1983, noted Dr. John Lewin, director of health for the state of Hawaii.

Several types of employers, though, do not have to provide coverage to certain types of workers:

- Federal and state government entities do not have to offer coverage to workers.
- Firms do not have to cover agricultural seasonal workers.
- Insurance and real estate companies do not have to offer coverage to sales staff paid solely on commission.
- Family-owned businesses do not have to cover some immediate family members, including parents and spouses. However, children who are at least 21 years old have to be covered.

Employers are also not required to offer health insurance to those covered by Medicare; recipients of public assistance; and followers of religious groups who depend on spiritual means for healing.

An employer failing to comply with the PHCA is subject to a penalty of not less than $25 or $1 per employee for each day it fails to comply, whichever is greater.

The state can close down an employer that does not comply with the law for 30 days.

The PHCA prohibits insurers from refusing to cover any employer or employee except for nonpayment of premiums.

The Legislature in 1989 created the State Health Insurance Program to cover the estimated 50,000 people that are not assured access to health care under the PHCA.

SHIP is designed to provide coverage for basic, medically necessary services for those who do not qualify for Medicaid, are not covered by an employer-sponsored plan and cannot afford individual health care plans.

A SHIP applicant also must have been without health insurance for three months.

The state wholly or partially subsidizes SHIP premiums, based on the recipient's income.

Enrollment in SHIP began in June 1990 and 15,000 Hawaiians are now covered. An additional 3,000 applications are pending.

—By Louise Kertesz

Hawaii law

Continued from previous page
Alexander Consulting Group's Mr. Robertson. "We try to be as creative as possible with as little as we have," he added.

"Major carriers have gone in and come out because they couldn't really establish any client base," said TPF&C's Ms. Cheng.

"Is the mandate we got in 1974 responsible for the relatively low number of insurers we have actually operating out here? That's something that should be considered" by the blue ribbon panel, said attorney Jeffrey Harris, a partner with Torkildson, Katz, Jossem, Fonseca, Jaffe & Moore in Honolulu and co-chairman of the Chamber of Commerce Human Resource Committee.

Mr. Slom would like to see businesses charged different rates for group health insurance depending on their implementation of wellness programs and their record of encouraging employees to quit smoking and adopt healthier lifestyles.

But, most plans in Hawaii are community rated, he noted.

"We're hopeful that in looking at health care costs (the blue ribbon panel) will come out with some kind of balanced approach to health care. We've experienced a lot of concern to provide good health services, but they haven't been real careful about who winds up paying for it," said Phyllis Baumwell, government affairs specialist at the Chamber of Commerce of Hawaii.

While the universal health care system has created problems for many employers, labor unions in Hawaii have "no complaints" about the state's health care system, according to Gary Rodriguez, president of the AFL-CIO in the state.

If changes are made, labor hopes the panel will consider "an alternative means of funding" health care for all Hawaiians. A system providing "identical treatment" for all the population—like Canada's system does—is labor's "primary goal."

But, labor would not favor any changes "that will place so great a burden on businesses that they will shut down," Mr. Rodriguez emphasized.

The state's Dr. Lewin concedes that Hawaii's health care system "is not perfect by any stretch of the imagination."

But, Dr. Lewin notes that "health insurance costs in Hawaii for small business are the lowest in the nation. Their rates are the same as for big business." ■

Northern Commercial

Continued from page 2
dropped (*BI*, Feb. 12, 1990; Aug. 27, 1990).

At the time, Mr. Campbell denied any wrongdoing by American Financial Co.'s insurance units, saying they had been duped by Consortium of 89 (*BI*, Jan. 8, 1990).

Separately, Northern Commercial in late 1989 had offered to act as a 100% reinsurer of a block of multiple employer welfare arrangement business written by Americas Life Insurance Co. of Phoenix after Arizona regulators rejected reinsurance Americas had arranged through Consortium of 89. The deal was never finalized, though, and Americas Life was ordered liquidated by an Arizona judge last year (*BI*, Jan. 22, 1990).

Northern Commercial's June 30, 1989, audited financial statement reports a total of $20.7 million in assets, including $12 million in certificates of deposit "with various banking institutions"; $5.6 million contributed by American Financial Co.; $1.6 million in state and municipal bonds that are not further described in the statement; and $1 million in cash.

The statement also reports that Northern Commercial maintains "a trust fund based on (National Assn. of Insurance Commissioners) requirements held by Cenwest National Bank for the benefit of U.S. policyholders of the company in the total sum of $2.5 million."

Business Insurance has obtained a copy of a June 15, 1989, letter on Cenwest letterhead purportedly confirming that the bank was holding $2.5 million under an irrevocable trust agreement with Northern Commercial for the protection of its policyholders.

The letter, addressed to Northern Commercial's Mr. Straton but headed, "To whom it may concern," is signed by "William Moot," whose title with the bank is not given. The trust agreement itself is also signed by "William Moot" and by Mr. Straton.

A California agent sought confirmation of the trust arrangement in February, but was told by a lawyer representing Cenwest that no such trust existed.

The lawyer, Denver E. Wharton, with the Johnstown firm of Kaminsky, Kelly, Wharton & Thomas, confirmed in an interview that the purported trust agreement was not executed by any Cenwest officer and that Cenwest has never had a banking relationship with Northern Commercial.

William Moot, a Johnstown lawyer, has never been a Cenwest employee, Mr. Wharton confirmed.

In an interview, Mr. Moot said that his signature on the June 15, 1989, letter and the trust agreement were fake and that "the first time I saw that letter was a month or so ago when Denver Wharton contacted me wanting to know what was going on."

Mr. Moot said he had talked with American Financial Co.'s Mr. Campbell in early 1990—several months after the date on the purported Cenwest letter—about the possibility of setting up a trust account for Northern Commercial.

Nothing ever came of the discussions, though, and Mr. Moot said he never heard from Mr. Campbell after May 1990.

Mr. Moot also confirmed that he has never been a bank employee, but said he has served on one of the bank's three advisory boards.

He added that he has contacted the FBI regarding the purported trust agreement.

Meanwhile, Northern Commercial has paid some of its claims with drafts drawn on an account at Excalibur Bank Ltd. of Santo Domingo in the Dominican Republic.

U.S. Claims Service Inc., an Orange Park, Fla.-based claims adjuster that handles Northern Commercial claims, has received complaints from claimants who did not want to accept the Excalibur drafts, confirmed Clarence Snider, president of U.S. Claims.

Mr. Snider said the claimants didn't know how to collect on the drafts, but he explained that they would be honored if they were sent directly to Excalibur for payment.

He added, though, that Northern Commercial has replaced Excalibur drafts sent to some claimants with checks drawn on Northern Commercial accounts in the United States.

Northern Commercial has not used the Excalibur account for a few months, and has instead been paying claims with checks drawn on accounts at Florida, California and Texas banks, Mr. Snider said.

U.S. Claims took over Northern Commercial claims handling responsibilities late last year from Worldwide Administrative Services Inc., an Atlanta-based administrator headed by Charlotte Rentz, the wife of Alan Teale.

Ms. Rentz and Mr. Teale were among the subjects of a Senate committee hearing last month focusing on the collapse of Victoria Insurance Co. Ltd. Ms. Rentz and Mr. Teale at one time were Victoria officers (*BI*, April 29).

WAS handled Northern Commercial claims from February 1989 until November 1990, when its responsibilities were terminated, according to Ed Jenkins, vp and chief financial officer.

Mr. Jenkins also said that "Alan Teale has no connection with Worldwide Administrative Services."

Northern Commercial claims handling had been subcontracted to WAS by World Insurance Network Ltd., another Atlanta-based company headed by Ms. Rentz that had a management agreement with Northern Commercial.

WIN acted as manager for several other Turks & Caicos companies, including Wilmington Marine & General, Wilmington National, Apex Placement Insurance Co. Ltd., Caribbean Excess Insurance Co. Ltd., Caribbean Protective Excess Insurance Co. Ltd., Caribbean Title Insurance Co. Ltd. and Overseas Deposit Insurance Co. Ltd. ■

Ernst & Young settles negligence charge

SACRAMENTO, Calif.—Ernst & Young agreed last week to pay $1.5 million to settle charges by the state accounting board that its predecessor firm, Arthur Young & Co., was grossly negligent in its 1987 audit of insolvent Lincoln Savings & Loan Assn. and its parent company, American Continental Corp.

That settlement is the largest ever for the California State Board of Accountancy.

Ernst & Young would not comment on its insurance program. It is known, however, that the self-insured retentions of the major accounting firms currently far exceed $1.5 million.

The accounting board had charged that Francis J. O'Brien, director of accounting and auditing for Arthur Young in Los Angeles, agreed to the "improper recognition of approximately $62 million in profits" during the 1987 audit.

Without those profits, Lincoln—whose demise is one of the largest savings and loan failures to date—and ACC would have had to report a pre-tax loss of about $36 million, the board said.

ACC filed for bankruptcy in April 1989. ACC bondholders, who lost about $200 million, filed a series of suits against Chairman Charles H. Keating Jr. and law and accounting firms that had worked for the company (*BI*, June 25, 1990; June 11, 1990).

As part of the agreement to settle the negligence charges, Ernst & Young also agreed to conduct training programs for its audit personnel in California over the next three years and comply with other accounting board procedures.

Mr. O'Brien was placed on probation for three years and was prohibited from participating in any audits for 12 months.

Ernst & Young admitted no wrongdoing and says it settled to avoid protracted and costly litigation.

"Our audit was made in accordance with professional standards," the firm said in a press release. "Any wrongdoing was by ACC/Lincoln."

—By Louise Kertesz

Update

Plant covered for blast loss

STERLINGTON, La.—Angus Chemical Co. of Northbrook, Ill., says it has "adequate" insurance to cover undetermined liability and property losses stemming from a chemical plant explosion in Sterlington, La.

The blast last week killed eight employees of another company and injured about 120 people, including workers and town residents.

Angus would not provide coverage details.

However, the company has $15 million of liability limits excess of $1 million written by PRIMEX Ltd., a Barbados captive formed by chemical manufacturers, a PRIMEX spokesman confirmed. The policy covers general liability claims, including employer liability and products and completed operations. PRIMEX reinsured $10 million of the $15 million in limits with Centre Reinsurance (Bermuda) Ltd.

Under Louisiana workers compensation law, surviving spouses with or without children can receive up to $282 weekly in addition to a $3,000 burial allowance.

Angus owned the nitroparaffin production unit—the world's largest—where at least one explosion occurred Wednesday afternoon and fires burned for about a day, said Jim Morrison, vp-finance.

But, the unit was operated and staffed by IMC Fertilizer Inc., also of Northbrook. IMC, which also operates two nearby ammonia fertilizer plants, would not comment on its insurance.

Neither the cause of the explosion nor damages had been determined late last week. But IMC had resumed some operations, pending a decision on whether to shut down for additional safety inspections.

Angus hopes to resume operation at its undamaged storage facilities and tank farm as early as this week, Mr. Morrison said.

Syndicate losses to be studied

Several new procedures at Lloyd's of London are designed to smooth out disputes between members and agents over huge impending syndicate losses.

Catastrophes and rising pollution and asbestos claims will force many members this year to pay cash calls for the 1988 underwriting year, which just closed under Lloyd's three-year accounting system (see story, page 65). Lloyd's is expected to post an overall loss in 1989, and losses may be significant in 1990, said Lloyd's Chief Executive Alan Lord.

To help deter lawsuits among members and underwriting agents stemming from the losses, Lloyd's last week announced several new practices. For example, Lloyd's introduced independent reviews of syndicates whose underwriting losses exceed 150% of their premium capacity. Reviewers, who will include retired underwriters, may go as far as interviewing policyholders about the losses, he said.

However, when members are satisfied with their managing agents' reasons for the losses, further review may not be needed, Mr. Lord said.

Though Mr. Lord would not say how many syndicates would be reviewed this year, he confirmed that some of those formerly managed by Feltrim Underwriting Agencies Ltd. would be reviewed. Feltrim members face more than $250 million of losses, mainly from catastrophes over the past few years (*BI*, March 11).

Lloyd's last week also established a conciliation scheme to settle disputes between members and agents.

Suit against distillers dismissed

AUSTIN, Texas—Liquor distillers have no duty to warn individuals that excessive consumption of alcoholic beverages may lead to alcoholism, the Texas Supreme Court ruled last week, reversing a state appellate court decision.

The case involves three product liability suits filed in 1988 against Joseph E. Seagram & Sons Inc., Brown-Forman Co., Hiram Walker Inc. and The Distilled Spirits Assn. of the U.S. Inc. The suits sought unspecified compensatory and punitive damages.

The plaintiffs, "who suffer or suffered from the disease of alcoholism," sued the distillers "for products liability and misrepresentation. . .negligence, breach of the implied warranties of merchantability and fitness, violations of the Deceptive Trade Practices Act and conspiracy. The essence of these causes of action is (the distillers') alleged duty to warn and instruct of the danger of developing the disease of alcoholism from prolonged and excessive consumption of alcoholic beverages," the Texas Supreme Court said.

A Beaumont County trial court dismissed the litigation, but the 9th District Court of Appeals reversed that decision. "The appeals court gave great weight to the industry's advertising," which the court felt encourages excessive consumption, said Seagram attorney David W. Ichel, a partner with Simpson Thacher & Bartlett in New York.

In reversing the appellate court ruling, the state Supreme Court said it agreed with the distillers that tort law "excuses a seller from the duty to warn as to dangers that are 'generally known and recognized.' "

Briefly noted

American International Group Inc. has confirmed that it is part of an investment group that is "exploring the possibility" of investing up to $1 billion in the Equitable Life Assurance Society of the United States, which is seeking investors to help it convert to a stock company from a mutual (*BI*, March 11). . . .The owners of Maine Yankee Nuclear Power Plant have $500 million of property insurance written by American Nuclear Insurers to cover damage from a fire last week at the Augusta, Maine, plant. The coverage will be more than adequate to cover property damage at the plant, an ANI underwriter said. . . .The 9th U.S. Court of Appeals in San Francisco late last month approved of **drug testing** of about 3 million interstate truck and bus drivers. The court ruled that the Federal Highway Administration's program of random, pre-employment, post-accident and biennial testing did not violate the drivers' constitutional right against unreasonable searches. . . .**AmBase Corp.** has agreed to contribute $12.5 million to its Carteret Bancorp. unit to settle a complaint filed earlier this year by the U.S. Office of Thrift Supervision. The federal agency objected to incentives and other payments to AmBase officers, including former AmBase President Marshall Manley. . . .**LTV Corp.** would pay $300 million in cash and $580 million in other assets in an initial contribution to restore funding to three underfunded pension plans, under a proposed Chapter 11 reorganization plan submitted to bankruptcy court.

Big reinsurers may get bigger

By MYRON M. PICOULT

Special to Business Insurance

OVER THE PAST SEVERAL YEARS, reinsurance buyers increasingly concerned about overall balance sheet strength and, in particular, the quality of reinsurance recoverables, have been engaged in a flight to quality. More business continues to gravitate to the stronger reinsurance companies, especially those with higher limit capacities. In essence, the reinsurance industry has been going through de facto consolidation.



Mr. Piccoult

For example, for the year ended Dec. 31, 1990, 83.6% of the premium volume reported by the Reinsurance Assn. of America is written by the top 20 reinsurance companies (*BI*, April 22). Hence, approximately 45 companies are chasing about 16.5% of the domestic industry's volume.

We and other observers have been awaiting a material consolidation in the reinsurance industry. To date, the pace has been slow. Note that the consolidation of two or more small reinsurers may not yield a substantive reinsurance purveyor that produces the desired consolidation result.

Some additional interest in some small reinsurers whose viability is in question could arise if Rep. John Dingell's Oversight and Investigations Subcommittee is successful in requiring offshore reinsurers to meet the reporting standards of domestically based reinsurance companies. However, success in such ventures will depend on acquiring a substantive rating from A.M. Best Co. and possibly other rating agencies and meaningful limit capacities. Indemnification of a reinsurer's reserves (when available and possible) could also move the consolidation process along.

It takes three to five years from the time that a primary insurer writes a piece of liability business before it begins to fester. We believe that some of the higher primary retentions will begin to show adverse development if, in fact, this is not already happening. This, together with the general deterioration in the balance sheets of many primary insurers, should lead to some increase in the demand for reinsurance coverage.

The recent pickup in demand for financial reinsurance underscores the point. We expect a handful of reinsurers to become the bankers to the primary industry as insurers seek to extricate themselves from the quicksand they stepped into.

Much continues to be written about the solvency of property/casualty business and potential problems with guaranty funds. It's important to realize that reinsurance companies are *not* subject to guaranty pool assessments. However, some reinsurance entities could be affected through aggregate loss covers.

Beginning with the filing of the 1989 statutory statements, insurers have been penalized for slow-paying recoverables. While some tightening of the rules is necessary to reduce abuses that enable insurers to sidestep some of the penalty, there is increased recognition of the value of timely loss payments from one's reinsurers. Hence, a "made in the U.S.A." label, implying the availability of timely payments, could spur volume growth for the stronger U.S. insurers.

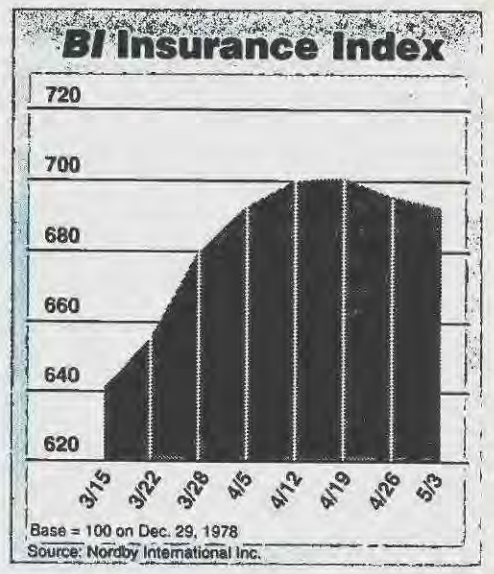
Likewise, difficulties in the London excess-of-loss market could enhance the prospects of major U.S.-based reinsurers. Finally, new regulations requiring the certification of an insurer's financial statements by an actuary should raise the accuracy of loss reserves and probably increase the need for reinsurance back-up.

A recent study we finished on the reinsurance industry—based on year-end RAA data—pointed up several interesting figures:

- Direct writers account for about 52% of the total volume vs. 48% for broker companies. However, several reinsurance entities are not included in the RAA data. Inclusion of the missing entities would probably raise the broker market to about a 60% penetration.
- Many industry observers view the premium-to-surplus ratio as a proxy for capacity. Our perspective is that both the premium-to-surplus ratio and reserve-to-surplus ratios together provide an insight into an insurer's capacity to write business. A review of the 56 broker companies in the RAA data shows a low premium-to-surplus ratio of 0.48-to-1 for the bottom 30 broker companies. This low ratio is directly related to the fact that the smaller companies are not being given the opportunity to quote on business. It is *not* a sign of material excess capacity.

It is our belief that the minimum capital needed by a free-standing company to be considered a player in the reinsurance market today is at least $100 million. This figure would be higher in order to be considered a meaningful player. Within the next few years, possibly sooner, that figure is likely to rise to the $250 million level. ■

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.



Insurance industry stocks dropped last week as the *Business Insurance* Index fell 2.4 points to 692.8 on May 3, from 695.2 on April 26. Advancing issues for the week were led by Pacificare Health System, up 23.1%; Frank B. Hall, up 10.7%; and Sierra Health Services, up 10.3%. Declining issues for the week followed Provident Life, down 12.8%; Alexander & Alexander, down 12.4%; and Statesman Group Inc., down 9.1%. The most active issue for the week was U.S. Healthcare, with 5.1 million shares traded. The *BI* Index was down 0.3%; The Standard & Poor's 500 rose 0.5%; the Dow Jones 30 Industrials were up 0.9%; and the New York Stock Exchange Composite rose 0.6%.

British Issues

May 2 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Commi Union	520	N/M	30.7	5.9	520—500
Genl Accident	541	N/M	35.7	6.6	541—529
Gdn Royal Exch	212	N/M	15.9	7.5	212—202
Royal	451	N/M	34.7	7.7	451—435
Sun Alliance	390	N/M	18.7	4.8	390—380
Brokers					
Bradstock	151	17.2	6.0	4.0	151—151
CE Heath	508	15.0	34.5	6.8	512—508
Hogg Group	200	12.1	10.7	5.4	200—200
Lloyd Thompson	367	24.4	10.0	2.7	367—367
PWS Holdings	95	11.6	4.7	4.9	95—91
Sedgwick Grp	253	24.3	16.0	6.3	255—250
Steel Brrl Jones	295	15.8	16.3	5.5	295—295
Willis Corroon	315	16.7	17.6	5.6	315—306

Source: Philip Olsen, Insurance Industry Analyst London

BI opinion survey

Continued from page 3

national health insurance program would lead to big tax increases and a deterioration in health care services.

"National health insurance in Europe costs three times what insurance costs here. It may take weeks and always several hours to see a doctor," the consultant said.

Opposition, though, is much more muted against the so-called "play or pay" approach to expanding access to health care.

Under that approach, employers either offer a health care plan or are liable for new state taxes. Just over 53% of the respondents were opposed such an approach, while 47% were in favor.

The pay or play approach was adopted by Massachusetts in 1988. Employers with six or more employees are liable for a new "medical security tax" of $1,680 per employee.

However, employers can offset that tax by each dollar they spend on their health care plan. Employers that spend more than $1,680 per employee on health insurance are exempt from the tax.

That provision, set to go into effect in 1992, has triggered massive opposition from the small business lobby, which has launched a drive to repeal the law (see story, page 1).

It is possible that respondents—generally medium-sized to large employers—are not so strongly opposed to a pay or play approach since most probably already offer health insurance and would not face any new requirements. ■

BI Industry Stock Report

APRIL 29, 1991 THROUGH MAY 3, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	21.75	-5.43	-5.95	28.00	16.13	597	1.00	4.60	16	9.24	2.35
Gallagher Arthur J. & Co.	NYS	25.00	0.00	7.53	28.38	19.75	44	0.64	2.56	19	5.33	4.69
Frank B. Hall	NYS	3.50	-9.68	-3.45	4.13	2.00	75	0.00	0.00	-7	-5.24	-0.67
Hilb, Rogal & Hamilton	OTC	16.25	3.17	10.17	17.00	11.25	902	0.36	2.22	24	4.60	3.53
Marsh & McLennan	NYS	80.25	2.07	2.88	87.25	59.75	428	2.60	3.24	19	12.05	6.66
Poe & Associates	OTC	12.25	3.16	53.13	12.25	7.75	64	0.40	3.27	12	2.40	5.10
BROKERS	AVERAGE		-1.0	9.2					2.3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	45.00	2.27	20.00	46.50	28.50	93	0.48	1.07	15	18.59	2.42
Berkshire Hathaway Inc.	NYS	8025.00	-0.93	20.22	8900.00	5675.00	0	0.00	0.00	-26	4282.70	1.87
ITT (Hartford Group)	NYS	60.13	2.12	25.26	60.88	40.25	1391	1.72	2.86	8	56.33	1.07
Sears (Allstate)	NYS	37.75	0.00	48.77	39.88	22.00	3033	2.00	5.30	13	39.77	0.95
CONGLOMERATES	AVERAGE		0.9	28.6					2.3	2		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	43.13	-1.99	10.58	54.38	29.00	1378	2.76	6.40	8	64.23	0.67
American General	NYS	39.25	3.29	27.64	50.63	23.50	540	2.00	5.10	8	37.14	1.06
American Heritage	NYS	27.50	0.46	30.95	27.88	19.63	7	1.04	3.78	12	22.60	1.22
American Indemnity/Fin'l	OTC	6.50	-7.14	100.00	7.50	2.75	14	0.08	1.23	12	17.38	0.37
American International	NYS	88.00	-5.76	14.47	102.00	57.00	2981	0.44	0.50	13	40.35	2.18
Aon Corp.	NYS	37.63	-1.63	8.27	41.38	26.75	223	1.60	4.25	10	21.37	1.76
Argonaut Group	OTC	94.75	-4.29	48.05	99.88	53.00	52	2.04	2.15	9	36.83	2.57
AVEMCO Corp.	NYS	32.25	1.18	27.72	34.25	21.13	26	0.44	1.36	17	9.52	3.39
Baldwin & Lyons Inc.	OTC	22.75	-7.14	21.33	25.25	17.00	39	0.28	1.23	8	20.80	1.09
Belvedere Corp.	ASE	2.88	-4.17	15.00	4.63	1.75	49	0.04	1.39	21	8.03	0.36
Chandler Insurance	OTC	4.38	2.94	-36.36	9.25	2.75	155	0.00	0.00	-6	9.53	0.46
Chubb Corp.	NYS	66.38	-2.75	22.35	75.25	34.63	1177	1.48	2.23	11	35.19	1.89
CIGNA Corp.	NYS	50.00	-2.44	22.32	56.75	33.25	964	3.04	6.08	11	73.15	0.68
CNA Financial Corp.	NYS	84.38	-1.75	22.95	92.50	49.50	77	0.00	0.00	15	64.74	1.30
Continental Corp.	NYS	28.13	1.35	13.07	31.38	15.75	476	2.60	9.24	11	42.30	0.66
Durham Corp.	OTC	32.50	1.17	16.07	33.00	23.00	283	0.92	2.83	16	26.32	1.23
Fund American Corp.	NYS	63.13	0.00	21.69	65.25	30.75	412	0.68	1.08	14	36.22	1.74
Fremont General Corp.	OTC	20.00	-3.03	37.93	22.13	10.13	355	0.80	4.00	6	20.33	0.98
Frontier Insurance Group	NYS	22.88	3.98	20.39	33.00	15.38	40	0.00	0.00	9	11.97	1.91
General RE Corp.	NYS	88.88	-5.33	-4.44	102.50	69.00	1521	1.68	1.89	13	37.50	2.37
Hanover Insurance Co.	OTC	30.25	6.14	14.15	30.75	21.00	40	0.44	1.45	12	32.03	0.94
Harleysville Group	OTC	30.63	8.41	33.88	31.50	13.50	44	0.64	2.09	9	18.94	1.62
Hartford Steam Boiler	NYS	61.50	1.23	26.15	63.75	43.50	106	1.80	2.93	16	17.05	3.61
Kansas City Life Ins.	OTC	34.50	0.00	11.74	36.50	30.00	38	1.20	3.48	9	39.22	0.88
Kemper Corp.	NYS	39.13	11.39	64.74	43.13	17.13	616	0.92	2.35	71	34.20	1.14
Lawrence Insurance Group	ASE	8.25	-5.71	17.86	9.00	6.38	5	0.48	5.82	13	4.40	1.88
Liberty Corp.	NYS	42.00	0.60	2.13	50.25	39.00	31	0.92	2.19	14	33.53	1.25
Lincoln National	NYS	50.00	-2.20	16.28	56.50	30.75	476	2.72	5.44	12	52.19	0.96
NAC Re Corp.	OTC	41.00	0.00	24.24	42.50	25.50	73	0.20	0.49	16	22.81	1.80
Navigators Group (s)	OTC	32.50	0.00	48.85	33.00	16.50	37	0.00	0.00	12	15.22	2.14
Nobel Insurance LTD.	OTC	4.00	1.57	33.33	4.38	2.38	94	0.00	0.00	-	7.76	0.52
NWNL Companies	NYS	26.38	-1.86	56.30	34.50	11.75	164	1.40	5.31	5	38.71	0.68
Ohio Casualty Corp.	OTC	45.25	0.56	10.37	47.25	26.75	204	2.48	5.48	10	36.38	1.24
Old Republic Int'l	NYS	29.88	0.42	30.60	29.75	17.38	136	0.68	2.28	7	30.70	0.97
Orion Capital Corp.	NYS	28.38	1.34	62.14	28.75	13.00	139	0.92	3.24	10	20.42	1.39
Phoenix RE Corp.	OTC	9.50	-5.00	22.58	11.25	5.00	8	0.20	2.11	119	12.99	0.73
Protective Life Corp.	OTC	19.25	-2.53	29.41	20.75	10.25	138	0.76	3.95	9	14.54	1.32
Provident Life	OTC	22.25	8.54	27.14	26.25	12.00	243	0.92	4.13	6	25.88	0.86
Re Capital Corp.	ASE	17.25	-2.13	33.98	18.63	11.75	30	0.00	0.00	12	14.43	1.20
RLI Insurance Corp.	NYS	15.00	-7.69	3.45	16.38	9.63	22	0.44	2.93	7	12.42	1.21
St. Paul Companies	OTC	69.50	-3.14	10.76	74.25	47.00	773	2.60	3.74	8	52.00	1.34
SAFECO Corp.	OTC	39.75	-0.93	20.91	44.75	25.13	1604	1.36	3.42	9	31.50	1.26
SCOR U.S. Corp.	NYS	14.50	1.75	17.17	15.25	8.38	20	0.24	1.66	10	10.61	1.37
Seibels Bruce Group	OTC	7.75	-6.06	82.35	11.63	4.25	77	0.36	4.65	-16	7.78	1.00
Selective Ins. Group	OTC	16.25	0.00	22.64	18.25	12.50	66	1.04	6.40	7	18.91	0.86
Statesman Group Inc.	OTC	2.88	15.00	83.94	3.00	1.25	183	0.00	0.00	-29	4.19	0.69
Tokio Marine & Fire	OTC	50.13	3.62	6.08	56.50	34.50	50	0.26	0.52	-	70.93	0.71
Torchmark Corp.	NYS	53.38	-2.95	9.21	58.50	38.00	241	1.60	3.00	12	16.70	3.20
Transamerica	NYS	32.88	-5.73	0.77	41.00	23.25	677	1.96	5.96	10	36.56	0.90
Travelers Corp.	NYS	24.00	3.78	44.36	32.38	11.50	1729	1.60	6.67	-13	41.44	0.58
Trenwick Group Inc.	OTC	26.50	-1.72	23.24	30.00	16.25	93	0.60	2.11	11	16.91	1.69
United Fire & Casualty	OTC	52.00	6.12	48.04	58.00	28.75	0	1.32	2.54	8	22.56	2.30
USF&G Corp.	NYS	11.50	-4.17	53.33	29.00	7.00	2053	0.20	1.74	-2	11.96	0.96
UNUM Corp.	NYS	66.13	6.44	41.82	69.00	32.13	464	1.04	1.57	12	34.18	1.93
USLIFE Corp.	NYS	40.50	5.88	44.64	41.75	23.25	236	1.64	4.05	9	55.76	0.73
Unitrin	OTC	37.88	2.36	23.17	41.50	24.50	497	0.80	2.11	14	33.99	1.11
Washington National	NYS	15.00	0.84	37.93	21.88	9.38	19	1.06	7.20	-16	31.21	0.48
USLICO Corp.	NYS	18.75	1.35	18.11	22.38	14.75	39	1.00	5.33	8	28.34	0.66
Zenith National Ins.	NYS	16.88	3.05	23.85	18.25	9.88	93	1.00	5.93	-33	13.81	1.22
INSURERS/REINSURERS	AVERAGE		0.1	28.5					3.1	10.5		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	23.25	-9.71	52.46	29.75	8.88	2500	0.00	0.00	20	5.44	4.27
HMO America Inc.	OTC	14.88	-5.56	128.85	17.13	4.25	1538	0.00	0.00	19	1.12	13.28
Pacificare Health Sys.	OTC	31.25	-3.85	92.31	34.00	12.00	1810	0.00	0.00	22	6.55	4.77
Safeguard Health Enter.	OTC	6.00	-7.69	26.32	7.63	4.00	7	0.00	0.00	21	2.99	2.01
Sierra Health Services	ASE	27.13	-3.13	97.27	29.50	5.50	338	0.00	0.00	47	0.62	43.75
United Healthcare Corp.	OTC	41.63	1.52	79.03	45.63	12.25	3184	0.06	0.14	33	3.97	10.48
United Medical Corp.	ASE	9.75	0.00	21.88	11.38	6.63	4	0.20	2.05	12	5.70	1.71
U.S. Healthcare	OTC	48.25	-3.50	64.26	54.25	14.00	5855	0.48	0.99	23	3.55	13.59
HMOs	AVERAGE		-4.0	70.3					0.4	25		
ALL COMPANIES	AVERAGE		-0.4	30.3					2.7	11		

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