

# Business Insurance

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## Texas school bus crash claims to pierce ACE coverage layer

HAMILTON, Bermuda—After five years in business, ACE Ltd. expects to pay its first claim soon.

The Bermuda-based excess casualty insurer expects to pay a portion of the settlements that Valley Coca-Cola Bottling Co. Inc. of McAllen, Texas, has made with the families of children killed or injured when a company truck crashed into a school bus near Alton, Texas, last year.

The accident killed 21 children and injured 22 others. *Continued on next page*

## LUI estimates size of insurers' deficit

### 6 units may need up to \$164 million

By STACY SHAPIRO

LONDON—Six insurers owned by London United Investments P.L.C. need 75 million to 100 million pounds (\$123.2 million to \$164.3 million) to remain solvent, says LUI's chief executive.

Meanwhile, brokers and other interested parties still are considering whether to contribute capital to keep the six companies solvent and ensure an orderly runoff of their business, according to the chairman of the British Intermediaries & Insurance Brokers Assn.

The six insurers, all of which were running off their business when they stopped paying claims in late March, at one time either participated as insurers on the H.S. Weavers (Underwriting) Agencies Ltd. line slip or reinsured Walbrook Insurance Co. Ltd., another LUI unit and the leading insurer on the line slip.

If the six insurers receive needed capital, Walbrook would not have

to increase its reserves for uncollectible reinsurance, said LUI Chief Executive Peter Wilson.

However, any bailout of the companies will take "a couple months" to organize, he said.

Even if the six other LUI insurers are ordered into liquidations, Walbrook would remain solvent, Mr. Wilson said. But the bailout of the six LUI companies "would ensure the solvency of Walbrook" and secure its ability to pay claims, he said.

But, Mr. Wilson said last week that he does not know whether Walbrook could ever begin underwriting again. Walbrook, which in the last few years has written 55% of the Weavers line slip, stopped underwriting in March pending the completion of an actuarial report on the solvency of all LUI insurance subsidiaries (BI, April 2).

Anglo American Insurance Co., which until March wrote the other 45% of the Weavers line slip, continues to underwrite from its own

offices—rather than Weavers'—after parting company with Weavers last month, according to temporary Anglo American underwriter John Steen of John Head & Partners of New York. An affiliate, Head Insurance Investors (Bermuda) Ltd., owns Anglo American (BI, April 23).

Since joining the Weavers line slip in April 1987, Anglo American has amassed 200 million pounds (\$328 million) of loss reserves, Mr. Steen said.

Anglo American was partially reinsured by the six troubled LUI companies, but that reinsurance was replaced when Head Insurance Investors bought Anglo American from Calfed Inc. earlier this year, Mr. Steen said. The amount now owed to Anglo American by the six LUI insurers is "very small," he said.

The latest chapter to the Weavers saga was unveiled publicly by Mr. Wilson last week following reports *Continued on page 69*



## Boston bash

The Risk & Insurance Management Society Inc. celebrated its 40th anniversary—and the election of its first woman president, Cheri Hawkins—with colonial fanfare at its 28th annual conference last week. A record number of registrants—more than 5,100—attended. Reports on employee benefit sessions begin on page 3. Reports on risk management sessions will appear in the May 14 issue.

## Berkshire's Buffett sees more competition ahead

By LINDA J. COLLINS

OMAHA, Neb.—The prospects of a tightening property/casualty insurance market are "very unlikely, absent a huge catastrophe, for the next couple of years," says insurance holding company chairman/investment guru Warren E. Buffett.

And, such a catastrophe would have to be of a much larger magnitude than Hurricane Hugo to stem current competition among property/casualty insurers, noted Mr. Buffett, chairman of Berkshire Hathaway Inc.

Speaking before a record crowd of 1,600 shareholders and guests at the Berkshire annual meeting last week, Mr. Buffett reiterated predictions made last year to shareholders that the soft market would continue for as long as three more years (BI, May 1, 1989).

While many insurers may now be



Warren E. Buffett

talking about rate increases, "you need fear on the part of a large number of insurance underwriters" before the market will turn, Mr. Buffett said. That has not yet occurred, he added.

"I would like to talk prices up too," but significant underwriting

losses and a shortage of capacity—not talk—are the driving forces behind rate increases, Mr. Buffett observed.

In fact, in Berkshire's annual report, Mr. Buffett said, "Berkshire's premium volume may drop to \$150 million or so in 1990 (from a high of \$1 billion in 1986), partly because our traditional business continues to shrink and partly because the contract under which we received 7% of the business of Fireman's Fund expired last August."

Berkshire, through two subsidiaries, reinsured this portion of Fireman's Fund Insurance Cos. book of business under a four-year quota-share treaty that terminated on Aug. 31, 1989.

"Whatever the size of the (premium) drop, it will not disturb us. We have no interest in writing insurance that carries a mathematical expectation of loss; we experi-

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## Agencies investigate benefit fraud charges against leasing firm

By DOUGLAS McLEOD

CHARLOTTE, N.C.—Federal and state authorities are investigating a Charlotte labor leasing firm that allegedly defrauded Travelers Insurance Co. and dozens of small employers in a group employee benefit program.

Charlotte-based Cap Staffing Inc., now in bankruptcy proceedings, is the target of a joint criminal investigation by the North Carolina Insurance Department, the U.S. Labor Department's Office of Labor Racketeering, the FBI and other federal agencies.

Cap Staffing "leased" workers to small employers, taking over payroll and other administrative functions and arranging group accident and health and life insurance. Cap self-funded the group health insurance program while Travelers provided claims administration services.

However, in a civil fraud suit filed by Travelers, the insurer charges that Cap failed to adequately fund the program, defrauding Travelers of more than \$800,000 in claims it paid on Cap's behalf over a six-month period.

Travelers has denied liability for another \$1.3 million in claims that remain unpaid, citing its "administrative services only" contract with Cap Staffing.

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Aetna suing Massachusetts over auto pool withdrawal  
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More companies reap savings with case management tools  
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Risk managers at small firms are delegating more: Survey  
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## Update

## ACE expects to pay first claim

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jured 60 others (BI, Sept. 25, 1989).

William J. Loschert, ACE executive vp, said he expects the total settlement paid on behalf of Valley Coca-Cola to reach \$150 million. ACE now writes up to \$200 million in casualty insurance excess of \$100 million.

Mr. Loschert's figure includes two announced agreements.

Under a tentative settlement reached last month with the families of 15 children killed in the crash, \$4.5 million would be contributed for each of the families to fund annuities (BI, April 23).

In February, insurers for the company agreed to fund an annuity that would pay \$2.7 million to the family of another child killed in the crash.

The bottling company also will likely settle out of court with families whose children were injured, the ACE executive said. Other suits are pending against Valley Coca-Cola.

ACE was founded in 1985 by U.S. corporations that could not find adequate liability insurance from commercial insurers.

## A&amp;A told to pay \$40 million

BALTIMORE—Alexander & Alexander Inc. will seek relief from a Maryland state court jury verdict that it pay \$40 million in punitive damages to a Baltimore brokerage that sued the retail broker for breach of contract, its attorney says.

A&A will ask the trial court judge this week to, among other things, overturn the verdict or reduce the damages, said Benjamin P. Gill Jr., assistant general counsel for Alexander & Alexander Services Inc., the retail broker's parent.

And, "if we don't get appropriate relief on our post-trial motions with the trial court, we plan to appeal." Mr. Gill said.

He also noted A&A is "not considering the verdict as insurable. It's a breach-of-contract action not subject to any insurance contract."

The dispute involved a broker-of-record agreement that B. Dixon Evander & Associates Inc. held with Mutual Fire, Marine & Inland Insurance Co. through the insurer's managing general agent, A&A subsidiary Shand Morahan & Co. Inc., from 1975 through 1985.

Dixon Evander alleged in the suit that A&A encouraged Shand Morahan to terminate the broker-of-record agreement and place coverage for the University of Maryland Medical Group—Dixon Evander's largest client—directly with Mutual Fire, explained Joseph B. Harlan, managing partner of Birrane, Harlan, Sharrettes & Cooke in Baltimore, which represents the plaintiff.

A&A also was ordered to pay more than \$250,000 in actual damages—representing Dixon Evander's lost commission income from the university account—plus interest.

## Reinsurer to appeal IBNR ruling

LOS ANGELES—Underwriters Reinsurance Co. will appeal a superior court judge's ruling that the Mission Insurance Group liquidator can demand immediate reinsurance payments for incurred-but-not-reported claims, says a lawyer for the reinsurer.

Los Angeles Superior Court Judge Kurt Lewin ruled May 3 that Insurance Commissioner Roxani Gillespie, as Mission's liquidator, "will be entitled to all damages flowing from the reinsurers' breach of the reinsurance agreements, including future damages proved with sufficient certainty."

Underwriters Re had filed a motion claiming Mission's liquidator was not entitled to accelerated payment of \$71 million for IBNR claims (BI, Jan. 29).

"We respectfully disagree with the trial judge's opinion and plan to file a petition for writ of mandate," said Gary Poon of Arnold & Porter in Washington, D.C.

Separately, the California Supreme Court has agreed to review an appellate court ruling permitting reinsurers to offset amounts they owe an insolvent insurer by amounts the insolvent company owes them (BI, Jan. 8).

Under the appellate court ruling, the reinsurers would have been permitted to withhold payment of more than \$300 million.

## Maine rules cleanup uninsured

PORTLAND, Maine—The costs of cleaning hazardous wastes from a policyholder's own property are not insured damages, the Maine Supreme Judicial Court ruled late last week.

The decision marks the second time this year Maine's highest court has denied coverage to policyholders for hazardous waste cleanups (BI, April 16).

In the most recent decision, the court held that Lido Co. is not covered by a commercial general liability policy written by Fireman's Fund Insurance Co. for a \$150,000 cleanup of gasoline that leaked from an underground storage tank at one of its gas stations in Plaistow, N.H.

The court, applying New Hampshire law, said: "Lido has failed to demonstrate that New Hampshire's highest court would reject the precedent set in *Desrochers*," a 1954 case in which the New Hampshire court held that cleanup costs were not insurable damages.

The court also rejected Lido's argument that Fireman's Fund should be legally barred from denying coverage for pollution claims because the insurer had previously paid for cleaning up a gasoline spill on Lido property in Massachusetts.

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## Errors &amp; omissions

• Mental Health Risk Retention Group incorrectly reported its year-end 1989 policyholder surplus in the chart of policyholder-owned risk financing facilities in the April 30 issue. The risk retention group had \$1.3 million in surplus as of Dec. 31.

• Due to a production error the captive manager of Financial Institutions Reserve Risk Retention Group Inc. was incorrectly listed in a chart detailing 20 leading Vermont-based captive insurers (BI, April 30). Johnson & Higgins Services Inc. is the captive manager.

## More firms reap savings from case management

By STACY ADLER

A female employee at General Mills Restaurants Inc. enters labor six weeks prior to her due date. Her physician wants to hospitalize her to continuously monitor the fetus. But, the self-insured employer intervenes, sets up a fetal monitor in the employee's home and saves more than \$15,000.

The company's medical cost savings illustrate why employers increasingly are turning to case management of catastrophic claims to control their health care costs.

Indeed, 62% of the nation's employers have implemented a case management program, and another 18% are considering implementing a case management program, according to a recent survey by Lincolnshire, Ill.-based Hewitt Associates.

A case management program can help employers reduce the cost of big-ticket health care procedures in many ways.



For example:

• Atlanta-based Kawneer Corp. was able to save more than \$450,000 when it transferred an employee's daughter who was being treated for mental health problems at a hospital to a halfway house. The daily cost of care at the halfway house—where the girl received treatment for nine months—was about \$300 compared with about \$2,100 at the hospital.

Kawneer, which implemented its case management program in January 1988, has realized average savings of \$100,000 to \$150,000 in the past two years, reports Leonard Rehm, director of human resources.

Kawneer, which manufactures architectural aluminum products for the commercial building industry, spends \$6.5 million annually for health care coverage for its 3,000 employees, Mr. Rehm said.

Kawneer's health care plan is underwritten by Hartford, Conn.-based Aetna Life & Casualty Co.

• Midland, Mich.-based Dow Corning Co. was able to save more than \$100,000 when it moved a comatose female employee from a hospital, where the daily cost of care was \$675, to a specialized nursing home facility, where the daily cost of care was \$300.

The employee had spent two years in the hospital.

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## Blasts laws on dropping auto coverage

## Aetna sues Massachusetts

By STACY ADLER

BOSTON—Aetna Casualty & Surety Co. is challenging the constitutionality of two Massachusetts laws regulating withdrawal of insurance companies from the private passenger auto market.

In a lawsuit filed last week in U.S. District Court in Boston, Hartford, Conn.-based Aetna claims the laws violate its right to due process.

The suit is believed to be the first of its kind in the state.

One law requires an insurer

wishing to withdraw from the private passenger auto market to pay an annual assessment for eight years into the state's residual market fund.

Aetna would have to pay more than \$200 million if it withdrew from the state's auto market, the insurer estimates.

The other law gives the insurance commissioner authority to revoke all state licenses of an insurer that stops writing private passenger auto coverage in the state.

Commissioner Timothy Gailey said the laws allow state officials

to prevent "unreasonable disruptions in the marketplace" and that he is confident they will be upheld in court.

He argues that Aetna's withdrawal from the state's private passenger auto market would be disruptive because the insurer writes 9% of the market.

But, Mr. Gailey said the withdrawal would not likely trigger an exodus of insurers from the state. He would not speculate on the impact of a withdrawal by Aetna, which is among the state's largest.

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## Data base may cut malpractice costs

By MEG FLETCHER

ROCKVILLE, Md.—A new national data bank of medical malpractice claims and disciplinary proceedings against health care professionals could help reduce medical malpractice claims against health care facilities, experts say.

Health care facilities soon will be required to tap the data bank for reports on physicians and dentists seeking medical privileges as well as those whose privileges are being reviewed.

However, the data bank also could open up new areas of liability

for health care providers and perhaps even employers, some consultants warn.

The National Practitioner Data Bank, which is expected to begin operating this summer, will generate an individual "rap sheet" on each health care professional licensed or authorized to practice in a state.

The data bank will contain information on such health care professionals as physicians, dentists, nurses and pharmacists. And, depending on the state, the data bank will contain information on as many as 50 other types of health

care professionals, such as nurse practitioners.

The type of health care professional who must be licensed or authorized varies from state to state.

The data bank will list any medical malpractice claim payments or settlements made on behalf of the health care professional after the program's inception.

The reports generated by the data bank also will list any disciplinary actions against physician and dentists, whether brought by a health care facility's peer review.

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## Inside

✓ Congress could muddy early retirement incentive programs by passing sloppy misguided legislation, as it appears about to do, says this week's editorial. **PAGE 8**

✓ Passing a greater share of health care costs to workers may be the only course left for firms to hold down costs, says consultant Holly King in Speaking Out. **PAGE 39.**

✓ A proposed EC directive will provide an additional incentive for manufacturers to audit their product safety risks, explains Johnson & Higgins' Douglas Smith in International Issues. **PAGE 40**

✓ Risk managers at small firms are taking a cue from their counterparts at large companies and delegating more tasks, a survey of risk management trends by Logic Associates Inc. shows. **PAGE 52**

✓ West Germany is under pressure to deregulate its insurance market. **PAGE 61**

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# RIMS benefit report

## Containing outpatient costs growing crucial

By JAMES M. BURCKE

BOSTON—The cost of outpatient medical care will continue to soar in the 1990s, fueled in part by a new Medicare physician reimbursement system that will result in still more cost shifting to employers.

However, employers can take steps to hold down the cost of outpatient care by implementing highly focused prospective procedure review programs to encourage less costly alternatives to expensive outpatient procedures, benefit managers and consultants agree.

Containing outpatient care costs is crucial as employers continue to encourage employees and dependents to use outpatient treatment as an alternative to more expensive inpatient care, agreed a panel at the 28th annual Risk & Insurance Management Society conference last week in Boston.

While encouraging outpatient treatment can reduce costs, "unfortunately, we forgot to put controls in" to control outpatient utilization, said panel moderator Carol S. Jacobs, manager-benefit administration at Merck & Co. Inc. in Iselin, N.J.

"As a result of no checks and balances, hospital revenues from outpatient visits almost tripled" from 1980 to 1987, Ms. Jacobs said, citing statistics from the American Hospital Assn. At the same time, inpatient costs rose only slightly, she said, adding that outpatient costs now account for nearly 50% of employers' health care expenditures.

However, employers' attempts to manage these costs are going to be frustrated by continued shifting of health care costs not totally reimbursed by government health care programs, like Medicare, to the private sector, said Glenn S. Meister, a managing consultant with A. Foster Higgins & Co. Inc. in Los Angeles.

Mr. Meister explained that during the 1980s, Medicare initiated caps on the amounts it would pay hospitals for inpatient care, which in turn increased utilization of outpatient procedures by Medicare recipients.

"Medicare is now looking at the other piece of the pie—the physician piece," he explained.

"As the Medicare changes of the early '80s focused on the hospitals, Medicare changes that we are faced with in the early '90s will focus on the physicians," Mr. Meister said, adding that caps on the amount of money physicians can charge Medicare patients will surely result in increased cost shifting to employers (BI, April 9).

The new Medicare reimbursement system, known as the Resource Based Relative Value Scale, takes effect in 1992.

"We anticipate that physicians will react quickly and will begin changing... their pattern of charges beginning later this year and accelerating into 1991 and through to 1992," he said.

Under the RBRVS, surgeons and other specialists will receive reduced reimbursement from Medicare. Reimbursements to primary care physicians will be increased.

This systems will create a double whammy for employers, Mr. Meister said.

"The primary care physicians, now that they have been validated by Medicare that their charges should in fact be higher, will charge you, the private sector payers, those higher fees as well," he told an audience composed primarily of benefit managers.



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Benefit experts (from left) Susan Nelson, Douglas Leland, Carol Jacobs and Glenn Meister take on outpatient costs.

# Workforce changes beget 'family' benefits

By JERRY GEISEL

BOSTON—Employers need to consider how they should overhaul their benefit programs to meet the needs of a rapidly changing workforce, a consultant advises.

"There will be astounding demographic shifts during the next 10 years. America will be unrecognizable" from the society of today, said Iris Goldfein, a partner with Coopers & Lybrand's Actuarial, Benefits and Compensation Division in Chicago.

And, employers will look to their employee benefit managers to see that they have the benefit programs necessary to keep pace with the changing society, Ms. Goldfein said at the 28th annual Risk & Insurance Management Society conference in Boston last week.

Two benefit managers who also spoke at the session explained how their companies have introduced so-called "work and family" benefits to meet the needs of their changing workforces.

Ms. Goldfein said that "companies will look to their benefit managers so companies are not caught unprepared."

And, "if you put your head in the sand now, you will be asked later on where you were when these changes were occurring," Ms. Goldfein said.

Demographic changes outlined by Ms. Goldfein that could prompt employers to offer new benefits include:

- Both the population and workforce are likely to grow at their lowest levels since the 1930s.

And, the pool of older workers—the aging baby boom generation—will continue to increase. "There will be a large glut of middle management clamoring for the few available executive openings. There will be no place for many workers to go," Ms. Goldfein said.

As a result, there could be a proliferation of early retirement incentive programs, also known as window plans, as employers try to reduce this glut of older workers.

- Women will constitute a much higher percentage of the workforce, with women comprising 60% of new entrants in the workforce between 1985 and 2000, she said.

Women today comprise 45.8% of the workforce, and that percentage is expected to rise to 47.5% by 2000.

By comparison, women comprised only 33.4% of the workforce in 1960, she said.

Already, there have been big increases in the percentage of working women with young children.

For example, in 1984, 61% of married women with children held jobs, up from just 28% in 1960. During the same period, the percentage of all children under age 6 whose mothers held jobs climbed to 52% from 19%.

With a more heavily female workforce, employers must try to help employees balance work and family commitments, Ms. Goldfein said.

Indeed, employers that try to meet the family-related needs of their workers have seen increases in productivity.

A recent survey by the National Council of Jewish Women brings that point home, Ms. Goldfein said.

According to that survey, pregnant women with employers that respondents described as having a high accommodation for their condition missed an average of 2.1 days due to illness during their pregnancies. However, pregnant women with employers the respondents described as having a low degree of

accommodation for their condition missed an average of 3.4 days of due to illness during their pregnancy.

The same survey also found that 73% of women with employers with a high level of accommodation while they were pregnant were very satisfied with their jobs, compared with 41% of women who said their employers were not very accommodating during their pregnancy.

The high accommodating employers "reached out to employees in time of their need" and their efforts worked, Ms. Goldfein said.

While hard to measure, a more content workforce also will be more productive, according to Ms. Goldfein.

"The least productive worker will be the one who is concerned about day care, a sick child or parent. It will be our job to teach management how to make employees more productive" through new benefit programs, Ms. Goldfein said.

Some employers already are launching new benefit programs to meet the needs of a changing workforce.

For example, American Telephone & Telegraph Co., one of the nation's largest employers with 265,000 workers, began offering

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**Employers that try to meet the family needs of their workers have seen productivity rise, a survey shows.**

# Scrutinize PPO data for actual savings

By CHRISTINE WOOLSEY

BOSTON—Employers should perform extensive data analysis before contracting with a preferred provider network or individual hospitals for managed health care services to determine their cost savings potential, an employee benefit manager stressed.

Indeed, employers may find that the services will be ineffective and could actually hike their costs, said Thomas G. Emerick, director of benefits at Miami-based Burger King Corp.

For example, Mr. Emerick concluded after investigating the advertised savings of several established preferred provider networks in various cities "that the vast majority were not good deals. They

didn't save money, and more often than not they cost employers money."

Mr. Emerick explained that "the problem employers ran into when PPOs were first developed was that they kept getting reports from their networks that every time employees stayed in a network hospital, they saved \$500. They didn't realize a stay in a non-PPO hospital" could have saved much more.

Mr. Emerick set out to directly contract with hospitals and providers in the 20 largest communities where Burger King employees are located. Burger King employs about 40,000 people around the country, he said.

"My CEO came to me and said: 'Show me some cost containment programs that work,'" Mr.

Emerick explained at the 28th annual Risk & Insurance Management Society conference in Boston last week.

Mr. Emerick investigated a variety of PPOs, including networks set up by commercial insurers, hospitals and Blue Cross & Blue Shield plans. He looked at networks in Cleveland, Los Angeles, Pittsburgh and Houston.

"It's important that PPOs not only have the appearance of saving money, but that they actually do save money," Mr. Emerick said.

For example, "most of the PPO deals I looked at involved only the highest-cost hospitals" in a community, he said. But, these network hospitals gave employers the highest discounts and were eager to sign up for PPO contracts, he said.

PPO networks "advertise that they will give these great discounts, but the only hospitals that can afford to participate are those with high margins anyway," he said.

Mr. Emerick outlined several steps employers can take to verify a network's advertised cost savings or to check the cost efficiency of a potential network hospital.

For example, employers should look beyond the advertised savings and compare the average cost per admission at each hospital in their community, he advised.

"You should determine the case mix by average cost per day, per hospital admission type," he explained. For example, examine a facility's costs per maternity admission, as well as medical/surgi-

cal, pediatric, psychiatric and intensive care admissions, he said.

In addition, employers should look at the utilization review features a network offers.

Even if an established provider network advertises complete services like preadmission review, case management and retrospective review, employers should investigate further, Mr. Emerick said.

He said he pulled together data on the 10 most common admissions for an employee group within a particular community.

When he approached a potential network hospital, the UR staff there assured him that they provided aggressive UR for those specific diagnoses.

However, when Mr. Emerick analyzed the length of stay for those 10 types of admissions, he found that the average length of stay in the PPO hospitals was 50% higher than what Burger King's own UR guidelines said was appropriate.

"We would have gotten a 15% discount on those admissions, but our employees would have longer stays," so the savings was a myth, he said.

Mr. Emerick said directly negotiating discounts with hospitals is easier than dealing with individual physicians.

"Doctors are much tougher to crack. There are more of them, and they come and go within a community," making updating PPO physician lists a task, he said.

And, arranging discounts with hospitals is most crucial because "hospital charges are 50% to 60% of your total costs. If you get a good discount out of them you can save a lot of money and time," he said.

Mr. Emerick pointed out that employers should select hospitals for their own networks based on historical use by their employees, the scope of the providers' services and locations of admitting physicians.

For example, employers should avoid hospitals that are too far away for the majority of employees to access.

Among the quality factors to consider when rating potential PPO hospitals are infection rates, the percentage of board-certified physicians and the ratio of registered nurses to average patient counts, Mr. Emerick added.

However, "there is a big question about how much the hospital affects the quality of a patient's outcome," he pointed out.

It is really the physicians that control the quality of care within a facility, Mr. Emerick said.

For example, if you have a hospital where the rate of Caesarean section births is higher than the norm, eliminating that hospital from a network will not necessarily eliminate the problem because the doctors performing C-sections often operate in several facilities around the community, he explained.

Therefore, employers must identify which doctors perform certain procedures more often than average, he said.

Overall, "the major ingredient in the success of a PPO is employee acceptance," stressed Herbert Leinberger, principal at employee benefit consultant Godwins Inc. in Coral Gables, Fla., a subsidiary of Frank B. Hall & Co. Inc.

Other speakers at the session included Patricia A. Hemingway, senior vp with PARTNERS National Health Plans in Irving, Texas; and Anne H. Bergman, vp and risk manager for BankAtlantic, Federal Savings Bank in Fort Lauderdale, Fla. Ms. Bergman also moderated the session.

## Too Many U.S. Firms Are In The Dark About Their Foreign Exposures.

A lot of American businesses have foreign exposures they don't even know about. Consider the many businesses without a single office in a foreign country. But the staff travels. So do the products. International risks—and potential coverage gaps—may result.

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# DOES IT SEEM LIKE INSURANCE COMPANIES ALWAYS HAVE SOMETHING UP THEIR SLEEVES?

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What most benefit managers are looking at these days isn't at all pretty.

While it's tempting to blame health insurers for rising rates in recent years, the causes are far more complex.

You have to consider factors like increasing employee demands, utilization, cost shifting and catastrophic claims that have been pushing employee health benefit rates higher and higher.

Couldn't somebody roll up their sleeves and try to get a grip on controlling these costs?

Well, at NWNL Group we are. One way we're helping to control rising costs is by simplifying mountains of complex data and turning it into valuable information that provides answers.

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## Opinions

# Congress breaking windows

**W**E UNDERSTAND WHY members of Congress want to overturn a U.S. Supreme Court decision that said older workers' benefits are not protected by the Age Discrimination in Employment Act.

But reversing that decision by passing sloppy, misguided legislation, as Congress seems about to do, would throw a cloud of uncertainty over early retirement incentive programs.

Last year, the Supreme Court—to the obvious anger of Congress—ruled that ADEA's protection against arbitrary age discrimination only extended to personnel-type issues, such as the hiring and firing of older workers, and not to employee benefit programs.

The decision effectively reversed a long-established Labor Department rule, known as the equal benefit/equal cost rule, issued to help employers comply with the age discrimination act.

Under that rule, employers could legally provide smaller welfare-type benefits, such as term life insurance, to older workers as long as the cost of the benefits was equal to that for younger employees.

The Supreme Court, in essence, said companies could reduce benefits to older workers without providing any cost justification.

Some members of Congress are seeking to nullify the Supreme Court's decision. To accomplish this, all Congress has to do is write the equal cost/equal benefit rule into law.

Legislators have not made that simple change. Instead, they are taking a meat ax approach, endangering other benefit programs that clearly help older workers.

The legislation now being considered by Congress says early retirement incentive programs, also known as window plans, would be considered lawful if they "further the purposes" of ADEA (BI, April 30).

That seems to suggest that if a window plan does not further that law's purpose, it may not be lawful.

Since the major purpose of the age discrimination act is to promote the employment of older workers, would any window plan, which by its very nature encourages older workers to retire, pass muster?

At the very least, the uncertainty over what is a lawful window plan is likely to produce a wave of litigation by workers who are not eligible to par-



ticipate in such plans.

They would claim that they were not offered the more generous benefits available through the window plan.

The problems with the legislation do not stop there.

The legislation, S. 1511 and H.R. 3200, also says that the heart of window plans—subsidized early retirement pension benefits—is lawful if offered permanently. Would that be interpreted to mean that a window plan that offers subsidized early retirement benefits on a temporary basis is unlawful?

Resolving that question undoubtedly would take a slew of lawsuits.

If employers do not know—without a lengthy court battle—what constitutes a legal window plan, they are unlikely to offer early retirement incentives.

Employees, of course, would be the losers. When companies must reduce their workforces, giving older workers incentives to retire early is a much better alternative than simply laying off large numbers of workers.

We hope legislators go back to the drawing board to take care of what should be done—reversing the Supreme Court decision—without interfering with employers' ability to offer window plans.

## Letters

# Duva stands behind program's success

To the editor: I read with interest Richard D. Quinn's letter to the editor in the April 4 issue of *Business Insurance*.

It is interesting that with all the articles written by *Business Insurance* that reviewed and explained Allied-Signal Inc.'s managed health care program that many incorrect statements were made in the letter.

For the record, we have had meetings with more than 50 major employers in the last year to review the experience of the

Allied-Signal plan. In addition, we have made numerous presentations around the country.

We have, and will continue to make our experience public since we believe that the Allied-Signal program's experience thus far offers some significant promise to slowing down the rate of health care cost increases for employers, both large and small.

We believe the managed health care approach offers a more disciplined and controlled approach to providing quality health care on a more affordable basis.

The Allied-Signal program was implemented on a nationwide basis. We have acknowledged that there are regional differences in the United States as to both the understanding and the acceptance of managed health care by providers and employees.

We had the most difficulty implementing the program in northern New Jersey, where our corporate office is located.

This is because the health care network was developed a little more than two years ago at the inception of the Allied-Signal managed care program (all other networks were in effect for longer periods).

However, the northern New Jersey network continues to show improvements and we believe that as more and more employers move toward the Allied-Signal-type arrangements, an increasing number of providers will recognize the need to participate, which will make the networks more appealing.

We are contacting Mr. Quinn to invite him to meet with us to go over the details of our program.

**Joseph W. Duva**  
Partner  
Ernst & Young  
New York

■ Until late last month, Mr. Duva served as corporate director of employee benefits at Allied-Signal in Morristown, N.J.

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## Outpatient care

Continued from page 3

Meanwhile, specialists, like surgeons, are going to be hard hit by the reduced fees to be paid by Medicare. "What they are going to do, we believe, is try to hold the fees they are charging now—and maybe even raise them—for non-Medicare patients," he stated.

To combat cost shifting "on the outpatient side, the key is prospective management of outpatient services," Mr. Meister said.

He noted that outpatient review "means a lot of different things to a lot of different people." However, many employers' outpatient review programs consist solely of retrospective review programs, in which the employer simply evaluates what types of services have been provided, he said.

"The key is to prospectively manage...to have some kind of mechanism to prospectively evalu-

ate the need for the care that is given," Mr. Meister advised.

The diversity of outpatient services provided by physicians requires employers to "focus" their efforts on particular procedures in order to effectively contain costs, said Doug Leland, vp of medical review services at Intracorp, a utilization review subsidiary of CIGNA Corp. in Berwyn, Pa.

"As you move into the outpatient area and you look at all the diversity between the different types of providers and procedures...it is also very important to become focused," he stressed. "Don't try to solve all the issues at one time."

One of the first steps in setting up a prospective outpatient review program is simply to select which procedures will be reviewed, Mr. Leland said.

"The more focused you are in procedure selection, the more impact the program will have," he said. By selecting only certain out-

patient procedures to be reviewed, the program will be "more convenient for employees, more convenient for the providers and less costly" for the employer.

Employers that have collected claims data can study that data to determine "where you have problems and where you don't have problems," allowing them to design their review programs accordingly, he said.

But "most claims payers have not been capturing data to that level of detail," Mr. Leland noted.

Employers that do not have sufficient data can analyze demographics—such as age, sex, occupation and past experience with second surgical opinion programs—to decide which procedures are the best ones to review, he said.

Under a typical prospective outpatient review program, Mr. Leland explained, an employee that is to undergo a targeted non-emergency outpatient procedure calls a

toll-free number, where his or her case is reviewed in consultation with the attending physician. Mr. Leland suggested that the initial reviewer should be at least a registered nurse.

If the treatment is judged to be appropriate, the employee is told to proceed. If there is some question, the case is referred to a review physician, who discusses the case with the attending physician. And if those two doctors do not agree on the appropriateness of the procedure or an alternative procedure, the case is reviewed by a specialist.

While this process is much like pre-admission certification programs, a key difference is that pre-admission review only decides whether a hospital setting is appropriate in each individual case, Mr. Leland explained. However, in a prospective outpatient review program, the attending physician's treatment recommendations are

challenged.

"It's a direct challenge to the attending physician who has already recommended that the procedure be performed," he explained. Thus, doctors who review cases not approved initially by the first-level review must be willing to question other physicians' recommendations.

Physicians who conduct the reviews "must be very skilled in that area of specialty and they have to be very skilled in discussing alternatives with a peer in a non-adversarial way over the telephone and reaching agreement on an alternative."

If there still is disagreement after three levels of review, the patient is asked to undergo a complete medical exam and a second opinion is formally given, Mr. Leland said. However, unlike second opinion programs, in which an expensive second examination is automatically ordered, a second exam is only required if three different reviewers do not agree with the attending physician.

If there is still disagreement after the second opinion is rendered, the employee should be allowed to still undergo the procedure—without any coverage penalties—if he or she chooses, Mr. Leland advised. However, after having four medical professionals question the attending physician's course of treatment, he hopes most employees will not insist on the original course of treatment, he said, noting that only 1% of cases reviewed through Intracorp programs get to the second opinion level.

Mr. Leland suggested that employers penalize employees that do not initiate the review process or do not go through all steps of the process.

However, "I do not recommend any penalty" if a patient decides to go through with a procedure that is not approved during the review, he reiterated. "What is key here is getting the process started," he said.

Savings generated by a prospective outpatient review program will vary, depending on types of procedures reviewed, qualifications of the reviewers and other factors, Mr. Leland explained.

In addition, you have to make sure how savings are calculated.

For example, some UR firms will track "gross savings," which is simply the cost of a procedure that is not performed following review. However, Mr. Leland pointed out that often a less-expensive alternative is substituted for a procedure that is not approved. In those cases, the cost of the substitute procedure must be subtracted from the cost of the recommended treatment to determine the "net savings" of the program, he said.

While stressing the many variables involved in these programs, Mr. Leland said an employer should "look for a between a 1½ and a 3½ return on investment in terms of net savings," meaning that the program should save the employer 150% to 350% of the cost of the program.

Texas Instruments Inc. introduced a prospective review program covering several outpatient and inpatient procedures earlier this year, according to Sue Nelson, corporate insurance manager at the Dallas-based high-technology company. The plan changes were prompted by a 56% increase in medical claims costs between 1986 and 1989, she said.

The TI health care plan covering most of the company's 49,000 U.S. employees paid \$12 million in claims for outpatient hospital care last year, she said.

Under the TI prospective review program, which is administered by Intracorp, employees scheduled to undergo one of eight inpatient and

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## Family benefits

Continued from page 3

on Jan. 1 a new child care resource and referral service as part of a package of work and family benefits included in labor contracts negotiation with its unions last year, according to John Driscoll, division manager of benefits administration in AT&T's Morristown, N.J., office.

"We recognized that there were changes in the workforce, and we have responded to those changes" by introducing work and family benefits, he said.

Under the child care resource and referral program, a network of about 300 community-based child care resource and referral agencies across the country are available to help AT&T employees find day care centers, nursery schools, and summer day camps.

AT&T pays the cost of the referral service, though employees are responsible for paying the child care provider they select.

During the first quarter of the year, 1,840 AT&T employees have used the child care resource and referral service, with 91% of employees reporting that they were very satisfied with the service, Mr. Driscoll said.

In addition, AT&T offers workers special unpaid leave programs to take care of a newborn or newly adopted child as well as other family needs.

For example, AT&T employees can take 12 months of unpaid leave to take care of a newborn or newly adopted child.

AT&T will finance health care benefits for the first six months of leave, and the company guarantees the employee will be reinstated to the same or similar job when he or she returns.

During the first three months of this year, a total of 592 employees opted for this program, Mr. Driscoll said.

## Outpatient care

Continued from page 10

outpatient procedures must either request a review or have their coverage reduced by 10%, Ms. Nelson explained.

"You can make whatever decision you want to make after the review process" and not be penalized, she said. "We thought it was important that employees understand all the factors when an attending physician is recommending one of these procedures."

The eight procedures for which TI employees must obtain prospective review are:

- Endoscopies.
- Caesarean sections.
- Hysterectomies.
- Arthroscopy.
- Foot surgery.
- Nasal surgery.
- Magnetic resonance imaging.
- Cardiac bypass surgery.

These procedures were selected in part because their utilization among TI's workforce exceeded averages recorded in Intracorp's data base, except for hysterectomies and bypass surgeries. Utilization of those two procedures was lower than average because TI has a young workforce, she said.

However, TI extended the review program to those procedures because "intuitively we felt there was utilization there that could be inappropriate and that alternative procedures could be used instead of a hysterectomy or a bypass," Ms. Nelson said.

In the first quarter of the program's operation, 490 procedures were reviewed. Of those, 24% of the cases were referred by the initial reviewer to a doctor, about 2% of cases were referred to a specialist and only four cases resulted in a second opinion, she said.

The session was coordinated by Susan Fazo, director of corporate communications at Intracorp. ■

scoll said.

To help employees meet short-term personal emergencies, AT&T on a trial basis is giving employees one paid day of personal time, usable in two-hour increments.

Previously, personal days had to be taken in full-day increments.

AT&T on Jan. 1 also introduced an adoption assistance program. AT&T will reimburse employees for up to \$2,000 in expenses associated with the adoption of a child under age 18.

Even though the program did not go into effect until Jan. 1, employees that adopted children on or after May 28, 1989—the date of the new contract—will be eligible for retroactive benefits.

Mr. Driscoll said that the retroactive element of the program should generate "lots of good will."

Through these and other work and family programs, AT&T believes it will be able to reduce em-

ployee stress as well as help the company recruit and retain workers.

Some new family-related employee benefit programs are proving far more popular than employers anticipated.

**To help employees meet short-term personal emergencies, AT&T on a trial basis is giving employees one paid day of personal time, usable in two-hour increments. Previously, personal days had to be taken in full-day increments.**

For example, when Wendy's International Inc. launched an adoption assistance program, it thought it would have about a half-dozen requests in the first year.

However, the company received four requests during the program's first week, said Karen Ickes,

Wendy's director of human resources in Dublin, Ohio.

Wendy's started the program recognizing that women are more committed to their jobs, reducing the time they have to give birth to children, she said.

"We introduced this program after a lot of employees asked us about it," Ms. Ickes explained.

Under the program, available to employees with at least one year of service and eligible for Wendy's group health insurance plan, the company will pay up to \$4,000 of

fees related to an adoption of a child and \$6,000 for adoption-related fees for a child with special needs.

While the adoption benefit program is proving more popular than expected, Wendy's found that employees were not interested in on-site day care centers, Ms. Ickes said.

In fact, 94% of the Wendy's employees surveyed were happy with their current child care arrangements, a percentage that Ms. Ickes described as "startling."

She believes that employees also were not interested in on-site child care centers because they thought such programs would not be flexible enough to meet their individual needs.

The session was moderated by George Tockstein, director of national administration for Coopers & Lybrand in New York.

Ms. Goldfein coordinated the session. ■

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# Passive payers must manage health costs

By JERRY GEISEL

BOSTON—Employers can no longer afford to be passive payers of health care bills, says a pioneer in the managed care movement.

Companies must learn to manage health care costs just as they attempt to control other corporate expenses, said Joseph W. Duva, a partner with Ernst & Young in New York and former corporate director of employee benefits at Allied-Signal Inc. in Morristown, N.J.

Allied-Signal "agreed as a company to no longer be a passive bill payer," Mr. Duva said at an employee benefits session last week at the 28th annual Risk and Insurance Management Society conference in Boston.

That shedding of corporate health

care passivity led Allied-Signal in 1988 to set up its trailblazing national managed care program, which is expected to save the company \$200 million in health care expenses over three years (BI, March 19).

Under that program, the "Health Care Connection," Allied-Signal employees nationwide are enrolled in HMOs operated nationwide by CIGNA Health Plans Inc.

Employees enroll in the managed care portion of the plan and select a primary care physician—or gatekeeper—just as HMO enrollees do to coordinate health care for that employee.

Employees in the program can use non-network providers but at sharply reduced coverage levels.

For example, employees who use network providers do not pay de-

ductibles, while employees who use non-network providers must pay an annual deductible equal to 1% of annual base pay for individual coverage and 3% of annual base pay for family

**With fee-for-service, 'providers treat a lot and charge a lot,' says TPF&C's Mr. Martingale.**

coverage.

In addition, employees who use network providers pay fixed-dollar copayments on some services, including \$10 for physician office visits and

\$5 for prescription drugs. Employees who use non-network providers must pay a 20% copayment, up to an annual maximum of 12% of their yearly base pay including the deductible.

Currently, the annual per-capita health care costs for the 113,000 employees and dependents in the program are \$2,450, 23% less than the company projected had they remained in a traditional indemnity plan.

In fact, the program has been so successful that CIGNA Corp., the plan administrator, has said it is making money, even though it agreed to hold cost increases for Allied-Signal under 10% in each year of the program.

If cost increases exceed this amount, the administrator has agreed to absorb the additional costs.

So far, the guarantee level has not been pierced, according to CIGNA officials.

"The program is working well. There have been significant savings," said Robert L. McGoldrick, a CIGNA vp in Hartford, Conn., who also spoke at the session.

Both Mr. Duva and Mr. McGoldrick acknowledged that there were some teething pains when the Allied-Signal program was launched.

For example, in the Northeast, it has taken time for CIGNA to build a managed care network because many physicians resisted practicing in a managed care setting. And a smaller network gives employees fewer physicians from which to choose.

But, both employees and physicians have become more comfortable with managed care, Mr. Duva said.

In fact, more than 75% of eligible employees use network providers 95% to 100% of the time, according to Mr. Duva.

"Once employees use the network, they like it," CIGNA's Mr. McGoldrick said, noting that they tend not to shift in and out of the network.

In fact, 83% of the money spent on health care by eligible employees is through the network, compared with initial estimates of about 75%, according to Mr. McGoldrick.

He said that health care is delivered much more efficiently in the network. For example, hospital stays have averaged 4.8 days, compared with an average length of stay of 7.3 days for employees and dependents covered under Allied-Signal's indemnity plan.

But employees and dependents in the network see their primary physician nearly twice as often—about four times a year—as those in the company's indemnity plan.

That difference is very positive, said Joseph Martingale, a principal with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. in Valhalla, N.Y.

As a result, medical problems can be detected earlier and treated at a lower cost than when problems are left unattended, Mr. Martingale said.

He believes the managed care movement is bound to grow as costs continue to escalate for fee-for-service indemnity programs. "Fee-for-service says: 'We will pay you (the provider) for everything.' The result is providers treat a lot and charge a lot," he said.

By contrast, with managed care, providers find the lowest cost method of treatment that is consistent with quality care, he said.

Mr. Martingale said that labor organizations—once cool to managed care—also are beginning to find the concept more acceptable than paying higher premiums and deductibles in fee-for-service plans.

In fact, Philadelphia-based Bell Atlantic Corp. and two unions representing its hourly employees are jointly developing a managed care network (BI, April 2).

While a managed care network has worked for Allied-Signal, employers elsewhere have different approaches to controlling health care costs, Mr. Duva said.

For example, several employers have established in-house medical clinics to try to control costs, Mr. Duva said, referring to the programs of Gillette Co., The Goodyear Tire & Rubber Co. and Southern California Edison Co. (BI, March 5).

While the ultimate approach may vary, the first step employers have to take is to set a health care objective rather than just pay bills, said Mr. Duva, who moderated the session.

The session was coordinated by Virgil Pope, director of marketing in CIGNA's Hartford office. ■

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# Identify needs before choosing a TPA

By MICHAEL BRADFORD

BOSTON—Benefit managers have to clarify objectives and expectations up front when shopping for a health care claims administrator, according to a consultant.

"It's easy to say you're not satisfied with your present claims administrator," said Mark Wagoner, a consultant with The Wyatt Co. in San Francisco.

But, "I think you want to list what your expectations are—you want more accurate processing, you want to be able to interface with other data, you want reasonable turnaround time. . . ." he said during a session at the 28th annual Risk & Insurance Management Society conference in Boston last week.

At the very least, "take out a yellow legal pad and draw a line down the middle of the page. On the left side list the positive things about your current administrator and on the right side list the negatives," he advised.

"But you have to start somewhere by defining your objectives and expectations," he said.

There are nine basic requirements to keep in mind when evaluating a third-party claims administrator's operation, according to Mr. Wagoner.

He said employers should consider whether a TPA's system is:

- Structured so that it can accommodate changes. "It should be designed with an open architecture" that will function with respect to various plan designs, said

Mr. Wagoner.

- Adaptable. "Does it run on a mainframe?" he asked. If so, can it run on a minicomputer that will allow users to access the system?

- Menu-driven. A system should guide the user, making it easier for claims processors to use, which will speed up claims handling.

"Are the screens arranged in a logical sequence to avoid backtracking? Is the system self-adjudicating, or does the processor have to stop halfway through" to handle different claims in different ways, Mr. Wagoner asked.

- Owned by a reputable company with staying power. "The ownership of the system, in my mind, is very important," he said.

For example, a "large claims payer might own the system, and

that's to your advantage. Perhaps they will have a tendency to support the system and remain in business for quite some time. Outside ownership might also be positive. They might have deep pockets and be able to weather some lean years," Mr. Wagoner said.

- Capable of maintaining benchmarks like utilization review profiles and profiles that track reasonable and customary charges for health care services.

- Available when needed. The hours of operation are often overlooked, Mr. Wagoner said.

"I think it might be important that the claims processing system be in the same time zone. If you, in the claims department, need to talk to someone and there's a three-hour lag, that might make it pretty

inconvenient. Also, if data needs to be transferred to other vendors, being in the same time zone might have an impact."

- Secure. It is important to remember that claims data involves proprietary information, Mr. Wagoner pointed out. Confidentiality must be protected.

- Large enough to accommodate growing numbers of claims. The system must be able to handle "not only growth in your employer group but also growth in other outside users. A claims system will not only have your organization as its customer and client but also additional organizations. Will it be able to handle that?"

- Set up primarily to pay health care claims or has the ability to handle other types of claims, like workers compensation claims or disability claims. Sometimes an employer may want the same TPA to handle other types of claims.

Employers should ask how the system develops reports and audit trails, Mr. Wagoner said. "Does the system communicate with other systems? Is it capable of accepting input from your utilization review vendor or pushing out eligibility information back into your human resource information system?"

Elaine M. Prokop, manager of risk and employee benefits at Tyco Laboratories Inc. in Exeter, N.H., told benefit managers that a claims administrator performs "a very important function" regarding managed care programs.

"We've introduced managed care for the first time this year with a utilization review program," said Ms. Prokop, who also moderated the session.

"We had several meetings with our UR firm and our claims administrator early on to make sure the systems were compatible and that they could interface correctly and appropriately to provide us with the data that we need to determine the impact of this kind of program on our claims experience in general."

Rosemary T. Weiner, vp of Medical Review Corp. in Morristown, N.J., stressed the importance of the smooth integration of utilization review information and claims data.

"There needs to be a clear understanding of the goals and objectives that will occur between the utilization review agency, yourself and the claims administrator," Ms. Weiner emphasized.

"A common problem that we encounter is that when an administrator has a claim and they don't have some certification from a review vendor, they will go ahead and apply a penalty," she said.

"That's fine—they're doing their job," Ms. Weiner said. "But at the end of the year, they can't tell you what the cuts were for. It's all put into a bin of benefit reductions. They can't tell you, for example, how many employees had a claim under the non-compliance of the pre-certification and what was the dollar amount. That's a very, very common problem."

Karen R. Bridges, group manager-claim operations for Employee Benefit Plan Administration Inc. in Hampton, N.H., said employers evaluating a claims administrator's computer system should be sure it includes certain flags that can alert claims processors.

For example, a flag could alert the system user if "a claim was paid previously to the same provider" on the same date and for the same amount but on behalf of a different family member, Ms. Bridges said. "Will the system stop you and question: Is this a duplicate or is it a good claim?"

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# Study benefit pools, global firms advised

By CHRISTINE WOOLSEY

BOSTON—Multinational employee benefit pools offer many advantages to international employers and are easy to establish, experts say.

But employers interested in pooling international benefit programs through an insurance network should evaluate the different networks offering such arrangements to be certain which one best fits their needs, says an international consultant.

Multinational pooling arrangements enables a multinational employer to combine the experience of its employee groups around the world to obtain through a network a more favorable experience rating and a myriad of administrative services than it could achieve by insuring those groups individually from local insurers.

"If you have a group of 25 employees in a country, you won't get a very sophisticated contract from local insurers," said Michael P. Stapleton, director of the Multinational Benefit Assn. in South Norwalk, Conn., the marketing arm of Brussels, Belgium-based Insurope.

"But, if you take it and combine it with multinational pooling, you'll get better experience rating," Mr. Stapleton said at the 28th annual Risk & Insurance Management Society conference last week in Boston.

There are several important factors employers should consider when choosing a multinational network, according to Paul Shimer, vp and senior consultant for international benefits at Johnson & Higgins in Hartford, Conn.

For example, employers should examine the rates available from different international networks, he advised.

And, he stressed, "the risk charge will vary inversely with the volume of business in the multinational pool."

Employers also should compare the different requirements each network makes for companies to qualify for a pooling arrangement.

Typically, networks require a minimum premium and a minimum number of covered lives.

For example, a network may require an employer to set up a pool of 100 lives and pay a minimum premium of \$20,000.

The products and services that networks offer also are important.

And, employers should be sure the insurance companies within the network can meet coverage needs, according to Mr. Shimer.

"When you can't get your general manager insured for four times annual salary, that's important" to note, he said.

And, the reputation of insurers should be checked. "Look at their service capabilities, their payment of claims and flexibility of premium payment methods," he said.

Non-financial network services—such as timely reporting with complete and accurate information—also should be assessed, he said.

"The more choices a network has to meet clients' needs, the better we can assess the added value" of a particular multinational network, Mr. Shimer said.

Meanwhile, employers with established captives can reinsure a portion of their multinational employee health care coverage, pointed out Richard Souders, national director of international services for Coopers & Lybrand-Actuarial, Benefits & Compensation Consulting Group in New York.

"The creation of a captive for this sole purpose is not a recommended exercise," cautioned Mr. Souders, who coordinated the ses-

sion. "But, if a company has a property/casualty captive, this could be an opportunity to expose it to another line of business that might be profitable," Mr. Souders said, noting that benefit networks award dividends to employers whose international loss experience proves better than had been expected when their premiums were set.

Employers could invest those dividends in their captives to give

it added flexibility, Mr. Souders pointed out.

The captive could assume a portion or all losses exceeding coverage available through the network, he said.

And, employers that are large enough and have a healthy captive may decide not to use a network but have the captive assume all of the risk.

Cooperation between the risk and benefits department within a corporation is vital in setting up

pooling relationships with property/casualty captives, according to Richard M. Inserra, president of Insurance Strategies Ltd., a risk management consulting firm in Ridgefield, Conn., and former vp-risk management and business development for Triangle Industries, now known as Trian Group L.P. Inc. in New York.

Because captives are usually controlled by the risk management department and international benefits are arranged by benefits staff

or the finance department, it is important that each party be aware of the other's concerns, he explained.

Mr. Inserra said his efforts at Triangle to put together a pool combined with the company's captive failed in part because of a split between the risk management and employee benefits departments.

Elizabeth Lankarge, director of corporate administration at Loc-tite Corp. in Hartford, Conn., moderated the session.



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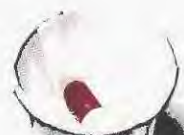
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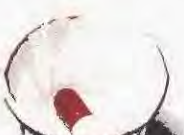
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# More firms seen offering wellness benefit

By LOUISE KERTESZ

BOSTON—There will be "a radical change in transforming sickness benefits into health benefits" during the 1990s as more employers implement or expand wellness programs, a health care consultant predicts.

Spurred by evidence of a correlation between lifestyle and medical claims, employers will increasingly focus on preventing illnesses by offering wellness programs, predicts Edward R. Stasica, president of Stasica Associates of Mount Pros-

pect, Ill.

Currently, wellness programs account for only a small portion of health care expenditures, which represent 12% of the U.S. gross national product, Mr. Stasica noted during a session at the 28th annual Risk & Insurance Management Society conference last week in Boston. However, more employers will begin to offer wellness programs, he predicted.

Twenty years ago, wellness advocates were "the sprout eaters," but that picture has changed, said Veronica Vaccaro, manager of mental

health promotion at the Washington Business Group on Health, a non-profit coalition of large corporations.

And, early employer-provided wellness programs were the corporate fitness programs for executives.

But, wellness programs have evolved to include a wide range of health promotion guidance available to a large number of employees and dependents, Ms. Vaccaro said.

Health promotion should be a "component and guiding principle" in corporate health care, she said. "Not many companies are approach-

ing it this way, but that's the goal."

Studies linking many of the leading causes of death to lifestyle are prompting employers to begin offering wellness programs, Mr. Stasica said. Research has found that lifestyle is to blame for 54% of the deaths attributable to heart disease and 69% of vehicle accident deaths, he said.

Humanitarian considerations aside, "it's probably in the economic interest of employers" to have wellness programs, Mr. Stasica said.

For example, one employer found that non-smokers saved the company

\$650 a year in medical costs, according to Mr. Stasica.

Another found the annual medical claims of smokers are 118% higher than those of non-smokers, he said.

Another found a workplace non-smoking policy significantly reduced housekeeping expenses, including the cost of cleaning windows, he added.

Mr. Stasica mentioned one other incentive employers have to help employees quit smoking: lawsuits by employees claiming they have been injured by "secondary smoke" in the workplace.

Some employers also have saved money by screening for colon cancer, mammography, high-risk pregnancy monitoring and other programs, he said.

In addition, "stress management is being legitimized as a health and wellness mechanism," he said.

"Intuitively, it makes sense that prevention pays," Ms. Vaccaro said.

However, she conceded that there is not "a great deal of data available" to support the concept.

Another problem is that those programs very often "preach to the choir": Only the healthiest workers participate in the programs, she said.

As a result, more employers will increasingly reward workers with healthy lifestyles by cutting health care premiums, experts predicted.

"Health insurance in the next few years will become more like auto insurance, which rewards good drivers," Mr. Stasica said.

And employers are finding other incentives to offer employees to lead healthy lifestyles.

For example, some employers are funding wellness programs by raising health care premiums "a fraction," he said.

And, one manufacturer recently promised to build a fitness facility at the plant that achieved the lowest ratio of non-smokers to smokers.

Governments also are stepping into the picture, Mr. Stasica said.

For example, last year Michigan became the first state to subsidize employer wellness programs, he said.

Small and medium-sized companies in the state are eligible for grants of up to \$3,000 if they implement wellness programs, he said.

Analyzing a company's risks is indispensable in designing a wellness program, experts said.

"Companies have told us that if you want us to do prevention, we have to have the big picture, the bottom line," Ms. Vaccaro said in an interview.

According to a survey of WBGH members, employers believe the most serious health problems involved chronic diseases, alcohol and substance abuse, mental health, AIDS and the use of tobacco, she said.

Employers also should consider demographics, such as the rising number of older workers, the disabled and women and minorities in the workforce, she said.

Mr. Stasica advised benefit managers to be adamant in seeking adequate data and having it analyzed site-by-site. Different facilities "may be different worlds in terms of health problems," he said.

A project by the WBGH is designed to help members develop a system that would integrate information about health care claims, employee assistance programs, workers compensation claims, disability claims, absenteeism and mortality, she said.

Such data will become the basis of informed health care decisions, she said.

While maintaining employee confidentiality, companies would share what they learn from such an analysis and apply that knowledge in designing wellness programs, she said.

Mr. Stasica coordinated the session.

Carol Brocci, a risk manager for SPX Corp. in Muskegon, Mich., moderated the session.



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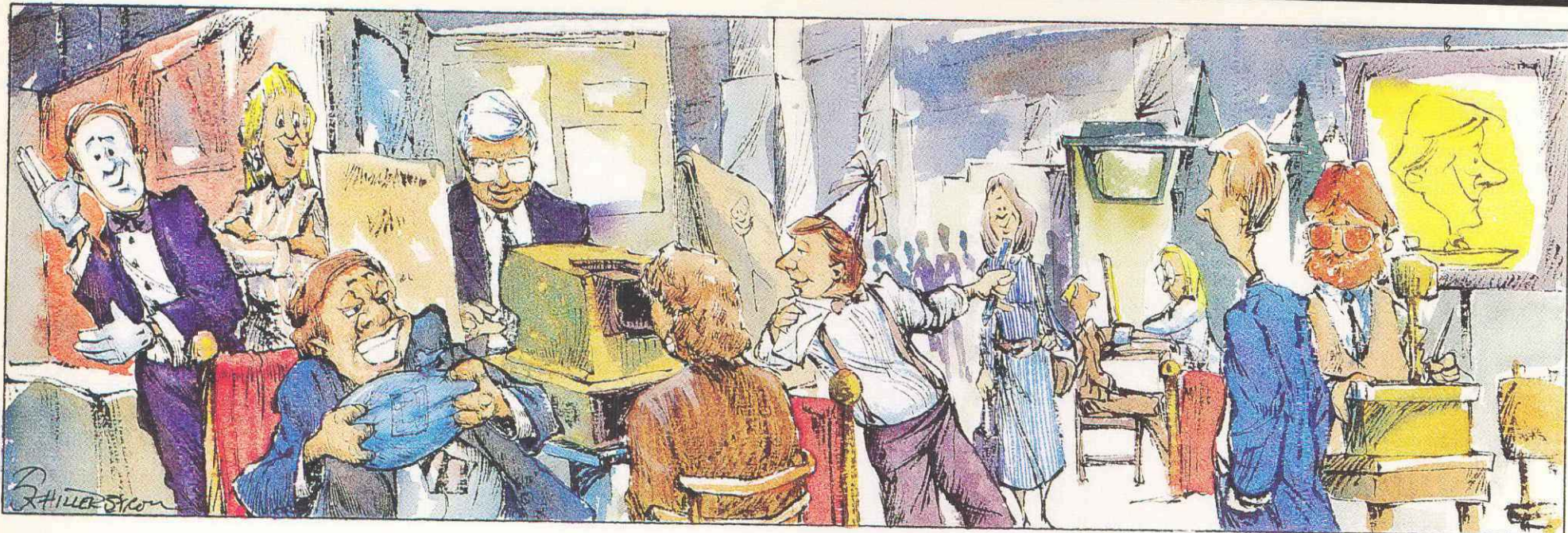
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## Exhibitors offer firms health Rx

By CHRISTINE WOOLSEY

BOSTON—Employee benefit managers touring the exhibit hall at the 28th annual Risk and Insurance Management Society conference here may have felt like they were in a doctor's office or a traveling pharmacy.

In addition to displaying literature detailing products and services, some vendors offered prescription bottles filled with candy, aspirin and adhesive bandages. Others performed free blood pressure tests and eye exams.

Health Examinetics Inc. conducted free blood pressure testing for conference-goers who wanted to measure how harried they had become after attending session after session describing soaring health care costs.

A former registered nurse administered the tests, remarking on how healthy those touring the exhibits appeared. After receiving a satisfactory bill of health, those who stopped by the Examinetics booth were told about the company's mobile health screening for employees.

Health Examinetics, based in Northbrook, Ill., will send a medical team to an employer's site to conduct Occupational Safety and Health Administration compliance tests for employees who are exposed to hazardous conditions, explained Cindy Leisch, marketing director. For example, technicians will investigate noise levels, the presence of toxic chemicals and overall environmental conditions.

Also, clients considering implementing a wellness program can have employees tested to get an overall view of employees' health, she said.

Health Examinetics will bring a team of registered nurses, X-ray technicians and physicians to a client's facility or a prearranged location. Within 40 minutes, the team will administer a variety of tests, including blood and urine samples to detect coronary disease, diabetes and liver and kidney disease; hearing and vision tests and specific drug tests.

Employers are charged a fee per employee per test or are billed on a capitated basis, Ms. Leisch noted.

After results are compiled, a confidential health profile is sent to the individual and to a designated physician. Individuals can compare their results against others' with a data base containing health statistics broken down by age and other factors.

"Healthy people are simply better and less costly employees," Ms. Leisch said. Periodic screening of employees can make people aware of potential medical problems early and prevent high costs associated

*Continued on next page*

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company, we still concentrate on the things we do best—like entertainment insurance, workers' compensation and specialized programs for

Continued from previous page with medical care should those conditions turn catastrophic, she said.

Pearle Inc. offered on-site vision testing in the exhibit hall.

Richard L. Broderick, a risk manager with VF Corp., an apparel manufacturer based in Wyomissing, Pa., underwent the two-minute examination. He said his company is considering implementing a vision plan.

"I'm amazed at how quick it was," he said, examining a computer print-out detailing the acuity of his vision.

Not everyone tested was as happy with the results.

One woman cheerfully approached the machine, manned by Dr. Ken Clayton, Pearle's vp of professional affairs, informing him she had 20/20 vision. Within two minutes, Dr. Clayton told her "Your right eye isn't helping you—and your left eye is doing all the work."

The machine used is simply an ancillary testing device to give optometrists an accurate starting point when

they are refining vision correction for a patient, Dr. Clayton explained. Pearle performs full eye examinations, including testing for glaucoma, before prescribing glasses.

Peter R. Barnett, vp of managed care for Dallas-based Pearle Inc., said this is the first year the company exhibited at RIMS. While employees are interested in vision care plans, there is still little interest from employers, he noted.

Elsewhere in the hall, employee benefit managers were presented with a variety of services to help treat health care-cost containment ills.

RIMS conference director Bobbie D. Zucker said there were 470 booths this year compared with 410 at the 1989 conference in Atlanta. And, she said, more companies displayed their wares this year: 270 vs. 242 in 1989.

Among the most prevalent benefit service displays were those for prescription drug programs available through independent vendors and

national and regional retail drug store chains.

While dispensing prescriptions of M&Ms candies to attendees, vendors explained that as employees make greater use of prescription drug programs, employers can implement some cost controls.

Mail service prescription programs are one technique employers can use to help contain drug plan costs and in some cases reduce costs, vendors say.

For example, Express Pharmacy Services offered by Thrift Drug Co., a Pittsburgh-based subsidiary of J.C. Penney Co. Inc., can save clients 16% to 20% of prescription drug plan costs, said Curtis R. Philson, regional sales manager.

Clients are offered a discount—based on patient volume—when employees get prescriptions filled at Thrift Drug pharmacies. The drug store chain operates like a preferred provider network, encouraging those employees to purchase medication at the 440 retail drug stores operated by

Thrift Drug.

Thrift also operates four mail service pharmacies. The drug chain's Express Pharmacy Services product allows employees to receive medication through a home-delivery prescription service.

Home delivery of medication can produce significant savings, especially for individuals taking so-called maintenance drugs used to treat chronic illness and conditions like high blood pressure, diabetes, ulcers and arthritis, Mr. Philson said.

"Fifty percent of prescriptions are generally for maintenance drugs, but that represents nearly 70% of prescription plan costs," he said.

Using a mail-order prescription plan can save employers money and please plan participants who no longer have to wait in line at retail pharmacies, Mr. Philson explained.

In addition to savings gleaned from discounts and substitution of generic drugs whenever possible, EPS saves clients money by dispensing larger

quantities of prescribed medications, he said. For example, while most retail pharmacies dispense a 30-day supply, EPS can typically reduce dispensing fees by offering 90-day supplies for maintenance drugs.

Self-administered employers can reduce administrative fees because they receive one monthly bill for all prescriptions filled by mail, rather than a separate bill for every employee's prescription filled at a retail pharmacy, Mr. Philson noted.

"The number of claims processed will be cut by approximately two-thirds and you receive only one invoice, issue one check and have one telephone number to call if you have any questions," he said.

Other prescription drug plan vendors are touting computerized controls used to assure quality control when dispensing prescriptions.

Hook-SupeRx Inc., a privately held firm based in Cincinnati that also was exhibiting for the first time at a RIMS conference, stressed the importance of pre-dispensing drug utilization review to conference attendees.

George B. Merchant Jr., HSI's general manager, said by including drug utilization review in the vendor's prescription processing, physician visits, tests and hospital stays of plan participants for harmful drug interactions could be reduced.

With an audience peering over his shoulder at a computer screen, Mr. Merchant explained that before dispensing any prescriptions, HSI's computer program checks the patient profile for possible drug interactions and for overall drug treatment factors or health conditions which could contribute to a drug-induced illness.

"A patient's health history is on file with HSI on our mainframe and any time a prescription is filled," the appropriate information comes up on a computer screen for the pharmacist to review, Mr. Merchant explained. For example, if a physician had prescribed a medication that would interfere with a second drug the patient is taking, the computerized system would generate a report describing the observed risk.

In addition, the drug utilization review program tries to eliminate medications that shouldn't be filled based on eligibility or coverage terms, Mr. Merchant added.

HSI consists of three drug store chains: Brooks Drug Inc. in Pawtucket, R.I.; Hook's Drug Stores in Indianapolis; and SupeRx Drug Store Co. in Cincinnati.

Around this year's exhibit hall, there were some pleasant diversions for benefit managers who didn't want to be too overloaded with serious cost-containment products and service information.

A party atmosphere surrounded Intracorp's exhibit booth as the Berwyn, Pa.-based cost-containment unit of CIGNA Corp. celebrates its 20th anniversary.

Conference attendees were encouraged to play "Win, Lose or Draw"—or in this case "Drawing the Line on Health Care Costs." A professional comedian posed as Bert Convy, host of the syndicated television show "Win, Lose or Draw."

"Bert" would give clues like, "This item is stringently reviewed by Intracorp's auditing services." Then, members of the audience would yell out guesses as someone frantically attempted to illustrate the answer: hospital bills. Winners received party hats and boxes of birthday candles.

"You can tell people know something about the industry by the way they are guessing the answers," noted Fran Atkinson, vp-marketing services.

A carnival-like atmosphere filled other parts of the exhibit hall, as vendors rivaled each other with attractions including a mime at the booth of Conservco, a Tampa, Fla.-based disability and medical cost management firm; an artist drawing caricatures at the booth of Beech Street Inc., a managed care company based in Irvine, Calif.; and a magician at CIGNA Corp.'s booth. ■



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# Early benefits decisions can smooth merger

By JUDY GREENWALD

BOSTON—Employers can mitigate hostile feelings among employees at companies they acquire by hammering out knotty benefits-related issues during purchase negotiations, say benefits experts.

Seventy percent of failed acquisitions are attributable to not resolving such issues promptly, asserted Raymond J. Rogers, a managing consultant with A. Foster Higgins & Co. Inc. in Boston.

Regardless of management attitudes, to employees at acquired companies there is no such thing as a friendly takeover, according to Mr. Rogers.

"They're all hostile," he said.

Making employees feel that they have not been sold into slavery

"means everything, I think," Mr. Rogers said during a session at the 28th annual Risk & Insurance Management Society conference in Boston last week.

Every company will probably have to deal with these issues at some point, according to Carla R. Eberling, director of risk management and employee benefits at New York-based Phillips-Van Heusen Corp.

"If it hasn't happened to your company, it more than likely is going to happen," said Ms. Eberling, who moderated the session.

However, predicting which benefit-related issues will emerge during an acquisition is difficult, said Larry S. Schumer, a principal in actuarial, benefits and compensation consulting at Coopers & Ly-

brand in Boston and coordinator of the session.

Referring to the dozens of acquisitions in which he has been involved, Mr. Schumer said: "I never fail to see at least one new issue in the next one I take on."

Taking a theoretical example of a company taking over the subsidiary of another firm, Mr. Rogers and Mr. Schumer looked at questions the purchaser may have to consider, including:

- If pension benefits are based on final average pay plan, should the acquiring company take into account past service with the former parent?

Failing to take past service into account could lead to a significant reduction in pension benefits.

An acquiring company has to

weigh doing what is best for the company against doing what is best for the employee, Mr. Schumer said.

- What happens to the early retirement programs?

Mr. Schumer said dealing with this issue is important. "Otherwise you have some really unhappy employees."

- What if the pension plans of hourly, non-union employees are underfunded, with a benefit increase expected soon, and the seller wants the buyer to inherit the pension plan?

Mr. Rogers said this issue must be negotiated before completing the sale, taking into account the anticipated benefit increase.

- What if the seller participates in a multi-employer plan that is

underfunded?

The purchaser must know if it is inheriting such liabilities, Mr. Schumer said.

- What if the company that sold its subsidiary will not share information about the funding status of the salaried employees' pension plan, beyond saying that the purchasing company should contribute what equals about 4% of payroll annually?

A selling company sometimes is unwilling to provide any more detailed information because that data might reveal aspects about the parent company's plans, Mr. Schumer explained.

"They say, 'You're not buying the whole company,'" he said.

If the acquiring company cannot obtain this information, it has to "work around that," Mr. Schumer said.

- Should the purchaser assume the acquired company's retiree health care liabilities, if the acquiring company does not provide this benefit itself on a company-paid basis?

- If the company making the acquisition offers a richer health care benefits plan than the selling company, does it offer its own plan to the new subsidiary?

Mr. Schumer noted that if the acquiring company decides to offer its plan to employees of the acquired company, it will mean incurring a significantly higher cost than that which is now reflected in the selling company's financial statement.

The new parent also could require employees at the acquired subsidiary to make plan contributions if they prefer the new parent's benefit plan, Mr. Rogers said.

- What approach should be followed if the selling company's stock is in the subsidiary's 401(k) plan, and how is the transfer of account balances handled?

- How has the acquired company's benefit administration been handled?

- What can be done for the acquired subsidiary's executives who, for example, lose their options to buy the stock of their former parent company? "It's something to be considerate of," Mr. Schumer said.

"You, as a buyer, might want to bring that up" in the sale negotiations, he said. For example, a buyer might want to ask a seller to allow the executives to exercise their stock purchase options before the sale is completed.

- What does the buying company do if the seller wants a guarantee that the purchases will not change severance policy for one year following acquisition?

If the buyer does not want to keep all of the seller's executives, it should be aware of the cost of severance pay, Mr. Schumer said.

He noted that in one \$300 million deal in which he was involved, the severance pay amounted to \$6 million. "It's something you really want to keep on top of," he said.

The structure of an acquisition also can give purchasing companies added flexibility in how they can handle benefits issues that may arise after the purchase, Mr. Schumer said.

For example, when purchasing a company's stock, the purchaser legally takes over the benefit obligations of the acquired company as well.

But when purchasing a company's assets, the purchaser has a lot more flexibility in what can be done insofar as employees and employee benefits are concerned.

"You can treat people a lot less generously, I think, when you purchase assets as opposed to purchasing stock," Mr. Schumer said.

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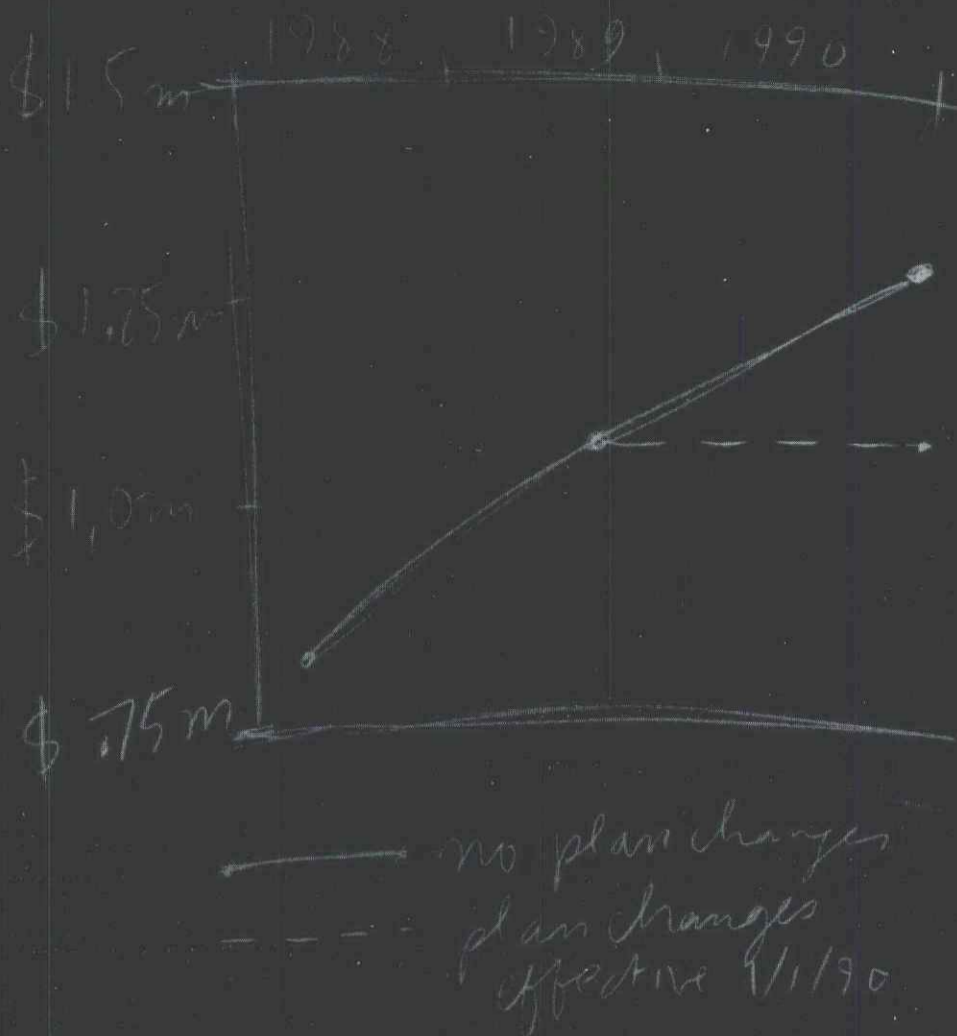
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# Control of disability claims changing

By ADRIENNE C. LOCKE

BOSTON—An integrated approach to disability management—with data from different lines of disability coverages combined under one management program—will enable any business to operate a cost-effective disability program, according to a panel of experts.

Thorough claims management, rather than simply claims processing, and good information management will provide the data necessary for objective and informative disability claims determination, the experts say.

However, no changes can succeed without a firm management commitment to the disability program, and a positive atmosphere for employees to return to, disability

benefits experts said during a session at the 28th annual Risk & Insurance Management Society conference last week in Boston.

Disability claims' hidden costs include recruiting costs, expense of training new employees, lost productivity, absenteeism, dealing with staff shortages, lower employee morale and increased turnover, said Elizabeth Solem, manager of disability programs at Minnesota Mining & Manufacturing Co. in St. Paul, Minn.

Those costs can be reduced with a disability management program that effectively returns employees to their jobs, Ms. Solem said.

However, Lawrence A. Jenson of CIGNA Employee Benefit Services Inc. called for a new approach to disability management.

The traditional method of claims handling and administration "doesn't work" any longer, said Mr. Jenson, an assistant vp of marketing in the special benefits divi-

**Employers are often the 'obstacle in getting a disabled employee back,' says Lawrence A. Jenson.**

sion of the Philadelphia-based CIGNA Corp. unit.

An employer that contracts with separate vendors to handle different types of disability coverages—

like workers compensation, long-term disability and short-term disability—with little or no coordination can create a costly overlapping of benefits, he said.

In addition, Sara D. Watson of the Washington Business Group on Health said disability costs are often wrongly classified as general health care costs.

"Much of what is considered health care costs are really disability costs. It's a very fine line," said Ms. Watson, executive director of the group's Institute for Rehabilitation & Disability Management.

Just as a cold can turn into bronchitis then into pneumonia, a case can move from simple medical care to a short- or long-term disability case, she said.

The Washington Business Group

on Health is a non-profit organization in Washington, D.C. Its members are about 180 large companies that seek to influence national health policy.

Integrating all disability lines into one management program lays the foundation for more effective claims and information management, says Richard A. Lewis, president of Thomas L. Jacobs & Associates Inc. in Chicago, a consultant and third-party administrator.

Such integration under one insurer or vendor can prevent coverage overlaps, he said.

It can also enable an employer to more effectively manage and reduce the direct costs associated with disability coverage such as salary continuation payments, cost of short- and long-term disability premiums and workers compensation payments, said Mr. Lewis, whose company administers STD and LTD benefits for large self-insured employers.

Better claims information makes claims determination quicker, easier and more accurate, and with it, employers can more accurately sort out inappropriate claims and determine which claimants can return to work, he said.

Employers, he said, need properly trained staffs experienced in disability claims management. And he recommends that staffs take a team approach "because it is very difficult to find one person" with the necessary experience in claims, Social Security disability benefits and medical disability benefits.

But even with such a staff, no disability plan will be effective without management support, Mr. Jenson cautions.

"Lots of times the employer is the obstacle in getting a disabled employee back on the job," he said.

Employers must be willing to accept a rehabilitated employee, and to modify the job or workplace to get the employee back to work, Mr. Jenson said.

Ms. Watson of the Washington Business Group on Health points out that legislative changes would benefit the disabled and increase the number of rehabilitated people returning to work.

The Americans With Disabilities Act, which was introduced last year and is expected to be approved by Congress, and the re-authorization of the Rehabilitation Act of 1973, scheduled for 1991, will make workplaces, public places and public transportation much more accessible to the disabled, eliminating one of the hurdles in getting the disabled back to work, she said.

Also, reforms of the health care system—including limits on insurers' ability to deny coverage to workers with pre-existing conditions—would help those disabled employees return to the workforce, she said. Those employees may stay away from work now because they fear losing the health insurance provided by disability coverage, she said.

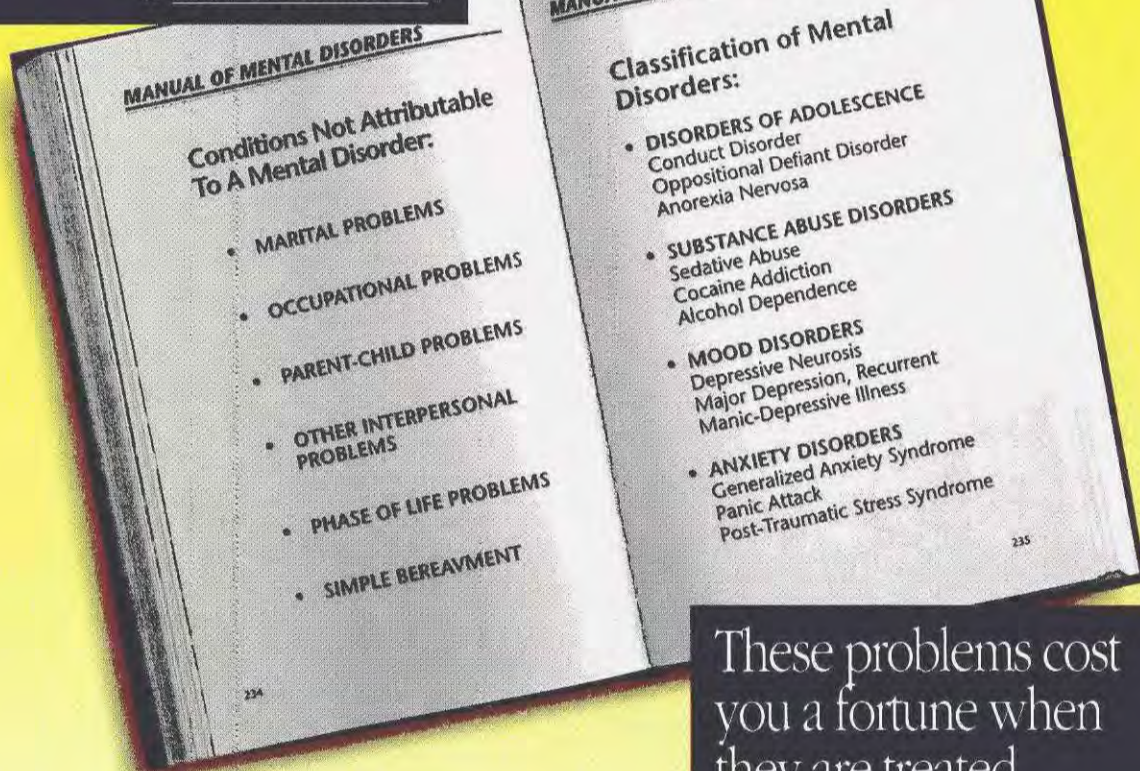
However, the relationship between management and its employees must be a good one so the employees will want to return to work, said Ms. Watson.

If employees are very unhappy with their work, they don't feel valued, they don't feel important, and it is very difficult to get them back to work, she said.

All the supportive phone calls and attempts to bring them back to the workplace won't work if they have been preceded by years of turbulence, said Ms. Watson.

Ms. Solem of 3M Corp. was the session moderator and Mr. Jenson of CIGNA Employee Benefit Services Inc. was coordinator.

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## OHS. The dollars and sense solution.

# RIMS, at 40, takes pride in its vigilance, clout

By CHRISTINE WOOLSEY

BOSTON—The Risk & Insurance Management Society celebrates its 40th anniversary recognizing that it is making a difference for its members, say its new and former presidents.

"One of the most important things we do is represent our interests to the government," said Ronald Stasch, whose term as RIMS president ended May 1.

"Our vigilance as an association has made a difference," he asserted during the RIMS membership breakfast meeting last week at the society's 28th annual conference in Boston.

Cheri Hawkins, who succeeds Mr. Stasch and is the first woman president of RIMS, agreed.

For example, she said, "a coalition of Texas RIMS chapters helped win reform of the workers compensation system" in that state (BI, Dec. 18, 1989).

Ms. Hawkins, manager of insurance for Weyerhaeuser Co. in Tacoma, Wash., also pointed out that RIMS testified before a House panel earlier this year that insurance buyers would face higher premiums and reduced capacity if Congress enacts a proposal to increase the federal excise tax on premiums ceded to foreign reinsurers to 4% from 1% (BI, Feb. 26).

In addition, letters from RIMS members arguing for the repeal of Section 89 helped persuade Congress to kill the controversial benefit law late last year, pointed out Mr. Stasch, corporate risk manager at Federal-Mogul Corp. in Detroit.

"What's important is that we are listened to, and the government sees RIMS as a reasonable voice" on these issues, Mr. Stasch said. "We have clout although we face significant adversaries."

RIMS is working with the Insurance Services Office Inc. in New York and the American Bar Assn. in an attempt to put coverage for sudden and accidental pollution back into commercial general liability policies, Ms. Hawkins noted.

Meanwhile, the organization is undergoing some internal changes.

"As RIMS grew, executive roles became blurred," he explained. As a result, RIMS' executive committee and board of directors recently formed a task force to study governance of the organization and propose improvements.

Among changes is a more formal method for selecting the executive director. After Ron Judd retires from that office in 1991, his successor will be appointed by the executive council.

A new policy also clearly states that staff reports to the executive director. Duties had been unclear at times. "These changes will make RIMS more responsive to member and chapter needs and more efficient," Mr. Stasch said.

Ms. Hawkins also pointed out that a succession planning task force, which was formed in mid-1989, recently recommended appointing a search committee and consultant to help the organization recruit members to serve as executive officers of RIMS.

This year, the society plans to enhance RIMSNET, its on-line insurance information network, with RIMSLINK, a 24-hour-a-day link with suppliers (BI, April 23).

"The world is headed in a direction of more and more information quicker and quicker," Ms. Hawkins said.

The society also plans to expand its services internationally because of the changing political climate in Eastern Europe and the Soviet

Union, Mr. Stasch said.

"Through our affiliation with IFRIMA (International Federation of Risk & Insurance Management Assns.) we're building a global network of risk managers," he said. RIMS wants to establish "a worldwide risk management educational standard to promote the universal application of risk management," he added.

Ms. Hawkins said she wants RIMS to be regarded as the ultimate authority on risk management, just as a securities broker projected itself as the authority on stock investments in its commercials several years ago. "I want to hear members say, 'I belong to RIMS and I think. . . and have everyone in the room stop and listen,'" she said. ■

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# Pepper health care mandate

By JERRY GEISEL

## Panel debates issue's fate in Congress

BOSTON—The Pepper Commission's recommendation to mandate employer-provided health care coverage could save billions of dollars now wasted because medical treatment is delayed, a staff member of the commission says.

If people had access to comprehensive health care coverage they would seek medical treatment sooner, contends Robert Friedland, a professional staff member of the 15-member U.S. Bipartisan Commission on Health Care, better known as the Pepper Commission.

By seeking care sooner, individuals' medical problems would be less likely to develop into serious complications that require more expensive treatment, he said.

The cost of offering mandated health care coverage would boost employers' health care costs by about \$20 billion a year, according to the commission.

While Mr. Friedland acknowledged an employer mandate would cost a lot of money, he contends in the long run "we all would benefit."

Health care for the uninsured is expensive because it is delivered late and in inappropriate settings, such as hospital emergency rooms, he explained.

"Earlier access would cut costs," Mr. Friedland said at a session on Congress' 1990 benefits agenda

during the 28th annual Risk & Insurance Management Society conference in Boston last week.

But, other speakers said legislators are unlikely to act quickly on the sweeping changes in health care delivery advocated by the Pepper Commission.

Phyllis Borzi, employee benefits counsel on the House Labor-Management Relations Subcommittee, said a lack of presidential leadership will keep the issue of access to health care coverage on the congressional back burner.

And James Ricciuti, deputy assistant secretary for health legislation at the Department of Health

and Human Services, said members of Congress—burned by the public outcry over the 1988 Medicare Catastrophic Coverage Act as well as employer anger over Section 89's complex non-discrimination rules for welfare plans—will remain wary about enacting new benefit laws.

The release of the Pepper Commission's recommendations in March (*BI*, March 12), came after months of public hearings and private briefings, said Mr. Friedland, formerly a senior research associate at the Employee Benefit Research Institute, a Washington, D.C.-based benefits think-tank.

A report to be published next month will add detail to those recommendations, which include:

- Employers with more than 100 employees would have to offer a health care plan meeting minimum federal standards to employees and dependents or pay a new payroll tax.

While the amount of that tax has not been specified yet, the commission has said the tax would be set high enough to prompt companies to offer health care coverage.

Companies offering the minimum health care plan—known as the "Specified Benefit Package"—would have to pay at least 80% of the premium for individual and family coverage.

More than half of companies now pay 80% of the premium for individual coverage. Only 40% contribute that much for family coverage.

In addition, annual deductibles could not exceed \$250 for individual coverage or \$500 for family coverage.

Coinsurance requirements generally could not exceed 20%, while the maximum annual out-of-pocket expense for an individual or family would be \$3,000.

However, employers would have to pick up 100% of the cost for prenatal care, well-child care, mammograms and Pap smears.

Employers offering a Specified Benefit Package would have to offer at least 45 inpatient days of mental health care coverage and 25 outpatient mental health visits annually. Workers could be asked to contribute up to 50% of mental health costs.

This proposal would take effect three years after legislation was enacted.

- Health care plans sold by commercial insurance companies would not have to comply with state benefit mandates.

Most states now require insurers to provide certain benefits—such as coverage for alcohol and drug abuse treatment—in their health care policies, a requirement that drives up the cost of coverage and makes it difficult for national employers that do not self-fund to offer a uniform benefit package.

A provision in the Employee Retirement Income Security Act of 1974 exempts employers that self-fund their health care programs from state benefit requirements.

- Employers with fewer than 100 employees would not have to offer the Specified Benefit Package if a certain percentage of their employees received health care coverage by a certain date.

For example, if by the fourth year of enactment, at least 80% of workers at companies with 25 to 100 employees are not insured by their employers, those companies would be required to provide coverage or pay the new payroll tax.

In addition, if by the fifth year of enactment, 80% of workers at companies with 25 or fewer employees are not insured by their employers, these companies would be required to provide coverage or pay the new payroll tax.

- A new public health care plan, which would replace the current Medicaid program, would be available for employees who work for companies that don't provide a health care plan and for people who are self-employed or unemployed.

An unspecified portion of wages would go toward the premium.

In addition, the self-employed and unemployed would pay premiums based on their annual income. Individuals with incomes below the poverty line would pay nothing.

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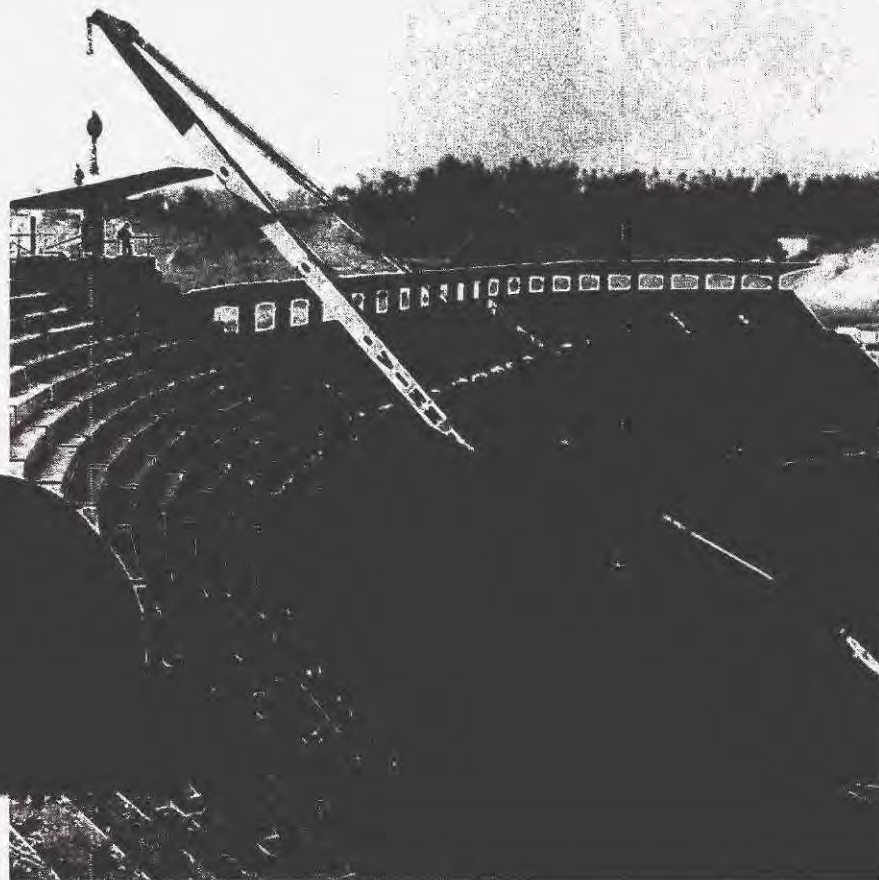
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Continued from previous page

The public plan would be financed by a combination of employer contributions—in the form of payroll taxes—individual premium contributions, federal government contributions and state contributions equal to what states now pay toward Medicare.

The Pepper Commission did not specify how the federal government would finance the public plan's estimated \$23.4 billion annual cost or a \$42 billion long-term health care package the panel also proposed.

Although the recommendation to require employers to offer health care coverage passed on an 8-7 vote, Mr. Friedland said commission support for the concept of an employer mandate was much greater than the vote would indicate.

Several commission members, whom he did not identify, supported requiring employers to provide health care coverage, but voted against the Pepper proposal because they did not agree with its specifics, he said.

The commission considered alternatives to an employer health care mandate, most notably expanding the Medicaid program and creating a national health insurance program, administered and funded by the federal government, he said.

Expanding Medicaid was rejected because it would have cost too much—an estimated \$36 billion in new annual federal subsidies—and still may have left a substantial chunk of the population without adequate coverage, Mr. Friedland said.

A national health insurance plan was rejected as politically unrealistic, he said.

Instead, the Pepper Commission focused on building on the current system in which most Americans under age 65 receive coverage from their employers.

Requiring employers to provide coverage, would put a huge dent in the ranks of the nation's uninsured, about 75% of whom are employees or dependents of employees, Mr. Friedland said.

However, the commission was aware that small firms would have difficulty paying for mandated health care coverage, he said. It recommended that small firms receive special tax breaks for offering such coverage.

Starting in the second year after enactment, employers with 25 or fewer employees and a payroll averaging less than \$18,000 per worker would become eligible for a 40% tax credit to offset the cost of their health care plan. This tax break would be available for five years.

Mr. Friedland said the Pepper Commission recommendations have opened a dialogue on expanding access to health care.

But Ms. Borzi, a veteran congressional committee benefits staffer, said without leadership from the Bush administration, the Pepper Commission's recommendations are unlikely to be acted upon anytime soon.

"The time is not ripe for the administration to take bold steps" on health care, Ms. Borzi said.

But Mr. Ricciuti, the HHS staffer, said Congress also is cool to the idea of enacting sweeping benefit legislation in the wake of last year's backlash over the Medicare Catastrophic Act and Section 89.

"It would be hard to underestimate how Medicare repeal and Section 89 has affected the way members think about health care. There was rebellion" from the elderly and employers, Mr. Ricciuti said.

The next time legislators consider a health care proposal, they will want to be sure that the "people really want it. . .not just the in-

terest groups. That is very important," he said, noting that retirees were more interested in long-term health care coverage than expanded Medicare benefits.

Legislators also want to be convinced that benefits legislation does not impose unreasonable burdens on employers, Mr. Ricciuti said, noting the rebellion of employers, especially smaller firms, upon discovering the huge compliance costs entailed in Section 89.

Both Section 89, which was passed as part of the Tax Reform Act of 1986, and the 1988 Medicare Catastrophic Coverage Act were repealed last November (BI, Nov. 13, 1989, and Nov. 27, 1989, respectively).

While the time for congressional action on health care issues may not be ripe, it is not too soon to consider ways of improving the nation's health care delivery system, Ms. Borzi said.

And policymakers, she said, could learn plenty from Canada, where provinces offer universal health care coverage.

Canada also better controls the growth of expenditures on expensive, high-tech medical equipment,

**'The time is not ripe for the administration to take bold steps' on health care, Ms. Borzi says.**

she said.

Hospitals in Canada, for example, have to pay for new medical equipment out of their overall budget funds provided by the provinces, Ms. Borzi noted.

"If a hospital wants an expensive piece of equipment, it comes out of

its budget," she said.

By contrast, Americans "are technology junkies," she quipped.

Ms. Borzi also said there is something to be learned from the way physician fees are controlled in Canada.

Under the Canadian system, provinces decide how much they will spend on physician fees. Ms. Borzi acknowledged that such controls on physician reimbursement would be strongly resisted by U.S. medical groups.

While the United States can learn much from the Canadian health care model, ultimately policymakers here will fashion a uniquely American solution to health care problems, Ms. Borzi said.

"Americans always have been able to come up with the right solution when everything else fails," Ms. Borzi said, quoting Winston Churchill.

Turning to another area, Ms.

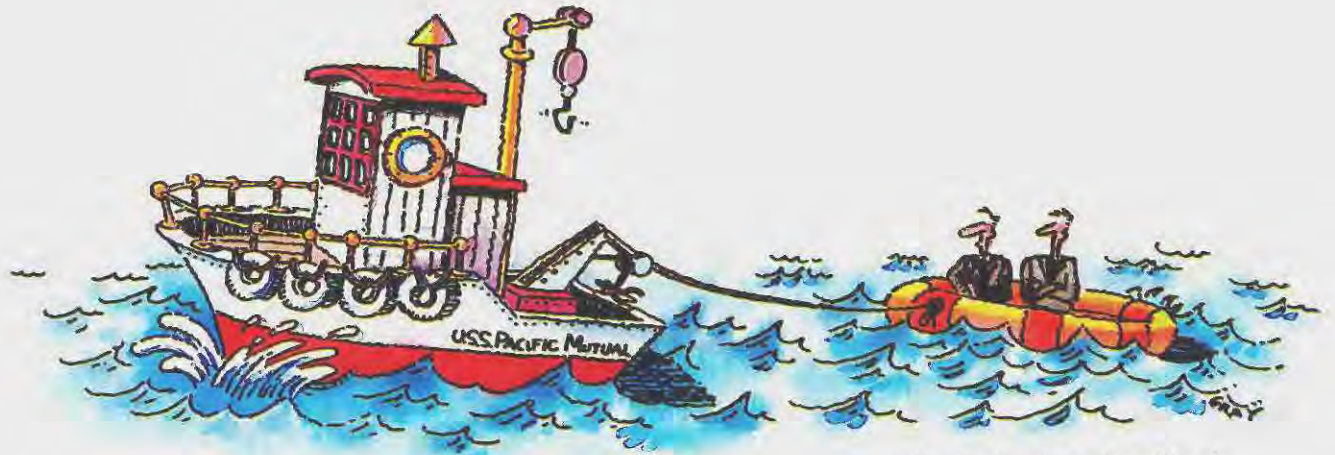
Borzi doubts that Congress will anytime soon enact legislation to tax employees on the value or cost of employer-provided health care coverage.

For example, several years ago, about 400 members of the House of Representatives supported a "sense of the House" resolution opposing taxation of health care benefits.

Still, the issue is not dead, Ms. Borzi said, noting that Richard Darman, the director of the Office of Management and Budget and a powerful figure in the Bush administration, has sent out signals that the administration might not oppose such a tax.

The session was moderated by Barbara Whitcher, director of benefit design and communications for John Hancock Mutual Life Insurance Co. in Boston. The coordinator was Mary A. Fruen, senior staff executive, also with John Hancock in Boston.

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# Federal intervention in health care

By MICHAEL BRADFORD

BOSTON—The odds of the federal government increasing its involvement in the U.S. health care system are rising along with health care costs, according to a panel of experts.

"There is clearly a general feeling that the health care system in the United States isn't working," said Kenneth F. Clarke, regional director of Godwins International Holdings Inc. in Atlanta, a unit of Frank B. Hall & Co. Inc.

"I forecast, as a consumer and a consultant, that there will be government intervention in the near future," Mr. Clarke said during a panel discussion on the prospects of government intervention in the health care system at the 28th annual Risk & Insurance Management Society conference in Boston last week.

"This intervention may take the form of a new delivery system; it may take the form of a general tax extending Medicare to uninsureds on a national scale;" or it may be the form of mandated employer-provided health care benefits for all workers, he said.

But, John Krichbaum, director of health policy development for the American Medical Assn. said the real question is: "Will Uncle Sam greatly expand" government's role?

Many AMA members feel that the government has been involved in national health care for several years, Mr. Krichbaum noted.

"Look at the Medicare program; look at the Medicaid program," he said.

However, he said, these programs are "certainly not models for great expansion of government into the financing of health care."

"The Medicare program is headed toward bankruptcy," he asserted.

And, "in the Medicaid program, only about 42% of those below poverty are actually covered by the program," he said.

Mr. Clarke expects that the federal government will create a national health care system.

A national health care program could cost up to \$100 billion, Mr. Clarke said.

"Nonetheless, the replacement of well-designed corporate systems by government intervention is a real possibility," he said.

A workable plan for a national health care system, though, is not forthcoming, panelists said, notwithstanding proposals by Sen. Edward M. Kennedy, D-Mass., (*BI*, July 17, 1989) and the Pepper Commission (*BI*, March 12) that would require employers to provide group health care plans meeting federal standards (see story, page 26).

But, Marcia Horton, second vice-president of government relations at Lincoln National Corp. in Fort Wayne, Ind., said she does not support having the government fully control of the health care system.

"When I think of government doing anything more efficient and better than private enterprise, I think it's funny," she said.

However, Ms. Horton said a "public/private partnership" of insurers and government could help control costs.

For example, Medicaid benefits could be provided to everyone below the poverty line, she said. And for the "near poor who are working," the government could partially subsidize the cost of their coverage.

If the current U.S. health care system is not scrapped in favor of a national program, changes still are needed to ensure its survival, the experts agreed.

Mr. Krichbaum listed several

## Bigger role seen to fix system's ills

AMA priorities for fine-tuning the health care system (*BI*, March 12). Among other things, the AMA recommends:

- Expanding Medicaid to cover all Americans below the poverty level.

- Creating state risk pools to provide health care coverage to individuals with poor health who cannot now obtain coverage.

- Reforming medical malpractice liability laws to reduce costs associated with "defensive medicine" and medical malpractice insurance.

Mr. Krichbaum said doctors now feel they have to do "everything

conceivable" to avoid a malpractice suit.

Ms. Horton agreed that the threat of lawsuits drives up the cost of health care.

Doctors and hospitals are careful to use only state-of-the-art technology for tests, and "that technology is not inexpensive," she said.

"We've heard hospitals say that unless they have the latest equipment, they could be open for malpractice claims," she said.

Mr. Krichbaum said he also opposes state-mandated benefits.

"There's nothing that's added more to the cost of health insurance than the 700-plus mandated

benefit laws across the states," he said.

It is obvious why companies operating in several states choose to self-insure rather than deal with various laws that mandate benefits, Mr. Krichbaum observed.

Eliminating state mandates would make coverage more affordable for small employers, Ms. Horton agreed.

Two states—Washington and Virginia—have passed laws reducing mandated benefits for small employers (*BI*, April 2; March 26).

And legislation pending in Illinois also would reduce such benefits (*BI*, April 16).

Mr. Krichbaum also said that employers' health care expenditures would decrease if benefits were taxed.

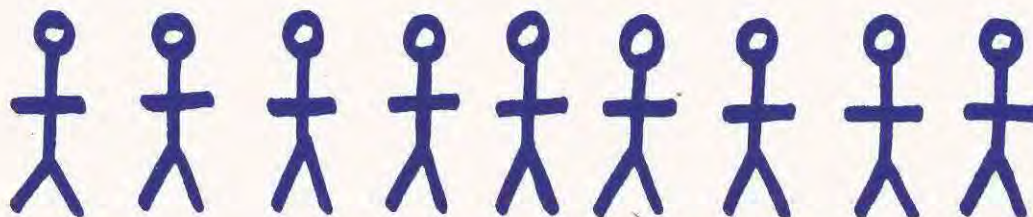
"There needs to be a limit on the amount of health care benefits that the employee can receive tax free," he asserted.

"Employers can continue to be able to provide whatever amount of health care benefit they choose and deduct it as a business expense. However, at some point, employees must be taxed on that benefit."

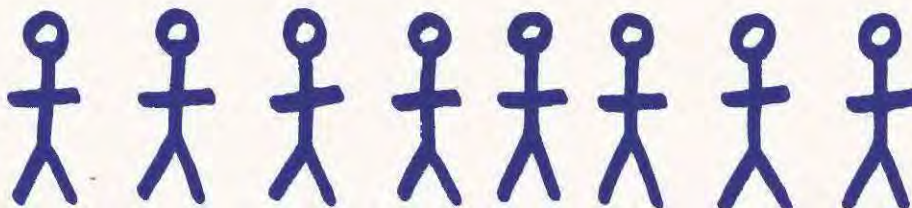
Such taxes would reward "economical health care insurance choices," he said.

Paul Clancy, director of risk management at Boston University, moderated the session. Mr. Clarke coordinated the session. ■

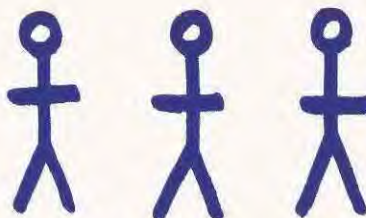
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# Incentives to prefund retiree care unlikely

By JERRY GEISEL

BOSTON—Employers should not count on tax breaks from Congress for prefunding retiree health care liabilities, a benefit consultant warns.

Legislation providing employers such incentives is unlikely at a time of large federal budget deficits, said Stuart Rubinstein, a senior consultant with Cooper & Lybrand in Boston.

Legislators are more interested in finding ways of extending health care coverage to the uninsured than giving companies tax breaks for retiree health care prefunding, said Mr. Rubinstein last week at the 28th annual conference of the Risk & Insurance Management Society in Boston.

And in the unlikely event legislators reverse course and approve new tax breaks, they undoubtedly would impose new vesting schedules for retiree health care benefits, according to Mr. Rubinstein.

Federal vesting rules—established by the Employee Retirement Income Security Act of 1974—now apply only to pension benefits.

Vesting rules "may be the price that would have to be paid" for retiree health care funding tax breaks, Mr. Rubinstein said.

To date, legislators have been more inclined to take away the few tax breaks that had existed for prefunding retiree health care liabilities, Mr. Rubinstein said.

For example, under the Deficit Reduction Act of 1984, employers lost their ability to tax-effectively

prefund retiree health care liabilities through special trusts known as Voluntary Employee Beneficiary Assns.

While employers can take tax deductions for retiree health care contributions to the trusts, investment income earned on assets held by VEBAs is subject to taxes.

"A lot of employers no longer are putting money into their VEBAs" for retiree health care expenses, Mr. Rubinstein said.

And last year, Congress overturned several Internal Revenue Service rulings that expanded employers' ability to prefund retiree health care liabilities through a special arrangement known as a 401(h) account.

Generally, contributions to a 401(h) account cannot exceed 25%

of the total amount contributed to a defined benefit pension plan and the 401(h) account.

For example, if an employer made a \$12 million contribution to its pension plan, it would be allowed a tax-deductible \$4 million contribution to the 401(h) part of the plan.

However, for many employers, this ability to contribute to a 401(h) arrangement had little practical significance because their pension plans were either fully or overfunded.

As a result, they could not make additional pension contributions and, thus, no 401(h) contributions.

However, a March 1989 IRS letter ruling suggested that even if the pension plan were fully funded, an employer still could make con-

tributions to a 401(h) arrangement, based on the annual cost attributable to the pension plan rather than the amount actually contributed to the plan.

The 1989 budget reconciliation law, though, wiped out that expanded opportunity to prefund through 401(h) by overturning the IRS private letter ruling, Mr. Rubinstein said.

As a result, a 401(h) account "is not a viable alternative for companies with fully funded pension plans," he said.

But, while legislators have largely been unsympathetic to employer demands tax breaks on retiree health care funding, there is congressional interest in allowing companies to transfer surplus pension assets to 401(h) accounts, Mr. Rubinstein said.

For example, the House of Representatives last year approved a provision as part of budget reconciliation legislation that would have allowed employers a one-time opportunity to transfer surplus pension assets into a 401(h) account. The proposal later was killed in a House-Senate conference committee (BI, Nov. 27, 1989).

While the proposal died, the idea of allowing employers to transfer surplus pension assets—without terminating their pension plans—is likely to continue to receive congressional consideration because it actually would increase federal revenues, Mr. Rubinstein said.

That is because companies transferring surplus assets to 401(h) accounts would cut back on their tax-deductible contributions for current retiree health care expenses. As a result, they would have increased taxable income.

While Congress is not likely to provide tax breaks, there are steps that employers can take to try to bring retiree health care costs under control, Mr. Rubinstein said.

For example, employers should identify retiree health care claims that are likely to result in big bills and apply case management techniques, he said. Under case management, cases that are likely to result in big medical bills are identified and strategies for providing alternative, but high-quality, care are developed.

"Our clients have been able to save big dollars" through case management, he said.

In addition, employers can raise premium contributions and deductibles and coinsurance requirements for retirees.

Retiree "cost-sharing is the only long-term method of controlling costs" Mr. Rubinstein said.

Employers also are beginning to link the amount of health care coverage they will provide retirees to the number of years of service the retirees provided, Mr. Rubinstein said.

For example, at Data General Corp., a Westboro, Mass.-based computer manufacturer, the company will pay \$50 a month toward the health care premium for retirees 65 and older with 20 years of service, said Ganne DeSomery, director of corporate risk management.

However, the company will pay only \$37.50 a month toward the health care premium for retirees with between 15 years and 19 years of service and \$25 a month for retirees with between 10 and 14 years of service, Mr. DeSomery said.

Data General decided to limit its contributions for retiree health care coverage to gain more control over costs, Ms. DeSomery said.

Ms. DeSomery moderated the session. Larry Schumer, a partner in Coopers & Lybrand's Boston office, coordinated the session. ■

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# Bucking the conventional wisdom

By MICHAEL BRADFORD

## Expert touts health insurance captives

BOSTON—Conventional wisdom says captives should not write health insurance, but that notion is not necessarily accurate, a consultant and captive expert says.

D. Hugh Rosenbaum, principal with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn., remarked that "everybody says it's not a good idea for a captive" because health coverages often "run at break-even or a loss."

"I'm here to tell you, there are two applications that will work," said Mr. Rosenbaum.

Specific stop-loss insurance for cases that cost more than about \$100,000 and aggregate stop-loss insurance are perfect candidates

for funding through a captive, according to Mr. Rosenbaum. "Those are very specialized kinds of coverages that are often charged for separately in medical plans and very often are overcharged."

Mr. Rosenbaum said he is working with two clients that are using captives to fund the excess medical exposure.

"Like property insurance, the results are up and down" for the clients that use the captive for those coverages, he said. "But overall, the result is up."

Mr. Rosenbaum was the coordinator of a seminar that focused on the use of captives to fund em-

ployee benefit plans. The session was part of the 28th annual Risk & Insurance Management Society conference held last week in Boston.

Mr. Rosenbaum pointed out that the U.S. Virgin Islands is the only U.S. domicile that allows captives to act as direct insurers of employee benefit plans.

The Employee Retirement Income Security Act prohibits offshore insurers from directly writing group health insurance programs. However, while the U.S. Virgin Islands is regarded as an offshore domicile for tax purposes, a Labor Department ruling defines

the territory as a "state" under ERISA.

"Why are there not dozens and dozens of captives there?" Mr. Rosenbaum asked.

Many captive owners are uncertain about how to structure such a company and are afraid to chance a loss with an unfamiliar concept, he said.

And, the U.S. Virgin Islands law allowing captive formation is "horrendously complicated," he added.

However, Mr. Rosenbaum noted that the domicile has re-drafted its captive insurance law and hopes to attract companies if the Legisla-

ture approves the amendments.

Mr. Rosenbaum also said that many single-parent captives are exploring the possibility of reinsuring employee benefit coverages, like health insurance, through their captives in other domiciles because owners perceive the captive insurer as having an excess of reserves.

"Many of my consulting assignments start out with captive owners saying they are thinking of expanding and they are looking at benefits," said Mr. Rosenbaum. That action is usually prompted by financial management that sees what it perceives as "too much money" in the captive, he observed.

Management may also be disillusioned by what it thinks is a small rate of return on capital invested in the insurer, said Mr. Rosenbaum. For example, a captive that returns only 11% of capital may prompt financial officers to say "either you show me something better than that or let's do something else" with some of the capital.

J. Brady Young, a consultant in Tillinghast's London office, told attendees at the seminar that not all corporations find it a good idea to fund benefits in a captive.

He referred to a large United Kingdom-based corporation that considered funding pension death benefits through its captive. "The premium was in excess of \$1.5 million pounds," said Mr. Young.

But the corporation considered fronting fees and administrative

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**'There are two applications' for benefit captives 'that will work,' says Mr. Rosenbaum.**

costs, "it didn't make a lot of sense" to use the captive for that benefit, said Mr. Young. "What's possible and what's practical are often two different issues. That has to be looked at."

Mr. Young did say, however, that many U.K. companies are considering captives for insuring private medical benefits that supplement workers coverage through the national health system.

Meanwhile, the captive insurance industry continues to remain strong despite some expectations that it might have been hurt by tax reform in the United States, said Mr. Rosenbaum.

"It remains quite vital," he said of the captive scene, "despite the news that it has been knocked for a loop by taxes."

According to numbers compiled by Tillinghast, there are 2,040 single-parent captives in various world domiciles and 945 group-owned companies.

Those captives generate \$9.5 billion in premiums and boast capital of \$10 billion, he said.

"If you have insurance business that produces less claims and losses than premiums and investment income, then you have the basis for a captive," said Mr. Rosenbaum.

Panelist Michael Poncill, vp of TPF&C International Benefits, another division of Towers, Perrin, Forster & Crosby Inc., in New York, told the group that multinational pools continue to offer large corporations a vehicle for funding benefits (see story, page 16).

Michael F. Grace, risk manager at United Banks of Colorado in Denver, served as panel moderator.

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# Benefits veterans offer tips to rookies

By ADRIENNE C. LOCKE

BOSTON—Rookie employee benefit managers can help smooth out what probably will be a tumultuous time in their careers by bonding up on key benefit laws and studying their companies' benefit philosophies, experts suggest.

New managers often find themselves deluged with rules and regulations they need to understand and master quickly. Many will have to make important funding, administrative and design decisions fairly early in their careers, according to a panel of veteran benefit experts.

But many new benefit managers do not know where to begin educating themselves, experts said at a session during the 28th annual Risk & Insurance Management Society conference last week in Boston.

And yet, "health employee benefits have captured the attention of every CEO and financial officer in the entire country, and as a benefit manager you are at the focal point of that attention and are in a position to have an impact at your company," said David T. Mohler, director of employee benefits at United Technologies Corp. in Detroit.

Benefit managers must first know and understand the laws that shape employee benefits, said Kathleen A. Sheldon, director of U.S. employee benefits at Wang Laboratories Inc. in Lowell, Mass.

The creation of Social Security and Medicare represent the first of many laws that either establish or affect employee benefits, said Ms. Sheldon.

With the advent of employer-sponsored benefits programs and the abuse and mismanagement of some of these plans that followed, the Employee Retirement Income Security Act of 1974 was passed to provide beneficiaries with some protection, she said.

ERISA established funding requirements for pension and welfare benefit plans; fiduciary responsibility for plan trustees and administrators; vesting schedules; and reporting and disclosure requirements.

Ms. Sheldon also outlined other significant benefits laws:

- The Age Discrimination in Employment Act of 1978, which ended forced retirement at age 65, and the 1986 amendments that prohibit forced retirement at any age.

- The Revenue Act of 1978, which created Section 401(k) defined contribution plans and Section 125 cafeteria plans.

- The Pregnancy Discrimination Act of 1978, an amendment to Title VII of the Civil Rights Act of 1964 that prohibits discrimination on the basis of "pregnancy, childbirth, or related medical conditions."

- Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 that allow a terminated employee to obtain continued health care coverage for himself and his dependents from his former employer at 102% of group rates.

New managers should not be afraid of changing plans—if their alterations are necessary and within the goals of the plan—because everyone has different ways of approaching the same problems, said Dave Fisher, risk and benefits manager at Mitsubishi Electric America Inc. in Cypress, Calif.

After reviewing all benefits currently offered, new managers should drop the benefits that do not meet company objectives, he said.

"Whatever fits or works for you,

do it," Mr. Fisher advised.

Mr. Mohler of United Technologies agreed, but added that the new employee benefit manager has to remain flexible.

"Make a road map so you can plan where you want to be in the future, but don't read that road map as if it is cast in stone—make it dynamic," he said.

Sandra K. Kertz, health product executive at John Hancock Mutual Life Insurance Co. in Boston, said new employee benefit managers also should evaluate a company's "internal environment" when determining how to control benefit costs.

"As an employer, you are limited to what you can do to affect your cost of health care. You can either affect the price of goods or the

usage," she said, referring to cost shifting and reducing benefits, respectively.

According to Ms. Kertz, an employee benefits manager must look at:

- The company's profitability. If the company is financially strapped, it cannot afford rich benefits.

- Whether the company is concerned more about product competition or competition for workers.

Employers in a competitive product market have to be conscious of benefit costs. But those in a competitive employee market have to attract and retain workers with rich benefit programs.

- Whether the company has a tradition of offering the newest and most innovative benefits

available.

- Whether the company wants to offer certain benefits regardless of price.

- State-mandated benefits. Employee benefit managers also should be aware of the trends that may affect benefit packages in the future, said attorney Robert C. Macaulay of Ropes & Gray in Boston, who specializes in employee benefits law.

Demographic trends, such as aging baby boomers, will lead to increased demand for medical services and more coverage for hospital inpatient days, Mr. Macaulay predicted.

In addition, economic trends, such as the federal deficit, will create more governmental pressure to tax employee benefits, according

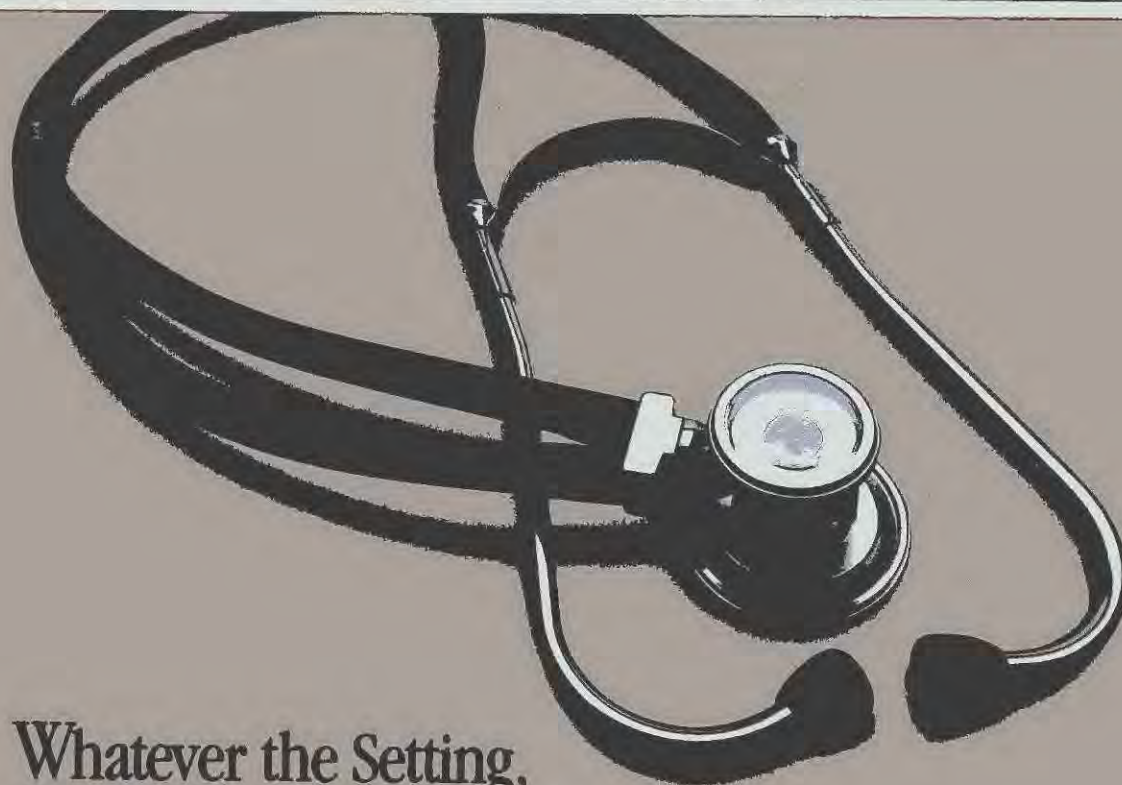
to Mr. Macaulay.

He also believes more employee benefit plans will increase deductibles and copayments for participants with unhealthy lifestyles.

"Benefit plans won't pay if you are not doing your part to manage your condition," he said.

For example, at Gosnell Development Corp., workers who do not use tobacco and who meet weight requirements will get rebates on their monthly health care premiums under a new incentive-driven self-insured program (BI, April 23).

United Technologies' Mr. Mohler was the moderator for the session. Christine Morley and Mary Emshemer, marketing assistants at John Hancock in Boston, coordinated the session. ■



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# Case manager views role in AIDS care

By JUDY GREENWALD

BOSTON—Case management can reduce the cost of treating covered lives with AIDS while assuring quality care, but employers should know when it is most appropriate, says a case manager.

"Wait until the timing is right before you start to implement" such programs, advised Jackie Mazoway, product manager for medical case management at Intracorp, the Berwyn, Pa.-based utilization review firm unit of CIGNA Corp.

For instance, case management is not necessary for an employee who is taking AZT as treatment for acquired immune deficiency syndrome and misses work only on an occasional afternoon for blood transfusions, Ms. Mazoway said, noting that one side effect of the drug azidothymidine is a lower blood count.

Employers should recognize that even case management cannot always manage all costs, Ms. Mazoway said at a session on how to handle AIDS cases during the 28th annual Risk & Insurance Management Society conference in Boston last week.

"You don't want to manage what you absolutely cannot manage," Ms. Mazoway observed.

For example, she cited the case of a mother who insisted on expensive treatment to extend the life of her dying son for only a short time. Little can be done to manage such costs, she said.

However, a case management approach in chronic cases could help extend the patient's life as well as help an employer contain treatment costs, Ms. Mazoway said.

Ms. Mazoway described the major phases of medical case management:

- Early identification.

AIDS cases can be identified in the early stages by looking for some "red flags": certain infections often related to AIDS; excessive claims; or a claim to pay for AZT.

- Assessment, which involves several factors.

For example, Ms. Mazoway said case managers should consider a physician's treatment plan. That doctor's perception and knowledge of the case are critical, she said.

Physical capabilities and limitations of the person with AIDS also should be considered, she said. For example, does the person with AIDS have to walk up several flights of stairs to reach his or her home? Ms. Mazoway asked. If so, the case manager should consider if he or she can go home.

Case managers also should factor in whether the person with AIDS is taking prescription drugs and what the potential side effects of those drugs may be. For instance, nausea may not be the side effect of a drug but rather an indication that the person with AIDS may have a dangerous virus, Ms. Mazoway noted.

The case manager also should determine whether the person with AIDS is taking any non-prescribed medications, she said. Some patients are reluctant to tell their physicians about such drugs, which can interfere with the effectiveness of prescribed medication.

Psychosocial factors—such as support from family, a friend or lover and a community—are also important, Ms. Mazoway said.

Ms. Mazoway also discussed financial aspects that must be considered during the assessment phase, including the availability of assistance from community programs, Social Security and other

sources.

"There's a lot of these programs. You just need to know where they are and how to access them," she said.

Case managers sometimes fall short in this area, she said after the session.

- Coordination.

This phase involves identifying a treatment team for the patient, a support team, alternative care providers and the extent of the patient's financial resources, Ms. Mazoway explained.

An emergency back-up plan for the patient's care also should be developed in case a primary plan of treatment, such as home health care, falls through, she said.

"You've got to have a back-up plan in place," Ms. Mazoway

stressed.

- Ongoing evaluation.

The treatment plan must be evaluated, Ms. Mazoway stressed. "You need to make sure it's work-

**'You don't want to manage what you absolutely cannot manage,' says Ms. Mazoway.**

ing," she said.

Bradley R. McDonald, corporate director-health systems for Minneapolis-based Honeywell Inc., said AIDS cases have "melded into the

mainstream of case management."

The Minneapolis-based manufacturer manages AIDS cases about the same way it handles other cases involving chronic diseases, he said.

Supervisor training is an important element in Honeywell's approach, Mr. McDonald noted.

For supervisors, the company provides AIDS education; disability management and job accommodation training; and case study reviews and group discussion.

Mr. McDonald said disability management should focus on supporting and assisting the supervisor. As more of the workforce contracts AIDS and continue to work, "this is going to become increasingly important in the future," he said.

But, Robert Bazell, health and science correspondent for NBC News in New York, said AIDS began as a disease of the inner city and homosexuals, and he believes "it's going to stay that way."

The disease has "imploded" among those two populations rather than "exploded" beyond them, he said.

"It's not an issue that's going to be a giant issue for many companies," though people with AIDS should be treated with compassion, Mr. Bazell said.

Howard A. Tawney, director of personnel at the Human Resource Institute in Brookline, Mass., moderated the session.

Susan Fazo, Intracorp's director of corporate communications, coordinated the session.



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# Wellness programs' extra benefits praised

By MARK A. HOFMANN

BOSTON—Wellness programs have the potential to do much more for employers than contain health care costs, a claims manager says.

A wellness program offers social and recruiting benefits as well as helping employers control health care costs, said Edward P. Holleran, president of third-party administrator ESIS Inc, a unit of CIGNA Corp. in Philadelphia.

Employers, therefore, should not look only at dollars and cents when putting together a wellness program, Mr. Holleran cautioned at a session, titled "Worker Wellness—Is it Financially Terminal?" at the 28th annual conference of the Risk & Insurance Management Society in Boston last week.

The so-called "graying of America" has made corporate wellness programs an integral employee benefit that employers cannot afford to be without, Mr. Holleran said.

"We are about to experience the worst labor shortage since the 1850s," Mr. Holleran said.

As a result, he explained, the labor force is going through the same metamorphosis that farm families experienced roughly 150 years ago, when the size of farm families shrank dramatically, pushing up the average age of farm workers.

"We are beyond the Baby Boom," and the average age of employees is projected to increase from 35 currently to about 42 within about 10 years, he said.

Many employers have put their faith in automation to compensate for the shrinking workforce, but "computers can only do so much," Mr. Holleran said.

As a result, some workers will not be retiring as early as others have been able to in recent years, he said. And, with age, workers become more prone to illness and, in some cases, on-the-job accidents.

But, wellness programs that emphasize healthy lifestyles and fitness can help keep aging workers on the job, according to Mr. Holleran.

Such programs also can help attract workers, he said.

"Very frankly, it's a recruiting tool," Mr. Holleran said. Young professionals often are more health conscious than their predecessors,

and many ask about health programs when interviewing for jobs, he noted. Wellness programs demonstrate that a firm cares about employees, Mr. Holleran said.

About 25% of the 4,500 employees at CIGNA's home office in Philadelphia participate in a company wellness program, he noted.

The program is "justified at CIGNA on a qualitative," rather than quantitative, basis, he said.

Rafael E. Castillo, risk manager for Adolph Coors Co. of Golden, Colo., and the session's moderator, agreed that worker wellness programs involve more than bottom-line concerns.

Mr. Castillo said Coors launched its wellness program in 1981 as a reflection of Chairman William K. Coors' philosophy. Mr. Coors be-

lieved that the company should encourage its employees to pursue a healthy lifestyle, Mr. Castillo said.

"The company has a moral obligation to develop and maintain a work environment that encourages every employee to be dedicated to wellness," says company literature about its wellness program.

A corporate wellness center at Coors' headquarters in Golden provides employees with such diverse activities and options as a health hazard appraisal; medical screening for participants in physical fitness programs, including cholesterol screening, body fat measurements, education on the use of exercise equipment and treadmill screening; and blood pressure and breast cancer screenings (*BI*, April 16).

The Coors program also includes nutrition education; stress management; a coronary risk identification and behavior modification program; parenting skills; weight management; smoking cessation; prenatal programs; cardiac and orthopedic rehabilitation; and back care programs.

And, the wellness program has helped the company control health care costs, Mr. Castillo said.

For example, Mr. Castillo cited the mammography screening program as an example of how Coors' corporate wellness program has paid off: Coors estimates that the program has saved the company about \$225,000 during the past three years.

Treating breast cancer detected in its early stages costs an estimated \$18,000 a case. Treatment costs soar to about \$60,000 per case if the cancer is not detected until its later stages, he said.

But, in general, the problem of tracking the cost-effectiveness of wellness programs defies an easy solution, Messrs. Castillo and Holleran acknowledged.

Worker wellness programs, which are relatively new, have not yet built up a large body of data illustrating their cost effectiveness, and relapses continue in programs that help workers quit smoking or lose weight, Mr. Holleran said.

Measuring savings from the programs is extremely difficult, because no one can say with authority how much poor health and unhealthy lifestyles actually cost an employer, Mr. Castillo said.

For example, when Coors in the early 1980s was researching the cost to the company of unhealthy worker lifestyles, consultants' estimates ranged from \$2 million to \$23 million for the company, which self-insures its health care, workers compensation and long-term disability plans, he said.

Estimates of savings generated by the wellness program range from \$1.25 to \$8 for every dollar spent on the program, he said.

In addition, Coors workers are scattered across the country, which presents another problem, Mr. Castillo said. While the company in some case has been able to contract with local health clubs and gyms to provide services such facilities are not readily available near other Coors locations, he noted.

Still, the Coors wellness program is here to stay, he said. "Is worker wellness financially terminal? We don't think so at Coors."

Other speakers were James M. Stohan, executive vp-administration for Denver-based VICORP Restaurants Inc., and Dale Wydman, risk manager for Denver-based Anschutz Corp., a holding company with energy, real estate and railroad operations. Neither firm has a wellness program.

Robert R. Deist, managing director of Marsh & McLennan Inc., Denver, coordinated the session. ■



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# Savings from claims data analysis viewed

By CHRISTINE WOOLSEY

BOSTON—Employers do not always have to overhaul their health care plan designs to control skyrocketing health care costs, says an expert on health claims processing.

Instead, employers can contain health care costs with only minor plan changes that are based on an analysis of claims data, according to Stephen F. Coady, president and chief executive officer at Health Economics Corp., a claims processing and utilization management firm in Dallas.

Perhaps the most important measure benefit managers can make in analyzing claims data is the relationship between benefit utilization and the age of workers, Mr. Coady explained during a ses-

sion on claims data at the 28th annual Risk & Insurance Management Society conference last week in Boston.

A data base that provides the ages of plan participants and their utilization of specific benefits gives employers an accurate idea of where they are spending the most money for health care, he said.

For example, employers can ask their claims processor to create a data base detailing hospital costs associated with different types of treatment, such as psychiatric and substance abuse, oncology and cardiology.

A claims processor could further identify the age and sex of employees who use these services most often.

Mr. Coady presented health care

data for a sample company that showed about 50% of the company's psychiatric and substance abuse costs were attributable to women aged 18 to 24.

**'Access to this type of data allows you to target overutilization and large exposures, says Mr. Coady.'**

Pinpointing that information gives that company's benefit manager an idea of how to change the company's benefit plan, Mr. Coady said.

"Access to this type of data allows you to have targeted interventions aimed at the people who are overutilizing a benefit or who are the biggest exposures," Mr. Coady said.

Therefore, rather than eliminate its mental health care benefit, the employer in the example could limit the number of covered inpatient days available to its workers' dependents, he said.

And "figuring out what percentage of employees make up the highest cost in the plan" allows employers to start case management efforts early to ensure all treatment is necessary and cost-effective, he said.

Mr. Coady also noted that claims data may be useful in negotiating labor contracts.

For example, during union negotiations, employers often suggest increasing workers' copayments for certain benefits to 20% from 10%, Mr. Coady said.

But claims data may indicate that only 10% of workers account for 80% of health care costs.

Therefore, while the increased copayment may help the employer somewhat, that 10% of workers still will run up health care bills far exceeding their out-of-pocket limit, he said.

Mr. Coady said employers also could use utilization data to set performance standards for health care service vendors.

Employers could present UR firms comparisons of their workers' utilization patterns and those of workers nationwide as surveyed by benefit consultants or health care organizations like the American Medical Assn.

For example, an employer could compare the relative frequency of Caesarian section births within its employee population to frequency level of Caesarian sections performed nationally.

"Most self-funded clients are showing about a 30% rate for C-section deliveries," Mr. Coady said. However, most obstetrics and gynecologists physicians suggest that a 12% rate is more appropriate, noted.

Employers that find their covered lives' Caesarian section birth rates are higher than the norm can approach utilization review firms and suggest that savings may still be available, he said.

"Tell them you did studies on a specific diagnosis and you want them to bring down utilization to normal use pattern," Mr. Coady said.

"You can calculate substantial reductions to your health care program by challenging C-section rates," he said.

Those savings could allow employers to implement programs designed to reduce expensive health care problems, he said.

For example, claims data analysis may show an employer that the rate of premature births among its covered lives is far higher than the national average of about 4% to 6%, Mr. Coady explained.

That data should alert the employer "to the importance of having a prenatal health care program," Mr. Coady said.

However, many programs require that the mother pay for prenatal care upfront.

"If a mom feels well or doesn't have the money to pay for prenatal care, she won't be identified as a candidate for high-risk pregnancy," Mr. Coady explained.

Proficiency at producing useful reports is not easily attained, Mr. Coady admitted.

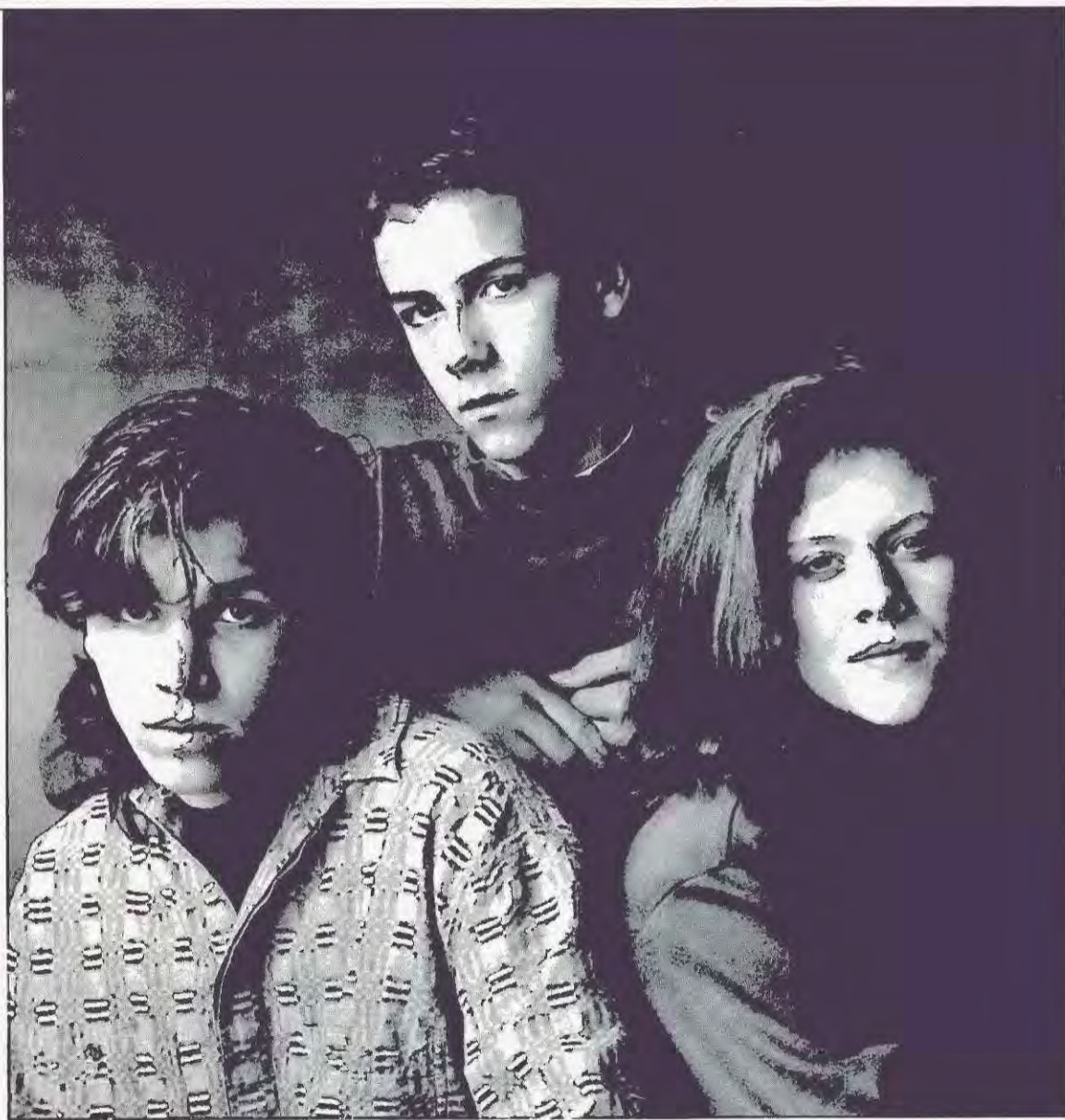
But, the real challenge is capturing the right type of data to analyze, he said.

Typically, that data includes information on claims paid and demographic information on employee populations.

"Most systems don't capture and most processors aren't keypunching the type of data you need. I urge you to attach to any renewal agreements with TPAs a sheet detailing the type of data you want them to capture," he said.

Mr. Coady recommends that any claims processing agreements with vendors spell out who owns the data.

Many times employers that not perform their own claims processing find that the vendor they are using has proprietary rights over the data, he warned. As a result, an employer may not be able to capture the particular data it wants.



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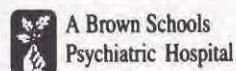
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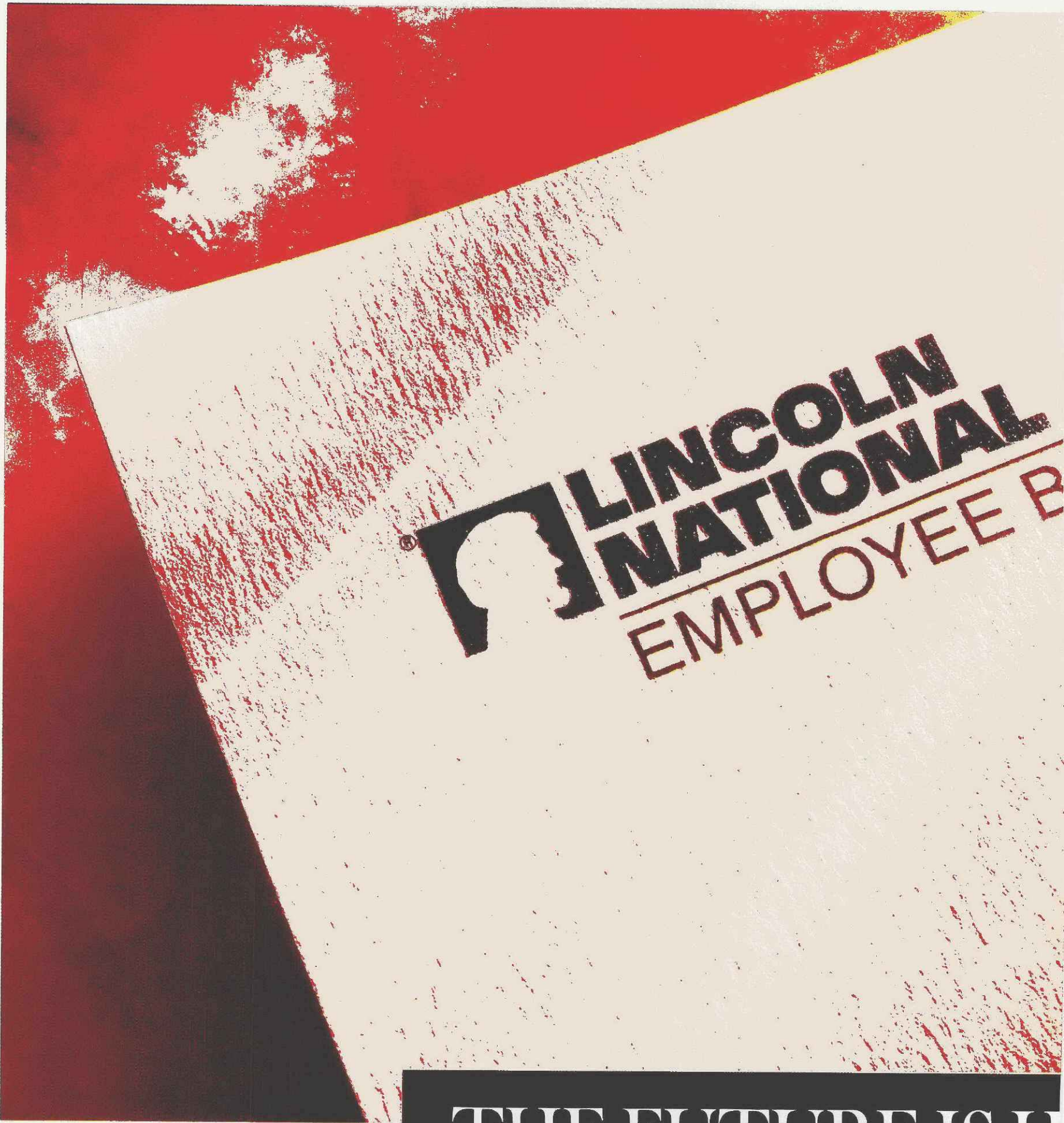
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The background of the entire page is a dark, marbled paper with intricate, swirling patterns in shades of black, dark green, and grey. In the center, there is a rectangular text box with a dark, textured background and a thin, light-colored border. The text inside the box is white, serif, and all-caps.

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# Benefit costs beyond 'fringe'

## Contributions from employees can ease burden

By Holly King

**I**N THE PAST, employers referred to their retirement and welfare benefits as "fringe" benefits. No more. The cost of these benefits has escalated to the point where they are a very real and significant piece of an employee's compensation.

As a percentage of payroll, the employer's cost of these benefits has almost doubled in the past 31 years. That means that although wages have increased in an effort to keep pace with inflation, benefit costs have increased at a rate significantly higher than the rate of inflation. And, while pensions as a percentage of payroll have increased an approximate 22% over the past 31 years, medical benefits as a percentage of payroll have increased more than 350%.

Until the late 1970s, most of the money spent on these employee benefits went to funding employees' retirement, but today medical costs constitute a much bigger piece of a much bigger pie. For example, in 1957, an employer's benefit costs comprised 6.3% of payroll, according to the U.S. Chamber of Commerce. Of that amount, 65% went toward pensions while 35% was for medical benefits.

By 1988, an employer's benefit costs had risen to 12.3% of payroll, the Chamber reports. Of that amount, 41% went toward pensions while 59% was for medical benefits.

The primary reason for this shift is soaring health care costs.

Spiralling health care costs are hampering employers' ability to improve current benefits or provide new benefits. Today there are 37 million uninsured Americans, most of whom are employed. One doesn't have to look far to find the employer that has shifted full-time employees to part-time status in order to avoid the cost of benefits for a portion of his workforce. Others have been forced to reduce or discontinue benefits completely.

On the other hand, employees generally perceive their health benefits as an entitlement rather than a benefit their employer generously provides—witness last year's negotiations between American Telephone & Telegraph Corp., as well as the regional telephone companies, and their labor unions (*BI*, May 29; June 5; July 17).

In recent years, some states have mandated certain benefits in an effort to provide minimum "core" coverage for employees. But this approach has backfired, too—some employers have chosen to eliminate coverage altogether rather than be mandated by a state insurance department.

Mandating health benefits continues to be a very real threat. It seems likely that it will receive more attention from the legislators in the 1990s. The debate and controversy on the legislation—which has been denounced by small business organizations but supported by labor groups and some major employers—has barely begun.

In the midst of the changing dynamics of our health care delivery system, how is an employer to keep benefit costs from blowing the budget? With a shrinking work force looming in the future, and some employers already feeling the crunch, benefit managers and CEOs alike shudder at the thought of cutting employee benefits. Most have already employed some form of cost containment or managed care in their benefit plans, and now are searching for additional ways to hold the line on benefit costs.

Passing a greater share of the cost to employees through increased contributions or decreased benefits seems the only avenue left, but how is this

### Speaking out

best done? To avoid the turnover and morale problems inherent in cutting benefits or increasing employees' share of the costs, employers need to apply some long-range strategic planning to their benefit plans. Some of the steps to take in this effort include:

- Take inventory.

What programs do you offer your employees? How much does each piece cost and what is the employee's share of this cost? What are competitors in your industry offering their employees, and at what price? Are you getting the greatest possible mileage in terms of morale and loyalty for the substantial investment you are making in benefits? Are you spending a disproportionate amount in any one area of benefits?

A complete benefit audit at the beginning of a new decade—1990—might prove time, effort and money well spent by every employer.

- Adopt a "defined contribution" approach to financing your employee medical benefits.

Perhaps the most realistic means of defining your contribution to these benefits is as a percentage of payroll, so that the contribution is indexed as wages and work force increase or decrease. The defined contribution approach has been used on the pension side of employee benefits for years, so it isn't surprising that many employers are turning to this approach to manage medical benefits in the wake of exploding costs.

If the employer's share of benefit costs is defined, the employee contributions then become the balancing item in the equation that reflects total benefit costs. In effect, by adopting a "defined contribution" approach toward financing benefits, you make a commitment for your share of the benefit costs and thus control your share of future benefit costs.

- Set a realistic budget based on total medical plan costs.

If you purchase medical coverage for your employees on an insured basis with a 12-month rate guarantee, you can set a budget based on the premiums charged. If you are on a self-funded or non-guaranteed basis, however, make sure your consultant or TPA is analyzing your experience and projecting medical costs realistically. Most insurance companies and consultants currently consider annual medical trend lines (which include cost shifting, deductible leveraging and increases in utilization) to be upwards of 20%.

"Experts" who underestimate your costs do you no favor—if employee contributions are set based on total costs that are too low, the employer must absorb the excess. This excess is absorbed in the current year if the employer self-funds medical benefits, or in the following year through rate increases if the employer offers an insured plan.

- Determine what you need to do to meet your budget.

If you define the employer contribution at a specified percentage of payroll, this usually involves a trade-off between decreased benefits and increased employee contributions. Traditionally, employers have required employees to share in the cost of medical benefits only to a very small degree.

There's a great deal of validity to the statement that the system won't change as long as employees and providers are spending someone else's money. It's as though the employer handed the employee a credit card to use in the medical "shopping mall," and certainly the employee finds no shortage of services to "buy."

Although both providers and employers have been

accused of being irresponsible spenders of employers' money, employers have a responsibility to clearly define the spending limits.

- Don't overlook low-cost enhancements.

Especially if you have to raise deductibles or employee contributions, you may be able to offer some perks that are relatively inexpensive. If you have not yet investigated Section 125 flexible benefit programs, do so. They can stretch your employees' contributions a minimum of 22% by converting employee dollars from an aftertax to a pretax basis.

Spending accounts for dependent care expenses and unreimbursed health care expenses are another low-cost method of capturing tax advantages for employees, and the employer can realize Social Security tax savings as well.

Also, a health care spending account can be used to supplement a lower level medical benefit plan. For example, the addition of higher deductibles can be minimized by the implementation of a health care spending account. A \$300 deductible costs an employee \$234 (assuming the lowest federal and FICA marginal tax rate) when paid through a health care spending account.

- Communicate!

The main reason employers offer any benefits at all is to maintain good employee relations. Many employers, however, don't take credit for their own benevolence, with the result that employees take their benefits for granted.

Certainly employees will never be enthusiastic about increased costs or decreased benefits. More employers are finding, however, that if they effectively communicate to employees that they are partners in this struggle to control benefit costs and that their share of the cost is only a fraction of the total cost, employees then better understand the need for changes.

Employees don't live in a vacuum—the same changes in benefits and costs are taking place where their spouses, neighbors and friends are employed. With the defined contribution approach, an employer can set the tone for future years by communicating the percentage of payroll the company will contribute.

Assuming wage and/or work force increases, the amount of money contributed by the employer will increase each year, but it will be a manageable increase. Employees will not be surprised by future changes to the employee benefit program because the defined contribution approach will have been established and communicated.

Employers may also want to consider offering a flexible benefits program in conjunction with adopting a defined contribution approach to give employees alternative plan options and the choice of how to spend their benefit dollars.

There is no panacea for the rising cost of medical services, but in order for employer-sponsored benefits to serve the purpose initially intended, employers need to do some long-range planning.

By adopting a managed approach to the cost of medical benefits, employers will find themselves and their employees acting more responsively and responsibly to the changing dynamics of America's health care delivery system. ■



Holly King is a consultant for Williams, Thacher & Rand-Gardner & White, an actuarial and consulting firm in Indianapolis.

# Product safety key EC concern for 1990s

By Douglas N. Smith

ALTHOUGH SOME "MAD HATTERS" believe that "if you don't know where you're going, any road will get you there," savvy risk managers know that "product safety" will be the road well traveled in the 1990s.

In the past, adequate product liability insurance helped to insulate multinationals from the double-edged costs of compensatory damages and legal defense fees. Today, frequency and severity statistics show manufacturers need to protect their public image and workers by developing design criteria that seek to prevent physical injury.

In the European Community, stiffening product liability laws can be attributed to the commission's Directive on Strict Liability for Defective Products (85/374). For example, the commission recently began legal proceedings against the United Kingdom, alleging its 1987 Consumer Protection Act allows a producer to escape liability through a broader "development risks defense" than is permitted by the commission's framework directive.

But, while the strict liability directive seeks to enforce the concept of consumer protection by harmonizing EC liability laws for defective products, its compensatory nature is perceived by some as a negative economic burden for member states. For this reason, Article 100a of the EC Treaty, which was added by the Single European Act, proposes to prevent injuries and reduce consumer claims through a complementary directive that would oblige EC manufacturers, traders and importers to produce and market only safe products.

In principle, the proposed general product safety directive aims to establish uniform levels of safety and enforcement methods to protect EC citizens against injury or damage from unsafe products. These objectives are deemed critical to the expansion of interstate trade and to the free movement of products throughout the EC's soon-to-be-single internal market.

The proposed directive will apply to all manufacturing and processing industries, as well as to wholesalers, retailers and some service industries. In other words, the proposed measures apply to all businesses, regardless of size, although retailers are expected to comply only to the extent that an activity on their part affects a product's safety.

The proposed directive does not apply to goods exported from the EC since exports would have to comply with existing international or bilateral agreements. However, goods imported into the EC will have to conform to the safety standards set by the proposed directive. This requirement is intended to bear down on the unfair price advantages that can be enjoyed by suppliers from non-EC countries with lesser safety standards.

Under the proposed product safety directive, member states would be required to institute pre- and post-marketing controls and mechanisms for monitoring the safety of products once they reach the marketplace.

Let's look at some of the key provisions of the proposed general product safety directive.

Article 2(a) defines a product as any industrial or agricultural product, including raw materials, substances and semi-finished products that are contained in a final product, reconditioned products, and moveables that are used in the construction of, or incorporated in, immovables.

Article 2(b) defines a safe product as "one that does not present an unacceptable risk for the safety and health of persons." Implicit in the term "unacceptable risk" is the notion that absolute safety cannot be required. The term also serves to differentiate between unsafe products and the strict product liability directive's definition of a defective product as "one that does not provide the safety which a person is entitled to expect."

Article 2(c) stipulates that unacceptable risks must be evaluated by testing a product's safety properties under normal use or consumption

## International issues

standards. Safety properties include, but are not limited to, design, composition, execution, functioning, wrapping, conditions of assembly, maintenance or disposal, instruction for handling and use, and specific representations made by, or on behalf of, the supplier.

Similar to the strict liability directive's stance toward defective products, Article 2(c) does not allow a product to be deemed an unacceptable risk simply because a state-of-the-art product is subsequently put into circulation.

According to Article 2(e), the "foreseeable time of use," which is defined as the reasonable lifespan of the product used under normal circumstances, also must be considered when testing a product's safety properties.

Of primary importance is Article 2(d), which defines a supplier as the manufacturer of a product, the importer into the EC from a third country, and distributors and other non-manufacturing professionals in the supply chain insofar as their activities may affect the safety properties of a marketed product.

Article 5(1) allows the directive to be superceded by EC *lex specialis*, based on the presumption that existing national consumer laws require the production and marketing of only safe products. However, in the absence of specific rules, Article 5(2) allows the product's safety properties to be examined vis-a-vis practical and available technology.

Article 6 of the proposed directive obliges all manufacturers to make appropriate arrangements to permanently monitor the safety of the products they market. Monitoring duties for importers, distributors, and other non-manufacturing professionals are restricted to the scope of their activities within the supply chain, but only to the extent that these activities affect the safety of the product.

Annex 1 to the proposed directive lists the following examples of appropriate arrangements for monitoring product safety:

- Marking a product or a batch of products to allow identification at a later stage.
- Regular or random product testing.
- Agreements to receive and exchange relevant safety data with other suppliers, professional customers and general business organizations in the same product sector.
- Systematic assessment and evaluation of consumer complaints for preventive purposes.
- Adequate record keeping.
- Nominating a person or service to organize and supervise appropriate arrangements.

Article 7 obliges member states to establish a public infrastructure to control compliance with the directive's commitment to produce and market only safe products.

More specifically, Article 7(1)(c) and Annex 2 empower national authorities to intervene against unsafe products through measures such as product recalls.

Article 7(2) specifies that compliance with Articles 5(1) and 5(2) cannot preclude the possibility of intervention by national authorities in instances where a product is found to be unsafe.

Article 9(1) obliges member states to exchange data with local authorities rapidly in the event of a grave and immediate product safety risk. When the scope of the emergency is community-wide, Article 9(2) requires the member state to report the unacceptable risk to the EC commission which, in turn, will rapidly transmit the data to all other member states.

Article 9(5) requires member states to consolidate administrative reporting requirements by empowering one single national authority to execute these measures, as well as those set forth under Article 14.

Article 10(1)(a) empowers the national authority to prohibit further marketing of a product, for a period not to exceed three months from the date of notice, when the product's safety properties appear to pose a grave and immediate risk.

Article 10(1)(b) allows the national authority to require relabeling or other warnings as a condition for recommencing marketing activities. Article 10(2) also empowers national authorities to withdraw products from the market if they present an unacceptable risk for the safety and health of persons.

Articles 11 to 14 establish a procedure for triggering an EC-wide emergency situation. For example, Article 11 permits the initiation of a procedure to investigate and decide applicable Community-level measures when the safety properties of a product represent an unacceptable risk that:

- Could seriously affect more than one member state.
- Cannot be adequately controlled via existing national laws.
- And, cannot be handled practically because of the community-wide dimension of the problem.

Article 12 outlines the measures that member states may be required to adopt in order to fulfill a request by the EC Commission for further information regarding an unacceptable risk.

Article 13 creates a Committee on Product Safety Emergencies to assist the Commission. The committee, which will be composed of member state representatives with voting rights, will be chaired by a non-voting representative of the commission.

Article 14 details the procedure for adopting interim community-wide measures in emergency situations. In cases where the EC Commission finds that a community-wide measure must be adopted immediately, a draft of the proposed measures must be submitted to the Committee on Product Safety Emergencies. However, any committee disagreement with the proposed measures must be reported to the EC Council, which has five working days to render a decision.

Any measures adopted under Article 14 will be valid for no longer than six months, but may be extended by following the same procedure. Member states have 10 days to implement any measures adopted under this procedure.

Article 16 stipulates that any preventive actions taken under the proposed product safety directive will not automatically constitute a claim for damages under the strict product liability directive (85/374/EEC).

Article 17 addresses the possibilities for redress and compensation under the proposed product safety directive.

In summary, the proposed general product safety directive is intended to complement the EC's strict product liability directive by obliging manufacturers, importers and traders to view the general objective of product safety as a public duty. As long as there is a strong reason to believe that a particular product does not comply with the general safety requirement, member states may adopt measures that will force the manufacturer to change the product's unacceptable risk and/or ban the manufacture or marketing of the unsafe product.

On the whole, the proposed directive will provide an additional incentive for manufacturers to audit their product safety risks. Why not begin your review today? ■



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.



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# Depression claim: Fact or fiction?

## Book gives tips for investigating psychological claims

### "Psychological Claims Investigation"

By Bill Kizorek and Dr. Paul Lees-Haley

Published by PSI Publishing,  
1163 E. Ogden Ave., Suite 705-360,  
Naperville, Ill. 60540  
\$35.00

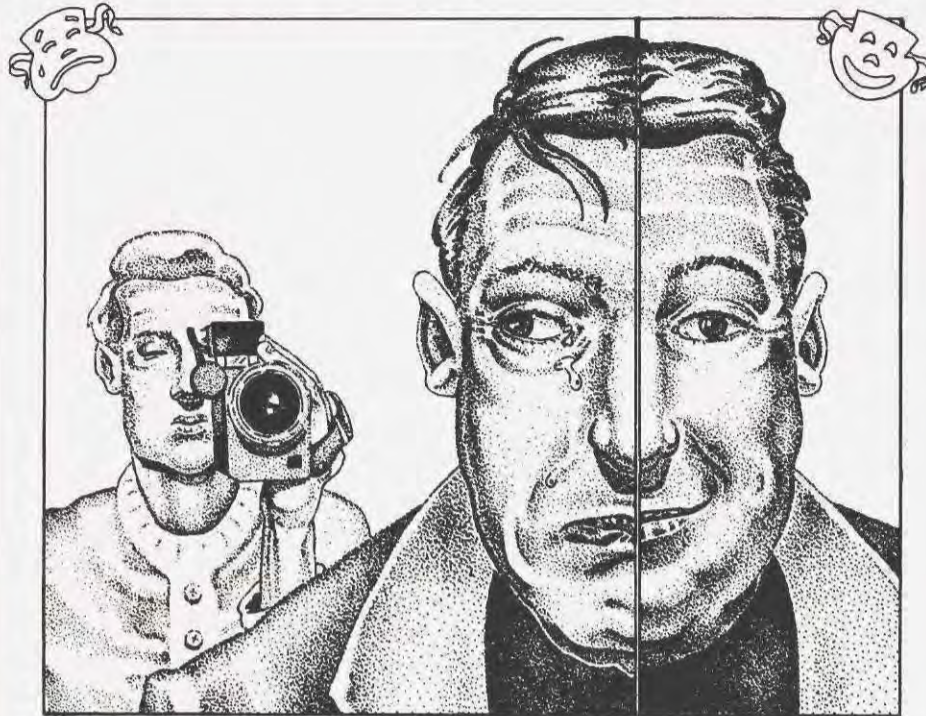
Bill Kizorek is president of Naperville, Ill.-based InPhoto Surveillance and a private investigator with decades of experience in insurance claims work. So he's entitled to be a tad jaded, a quality to which he freely admits in his introduction to this breezy examination of psychological claims investigation.

"At times, it appears that I don't believe all claims are authentic. This disbelief has come after years of watching claimants limp out of a doctor's office with a claim and then jog into a supermarket 20 minutes later. As psychological claims grow in popularity, there will be claimants who fake symptoms in order to convince a specialist that their affliction is real," warns Mr. Kizorek.

Co-author Paul Lees-Haley—an Encino, Calif.-based psychologist who specializes in trauma evaluation—has a warning of his own in a companion introduction when he notes, "If the evidence doesn't make sense, something is amiss."

The central theme of this book is how to gather evidence during the investigation of psychological claims.

Dr. Lees-Haley's chapter,



'Psychological Claims Investigations' contains several illustrations by Kevin Berg.

if a claimant's condition is fictitious.

The psychologist concludes that "surveillance and investigative interviews are underutilized in psychological claims because the damages are regarded as too intangible to document. In fact, when conducted by imaginative experts, these techniques will confirm legitimate claims and rebut exaggerated and fraudulent claims. Creative use of investigative interviewing and surveillance can make the difference in what appears to be a hopeless case."

Mr. Kizorek bolsters Dr. Lees-Haley's clinical observations with anecdotes, asides about the civil justice and insurance systems in the United States and abroad and the evolution of disability claims from the broken bone to the "ideal painless claim—the one with no physical injury," better known as the psychological claim.

Mr. Kizorek says that while there are true mental disability claims, the investigator must be alert to the possibility of trickery. To help an investigator uncover the true extent of an alleged psychological disability, Mr. Kizorek offers his own list of do's and don't's, including using powerful lenses to record a subject's facial expressions to avoid entrapping a claimant.

Shot through with humor and lavishly illustrated, "Psychological Claims Investigation" is an easy-to-read primer on an increasingly common disability claim and how to determine if it stems more from greed than injury. ■

### Books & ideas

"Surveillance of Psychological Claimants: Practical Techniques," spells out five steps in surveillance:

- Define the issues, which is to define the arguments and allegations of the claimant.
- Identify observable manifestations of the issues.
- Directly investigate the claimant's

current functioning.

- Indirectly investigate current functioning and past history.
- Assess, organize and apply the findings.

As part of the investigation of current functioning, Dr. Lees-Haley discusses how several diagnostic characteristics of depression can be observed to determine

# Exclusion void if not in benefit booklet: Court

A group health policy exclusion for a hospitalization in progress, which was contained in a master policy but was omitted from the benefits booklet provided to the policyholder, was not enforceable, according to a Maryland appellate court.

In 1981, Gloria Powell had her minor dependent son admitted to a health facility for treatment of his emotional problems. Coverage for the \$190 per day treatment was by her former husband's military insurance.

In January 1983, Ms. Powell, as a state employee, enrolled herself and her minor daughter, but not her son, in her employer's group health plan with Blue Cross & Blue Shield. She received a program benefits booklet and read it thoroughly. The booklet stated that both the basic and major medical plans provided coverage and benefits relating to care for nervous and mental conditions.

Concerned over the adequacy of coverage under her former husband's insurance, Ms. Powell enrolled her son in the BC/BS program after confirming her conclusion that, despite his hospitalization, he was eligible for coverage. Thereafter, BC/BS did pay the son's September and October 1984 costs at the health facility.

In 1984, BC/BS replaced the group coverage with a new high option plan. Ms. Powell chose to continue her current coverage. The new booklet specifically excluded coverage for a person who was in the hospital at the time that coverage would otherwise have become effective. BC/BS subsequently notified Ms. Powell that her son's hospitalization was not covered and demanded return of the previously paid amounts. Ms. Powell

### Legal briefs

and her son's health care facility sued BC/BS and won in trial court.

The appellate court noted that the majority of courts addressing the issue refuse to enforce policy exclusions contained in the master policy but which have been omitted from the benefits booklet or other explanatory materials provided to the policyholder.

The appellate court agreed with the majority view and said that it would be unfair to permit an insurer, which usually drafts the booklet, to raise as an impediment to coverage, a provision in the master policy that is not contained in the explanatory literature.

*Blue Cross & Blue Shield vs. Chestnut Lodge*, Court of Special Appeals of Maryland, Dec. 22, 1989 (BI/01/June-\$10).

### Court says loss was fortuitous

A fortuitous loss in a multiperil insurance policy is one that does not result from any inherent defect in the property insured, ordinary wear and tear, or intentional misconduct, according to the Supreme Court of Virginia.

Allied Realty Development Ltd. owned a warehouse located at the base of a hill. The structure included a group of interconnected single-story warehouse units constructed of cinder block and steel-reinforced concrete.

Later, Allied extended the rear wall above the roof line of the building, creating a level area above and behind part of the single-story warehouse.

Five house trailers were placed on the level ground.

In 1985, Allied discovered a number of cracks in some of the warehouse walls. Its architect concluded that the structural components of the building had failed.

Further evaluation concluded that the warehouses were unsafe for occupancy. The city condemned the property.

Allied was covered under a multiperil insurance policy issued by Fidelity & Guaranty Insurance Underwriters Inc. Allied made a claim for costs of removal of the fill, reinforcing the structural support of the wall and other remedial work. Fidelity denied coverage alleging the loss was not a fortuitous loss. This suit ensued. The trial court ruled for Allied.

The appellate court concluded that, considering the parties' knowledge at the time they entered into the insurance contract, neither party regarded the loss as "inevitable." According to the court, the loss here was a fortuitous event—i.e., unexpected—under the policy. Furthermore, the court concluded that none of the policy exclusions were applicable.

*Fidelity & Guaranty Insurance Underwriters Inc. vs. Allied Realty Co. Ltd.*, Supreme Court of Virginia, Sept. 22, 1989 (BI/05/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.*

# Supervisors should look for drug abuse

By MICHAEL SCHACHNER

BOSTON—Drug and alcohol testing programs will not help prevent workplace injuries unless supervisors also are trained to detect the behavioral changes that indicate an employee has a substance abuse problem, says a business management consultant.

"The fundamental key to a successful drug and alcohol abuse program is training supervisors on how to identify employees who are not fit to perform their job and what the role of the supervisor is when such a situation presents itself," said Gary R. Danielson, a partner with Industrial Relations Inc., a Detroit-based management consulting firm.

For example, Joseph Hazelwood, the captain of the Exxon Corp. tanker that ran aground in Alaska's Prince William Sound last year (*BI*, April 3, 1989) and the conductor of a Conrail freight train that collided with an Amtrak passenger train in 1987 killing 17 people (*BI*, Jan. 12, 1987) each had exhibited behavior patterns common to drug and alcohol abusers long before the infamous accidents, Mr. Danielson noted.

In fact, the Conrail conductor was later found to have been smoking marijuana at the time of the accident (*BI*, Jan. 26, 1987), he said, speaking at a session on workplace drug programs at the 28th annual Risk and Insurance Management Society conference held last week in Boston.

"Both Exxon and Conrail had drug and alcohol policies," Mr. Danielson said.

Mr. Danielson said there are five elements an employer must have in its drug and alcohol abuse program to ensure employee reliability:

- Top management must be committed to employing reliable people and making sure drugs and alcohol are not acceptable in the work environment.

- Employers must communicate this commitment to all levels of employees.

- "In many cases employers are killing their people with kindness. Nobody wants to say, 'You have a drug problem and you're relieved of your job until you undergo counseling,'" Mr. Danielson said.

- Employers must have a written policy regarding the need for reliable employees that clearly states drugs and alcohol are unacceptable in the workplace.

- Employers must construct a written procedure that spells out how the policy will be enforced and what responsibilities employees and supervisors have.

- Sufficient supervisory training on how to identify employees with drug and alcohol problems is critical.

Among the signs that could indicate an employee has a substance abuse problem are high absenteeism and drunk driving convictions, Mr. Danielson said.

"Some companies don't even want a drug program" that tests employees for substance abuse, he noted. "They can be difficult to administer and may expose the company to liability."

But, "in many cases, behavioral analysis can work equally well," Mr. Danielson asserted.

Carmel Cosgrave, an attorney with the Chicago law firm Querry & Harrow who specializes in federal and state workplace drug testing legislation, noted the debate over the usefulness of drug testing.

"Drug testing doesn't reflect impairment or intoxication. It only tests for past use, and some drugs can stick in a person's system for days, weeks, even months," she pointed out.

Currently, six industries regulated by the Department of Transportation, businesses with federal contracts and companies involved with nuclear energy must conduct pre-employment drug screenings, Ms. Cosgrave said.

And, those same employers can randomly test workers for drug use with immunity from employee lawsuits under Health and Human Services regulations, Ms. Cosgrave added.

Many other employers can conduct limited pre-employment and employee drug testing under case or state law, she noted.

Connecticut, Iowa, Louisiana, Maine, Minnesota, Montana, Rhode Island, Utah and Vermont have passed laws allowing employers to test workers and job applicants for

drug use, Ms. Cosgrave said.

Only Louisiana and Utah allow employers to conduct random employee drug tests, she said.

And, various drug testing laws are pending in approximately 30 states, Ms. Cosgrave noted.

Risk managers responsible for drug and alcohol testing programs should identify the key jobs, operations, property and personnel that could be most adversely affected by a substance abuser, advised Fred Potenza, executive vp with Gallagher Bassett Services Inc., a risk management consultant based in Rolling Meadows, Ill.

"A risk manager can assist by systematically identifying and evaluating the unique, major risks that the organization faces from substance abuse," Mr. Potenza

said.

For example, "in terms of improper job performance, a bus driver on crack can do more potential damage than a ticket taker," he said.

Mr. Potenza said amassing this information enables the risk manager to summarize the vital loss exposures the company faces. This information helps employers:

- Estimate the impact of the substance abuse problem and determine where application of a substance abuse program can make an impact.

- Get the necessary financial backing from management for drug testing program.

- Start estimating the benefits such a program might bring.

- Measure new loss exposures as

the company's operations, property and personnel change.

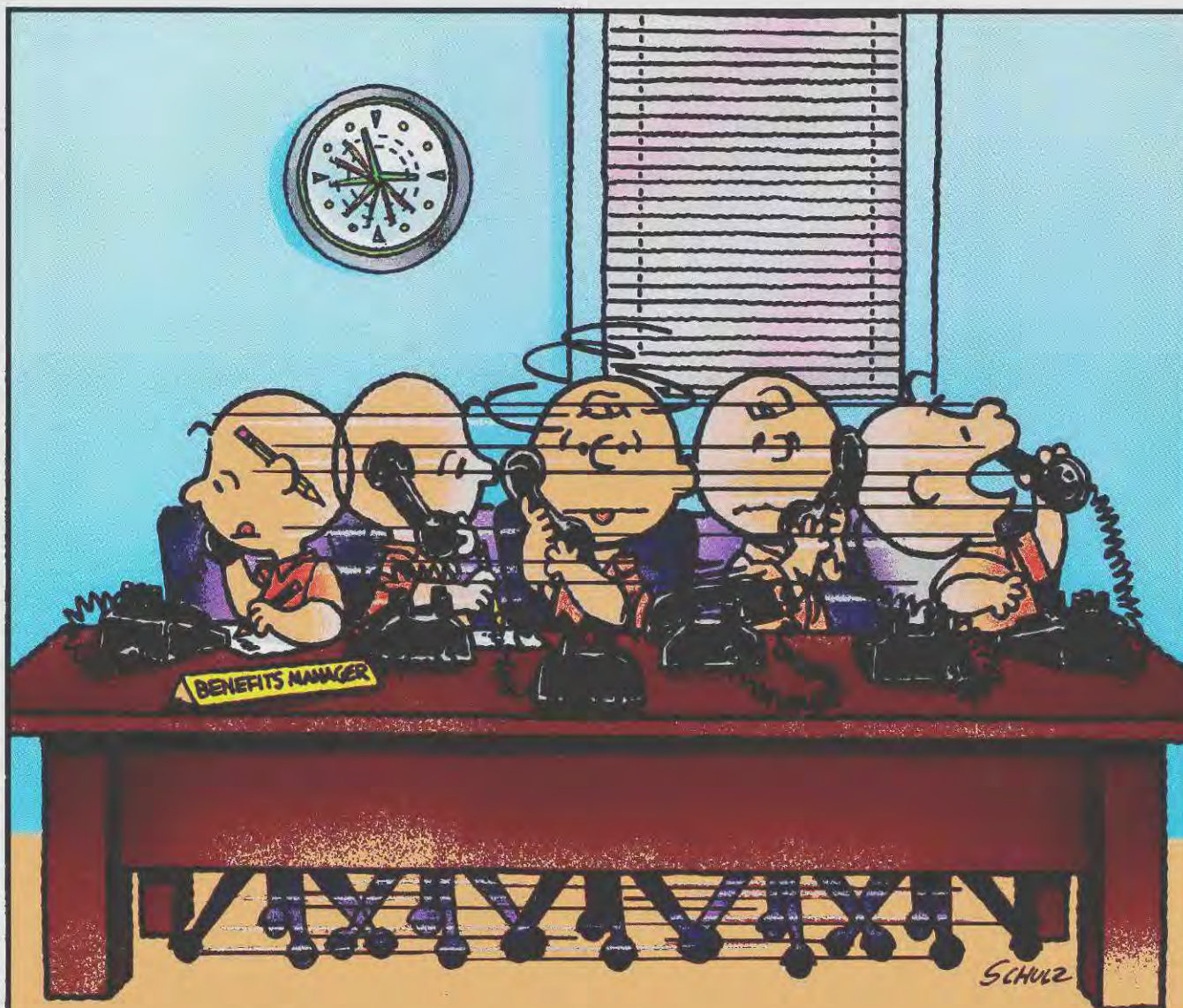
Mr. Potenza also said a corporate drug testing program can reduce insurance premiums.

When choosing a drug testing method and laboratory, a risk manager should consider the training and certification of lab personnel, Mr. Potenza said.

Employers also should insist that labs document the chain of custody of specimens to prevent tampering, substitution or misplacement.

In addition, labs should conduct confirmation tests when a specimen tests positive, Mr. Potenza urged.

Ellis Mirsky, chief counsel-litigation management for GAF Corp. in Wayne, N.J., moderated and coordinated the session. ■



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# Team USA skates to first hockey win at RIMS conference

By MICHAEL SCHACHNER

BOSTON—An injection of new blood and some solid veteran play propelled Team USA to a 6-3 victory over Team Canada last week, its first win in four Risk & Insurance Management Society Hockey "All-Stars" challenges.

If the U.S. property/casualty insurance market is messed up, "we figured we at least have to do well in hockey," quipped Peter J. King, of Marsh & McLennan Inc. in Philadelphia, a Team USA veteran.

But it was the newcomers who turned things around for Team USA.

Soon after the opening faceoff, it was evident that some new players—including a few not listed on the pre-game roster—added quickness and scoring potential.

The team's youth impressed not only Team USA Coach Stan Tait, of Cadbury Schwepps Inc. in Stamford, but also Team Canada Coach Brian Hammond, of the Federal Development Business Bank in Montreal.

"They took the puck out of their end well, and we had a problem clearing it from ours," Mr. Hammond said.

Equally evident was Team Canada's short bench and lack of firepower in the game.

Coming into this year's match, Team Canada had a two-game winning streak after a 5-5 tie in the 1986 inaugural game.

Proceeds from the game benefit the Spencer Educational Foundation, which awards scholarships to students of risk management, insurance and employee benefits.

The action started quickly at Boston University's Walter Brown Arena.

Team USA was first on the scoreboard at 7:37 of the first period when Mr. King banged a loose puck in front of Team Canada's net past goaltender Steve Patenaude, of Arkwright Mutual Insurance Co. in Montreal.

Team USA forward Bob Nason, of Trenwick America Reinsurance Corp. in Stamford, converted a pass from Mike White, of the Holborn Agency in New York, just 33 seconds after Mr. King's goal.

With a 2-0 lead only eight minutes into the game, the Americans appeared to be off to the races.

But Team Canada quickly regained its bearings. At 9:27, team captain Joe Hardy of The Oshawa Group Group Ltd. of Etobicoke, Ontario, pushed a shot unassisted past Team USA goalie Terry Taillefer, of Ranger Associates in East Norwalk, Conn.

It was one of very few mistakes by Mr. Taillefer, a new member of Team USA.

Though Mr. Taillefer was tested less frequently than his counterpart, Mr. Patenaude, the American's splendid goaltending improved as the game went on and was a key to the win.

Having an ex-collegiate goalie marked a stark improvement for Team USA. In last year's 10-7 loss, an accountant from Atlanta was in the net.

After Mr. Hardy's goal, the teams settled down for several minutes of up and down rushes, with Mr. Patenaude making several key saves.

Backed by Patenaude's strong play, Dan Vujacic, of SCOR Reinsurance Co. in Toronto, tallied Team Canada's second goal at 14:32. He took a pass behind the net from Mr. Hardy, skated out to the right faceoff circle and fired a rising wrist-shot over Mr. Tail-

lefer's glove and just underneath the crossbar.

But, the flashy goal—the game's only genuine eye-pleaser—did not push the game's momentum to the Canadian team.

Just 23 seconds later, the Americans regained the lead on a goal by team captain Joe Tarbell, of Corroon & Black Corp. in Boston.

Another Team USA newcomer—Karl Burns, of American International Group Inc.—finished the first period with a score at 16:47 off a rebound of a shot by Mr. King.

Team USA left the ice after the first period confident that their first victory was within reach.

Youth and a deeper bench allowed Team USA to control the tempo of the second period.

The Americans outshot their opponents by a wide margin and kept the puck out of their own end.

However, youth could only get the Americans so far.

With feisty USA defenseman Pat Hickey of Leonard Newman Agency in White Plains, N.Y., in the penalty box, Team Canada elder skatesman Lionel Lalonge, of Reed Stenhouse Ltd. in Montreal, cut the lead to 4-3 on an unassisted power play goal at 4:07.

"I was real pleased to see Lionel get that goal," Mr. Hammond said.

But soon after the goal by Mr. Lalonge—who played junior hockey with National Hockey League legends Bernie Geoffrion and Jean Beliveau—Team USA recaptured a two-goal lead. At 6:11, Jim Sweitzer, of General Re Corp., in Stamford, Conn., converted another power play goal off assists from Mr. Tarbell and Bill Baker, of General Re in New York.

Mr. Baker, another Team USA rookie, rounded out the scoring with only 11 seconds left while Team Canada was short two men.

Mr. Baker was selected Most Valuable Player for Team USA.

Ken Green, of Union Gas in London, Ontario, was Team Canada's MVP.

Mr. Tait said his club was prepared to come out on the offensive.

"Last year, we scored four goals in the final period. So we thought we'd come out and get them from the get go," the coach said. "It was an excellent game for us and we're really happy to have won."

As competitive as these old-timers were on the ice, they tried to keep things in perspective later.

Before uncorking the "victory champagne"—a case of Budweiser—members from both teams were already securing a rink for next year's match in New Orleans. ■

BOX SCORE

Team Canada	2	1	3
Team USA	4	2	6

First period—1, Team USA, Peter King (Nick Steffey, Karl Burns), 7:37. 2, Team USA, Bob Nason (Mike White), 8:11. 3, Team Canada, Joe Hardy (unassisted) 9:27. 4, Team Canada, Dan Vujacic (Hardy, Ken Green), 14:32. 5, Team USA, Joe Tarbell (unassisted), 14:55. 6, Team USA, Burns (King, Peter Bostwick), 16:47. Penalties—Bob Pusiak, Team Canada (tripping), 10:24; Pat Hickey, Team USA (holding), 17:54.

Second period—7, Team Canada, Lionel Lalonge (unassisted) 4:07. 8, Team USA, Jim Sweitzer (Tarbell, Bill Baker), 6:11 (pp). 9, Team USA, Baker (Tarbell), 19:49 (pp). Penalties—Hickey, Team USA (charging), 3:55; Ken McCormick, Team Canada (tripping), 4:43; Mike White, Team USA (holding), 13:56; Hickey, Team USA (interference), 15:10; Pusiak, Team Canada (double minor, charging, roughing), 17:52; Brian Matthews, Team Canada (slashing), 17:52.

RIMS Conference Spencer division

Team Canada	W	L	T
Team USA	2	1	1
	1	2	1



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## Markets

# UNUM acquires British insurer of LTD coverage

UNUM Corp., a provider of group long-term disability coverage, is acquiring London-based National Employers Life Assurance Holding Co. Ltd., one of the largest U.K. insurers of this coverage.

Portland, Maine-based UNUM plans to purchase the group permanent health insurance specialist, a unit of Invesco MIM P.L.C. of London, for 40 million pounds (\$65.3 million at current exchange rates).

National Employers currently writes about 40% of the U.K. group permanent health insurance market, which is comparable to group long-term disability insurance. In addition, the company writes life insurance and markets pension products.

The acquisition, which is subject to approval by the U.K. Department of Trade and Industry, is expected to be completed by June 30.

John Finnan would remain chief executive officer of National Employers Life.

UNUM also plans to negotiate the purchase of outstanding shares of National Employers Life Permanent Health Insurance Ltd., which are held by policyholders of the Dorking, England-based insurer. NELPHI, a subsidiary of National Employers Life, also specializes in group permanent health insurance.

National Employers Life reported 1988 statutory net premium volume of \$197 million.

UNUM also has created a long-term care insurance division. The new division will consolidate the marketing of the insurer's various long-term care products, which currently are marketed by different divisions.

## International firm

Milliman & Robertson Inc., a Seattle-based benefits consulting and actuarial firm, is expanding its international capabilities by creating Woodrow Milliman, an affiliation of 11 consulting and actuarial firms.

"The formation of Woodrow Milliman broadens and strengthens our international capabilities and now encompasses 47 cities in 11 countries," said James A. Curtis, chairman and chief executive officer at Milliman & Robertson's corporate office in Seattle.

The international network includes companies in North America, Europe and the Pacific Rim. The firm will continue as Milliman & Robertson Inc. in the United States, but will be known as Woodrow Milliman elsewhere.

In addition to Milliman & Robertson, the founding members of Woodrow Milliman are: Actuariel Bureau Dr. W.G.J. ten Pas in Amsterdam, the Netherlands; Aktuar-Consult in Oslo, Norway; Aserplan, with offices in Madrid, Barcelona and Palma de Mallorca, Spain; Bacon & Woodrow, with 10 offices in the United Kingdom and the Channel Islands; Bacon, Woodrow & de Souza in Port of Spain, Trinidad; CONAC in Brussels, Belgium; Delany, Bacon & Woodrow in Dublin, Ireland; Eckler Partners Ltd. in Canada; SB Aktuar-Radgivning ApS in Copenhagen, Denmark; and Trowbridge Consulting, with offices in Sydney and Melbourne, Australia.

For more information about Woodrow Milliman, contact James A. Curtis, Milliman & Robertson Inc., 1301 Fifth Ave., Suite 3800, Seattle, Wash. 98101-2605; 206-624-7940.

## New AIG unit

American International Global, a unit of New York-based American International Group Inc., is forming a subsidiary to provide services to foreign-based multinational firms with North American property/casualty insurance programs underwritten by AI Global offices outside the United States.

Among other things, the new entity, AI Global Multinational Services Unit, will issue such statutory policies as workers compensation and automobile insurance and provide claims and engineering services, explained Vincent J. Masucci, president of AI Global in New York.

The new unit will serve as a single contact point in the United States for foreign policyholders and their servicing brokers.

AI Global Multinational also will assist in underwriting and servicing foreign-produced U.S. business. For example, if a master insurance policy is underwritten by AI Global in Paris or Tokyo, the new multinational unit will issue corresponding policies in North America, making certain they comply with state and federal regulations, as well as the master policy.

For more information, contact Edward J. Dolezal, Vp-International Division, AI Global Services, 99 John St., Second floor, New York, N.Y. 10038; 212-770-9127.

## New EAP

Five employee assistance firms recently merged to form Assured Health Systems Inc., a national employee assistance program and managed care company based in Burlington, Mass.

The firms that merged to make up the new company are: Parkside EAP in Chicago; McLean Health Services Inc./Employee Assistance Programs in Boston; LifeCare Systems in San Francisco; Professional Employee Advisement Program in Denver; and Managed Health Solutions Inc. in Marblehead, Mass.

Assured Health Systems provides employee assistance programs, including mental health and chemical dependency services, mental health utilization management, quality assurance and preferred provider network development.

The company operates 10 regional offices and serves more than 200 organizations and 1 million covered lives nationwide.

For more information on Assured Health Systems, contact Keith Dixon, Vp-marketing, Assured Health Systems Inc., 20 Mall Road, Suite 130, Burlington, Mass. 01803; 617-273-9966.

## Mental health PPO

Cost Care Inc., a health care cost containment company in Huntington Beach, Calif., has created a national psychiatric and substance abuse preferred provider network.

*Continued on next page*

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## Markets

Continued from previous page

PsychNet currently consists of 320 mental health/chemical dependency hospitals in 43 states and Puerto Rico.

By the middle of 1990, the number of contracted hospitals is expected to exceed 500, said Lawrence Goelman, president of Cost Care.

"The employer can select the level of cost management desired," Mr. Goelman explained. For example, clients may use the network only for mental health and substance abuse services or they can also opt for utilization review and full case management services.

For more information about PsychNet, contact Ray Foote, Vp-marketing, Cost Care Inc., 17011 Beach Blvd., Suite 400, Huntington Beach, 92647; 714-842-4909.

### Broker agreement

Corroon & Black Corp. has reached an exclusive correspondent agreement with Nikols S.p.A. of Milan, Italy.

Under the terms of the agreement, New York-based Corroon & Black will serve as Nikols' exclusive correspondent for insurance brokerage business in the United States, while Nikols will represent Corroon & Black in Italy.

Nikols also will exclusively service C&B clients that operate in Italy while Corroon & Black will exclusively represent Nikols' Italian clients with U.S. operations.

Corroon & Black is the world's fifth-largest broker with 1988 gross revenues of \$425 million.

Nikols provides consulting and insurance services, including risk analysis, program management

and reinsurance. In 1989 it reported gross revenues of \$40 million from retail brokerage and \$3.2 million from wholesale brokerage.

### Hall acquisition

Broker Frank B. Hall & Co. Inc. acquired Marine Insurance Service Inc., a Metairie, La.-based broker specializing in coverages for inland river vessels.

The company will be merged into Hall's New Orleans operation as the Marine Insurance Service division of Frank B. Hall & Co. of Louisiana. Terms of the purchase were not disclosed.

The acquisition will enable Hall, the sixth-largest U.S. broker with 1988 gross revenues of \$367 million, to expand in the "brown water" business, putting together insurance for "supply vessels, tugboats, barges and other inland traffic," said Charles D. Warren, chairman and chief executive of Frank B. Hall & Co. of Louisiana.

Edward J. Ryan Jr., president of Marine Insurance Services, has been named president of the new division.

For more information, contact the Marine Insurance Service division of Frank B. Hall & Co. of Louisiana, 639 Loyola Ave., Suite 2400, New Orleans, La. 70113; 504-522-5341.

### Poe acquisitions

Tampa, Fla.-based brokerage Poe & Associates Inc. has made several recent acquisitions.

Poe, the 15th-largest U.S. broker based on 1988 gross revenues of \$35.1 million, recently acquired Neil Wiley Insurance Services Inc. in Atlanta, which specializes in providing insurance for the transportation industry. The acquired agency will not move.

Poe's Houston subsidiary, P&O of Texas Inc., acquired two Houston insurance agencies: Bynum, Beck & Drew and Beck/William Schwartz Benefits Inc.

Bynum, Beck & Drew specializes in property/casualty insurance, and William Schwartz focuses on life and employee benefits coverages.

The new company, Bynum, Beck & Poe Inc., is located at 1 Riverway, Suite 1500, Houston, Texas 77056; 713-621-1020.

In addition, Poe acquired Browne & Browne Inc., a property/casualty insurance agency in Fort Lauderdale, Fla. The agency will combine with Poe's existing Fort Lauderdale office, adding 20 staff members.

Poe also acquired the professional liability division of Arthur A. Watson & Co. Inc., a Wethersfield, Conn.-based broker with 1988 gross revenues of \$11.8 million.

The division, to be renamed

Physician Plans Inc., provides insurance programs to more than 4,000 physicians, attorneys and other professionals in Delaware and Connecticut. The company will operate out of its existing Connecticut offices in Wethersfield.

### New offices

The Wyatt Co. has relocated its consulting office in New York City to 461 Fifth Ave., New York, N.Y. 10017-6202; 212-725-7550.

Independence Insurance Co. Ltd. moved its offices to Jardine House 33/35 Reid St., Hamilton HM 12, P.O. Box HM 2077, Hamilton HM HX Bermuda.

Caronia Corp. relocated its corporate offices to Corporate Center, 395 N. Service Road, Suite 200, Melville, N.Y. 11747; 516-845-5000.

Claims adjuster R.L. Gresham & Co. Inc. opened a new branch office in Yuma, Ariz. The address is 1500 Fifth Ave., Yuma, Ariz. 85364; 602-782-2294.

### Mergers/acquisitions

South Pasadena, Calif.-based property/casualty broker Bolton & Co. has acquired Warner-Olson Insurance in Camarillo, Calif. The new company is called Warner-Olson/Bolton and will remain in Camarillo.

Richmond, Va.-based broker Hilb, Rogal & Hamilton Co. acquired The Warwick Agency Inc. in Brunswick, Ga. The agency will merge with Hilb's subsidiary in St. Simons Island, Ga.

### Name change

New York-based benefit consultant William M. Mercer Meidinger Hansen Inc. changed its name to William M. Mercer Inc. ■



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## Datebook

### MAY

**MAY 10. The Employers' Perspective on Unemployment Insurance** workshop in Rosemont, Ill., sponsored by The Illinois State Chamber of Commerce; \$120 for ISCC members; \$180 for non-members. ISCC, 20 N. Wacker Drive, Chicago, Ill. 60606; 800-621-4220.

**MAY 10-11. Advanced Safety Management** seminar in Anaheim, Calif., sponsored by Organizational Safety Services Inc.; \$285, Keith E. Barenklau, OSS, 11831 Rothbury Dr., Richmond, Va. 23236; 804-794-0691.

**MAY 10. Insurers Vs. Insurer Disputes** seminar in New York City, sponsored by the Practising Law Institute; \$350. Also **June 28** in San Francisco. PLI, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

**MAY 10. Property & Casualty Market Conduct Seminar** in New York City, sponsored by the law firm of Bower & Gardner; \$250. B&G, 110 E. 59th St., New York, N.Y. 10022; 212-751-2900.

**MAY 10-11. IAHMO Annual Spring Symposium: Managed Care in the Non-Acute Setting** in Chicago, sponsored by the Illinois Assn. of Health Maintenance Organizations; \$75 for IAHMO members; \$90 for non-members. IAHMO, 321 N. Clark, Suite 3400, Chicago, Ill. 60610; 312-245-8780.

**MAY 11. Arbitration Day '90** seminars in New York City, sponsored by the American Arbitration Assn.; \$95 for AAA members; \$110 for non-members. AAA Department of Education and Training, 140 W. 51st St., New York, N.Y. 10020; 212-586-7000.

**MAY 13-15. Utilization Management for Ambulatory & Ancillary Services** conference in Orlando, Fla., sponsored by the Group Health Assn. of America Inc.; \$495 for GHAA members; \$575 for non-members. Also **July 22-24** in Vancouver, B.C. Group Health Assn. of America, Dept. 0612, Washington, D.C. 20073-0612; 202-778-3228.

**MAY 13-15. 1990 National Financial Insurance Conference** in Dallas, sponsored by LOGIC Inc.; \$325 for LOGIC clients; \$425 for others. Eddy Manders, LOGIC Inc., 9330 LBJ Freeway, Suite 500, Dallas, Texas 75243; 214-238-1898; 800-527-2323.

**MAY 13-18. Industrial Hygiene in the World of Tomorrow** conference in Orlando, Fla., co-sponsored by the American Industrial Hygiene Assn. and the American Conference of Governmental Industrial Hygienists; \$140 for AIHA members; \$25 for emeritus or honorary members; \$30 for retired members, and spouses; \$170 for non-members. AIHA Conference, P.O. Box 8390, 345 White Pond Drive, Akron, Ohio 44320; 216-873-2442.

**MAY 14-15. Understanding Reinsurance Contract Language** course 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 14-16. Environmental Regulation Course** in Hartford, Conn., sponsored by Executive Enterprises Inc.; \$990. Also **May 15-17** in San Diego, **May 21-23** in New Orleans. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**MAY 14-17. Loss Control Management** seminar in Calgary, Alberta, sponsored by the International Loss Control Institute; \$720 for ILCI members; \$800 for non-members. Also **June 18-21** in Philadelphia; and **June 25-28** in Atlanta. ILCI, 4546 Atlanta Highway, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208; 800-554-6001.

**MAY 15. Insurance Tax Update: 1990** in Atlanta, sponsored by KPMG Peat Marwick; no charge. Also **May 17** in Los Angeles. KPMG Peat Marwick, Executive Education, 3 Chestnut Ridge Road, Montvale, N.J. 07645; 800-762-3932.

**MAY 15. Advanced Risk Management Financing Techniques** seminar in Allentown, Pa., spon-

sored by The Society of Chartered Property & Casualty Underwriters; \$125 for Society of CPCU members; \$165 for non-members. Mari Jennings, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, CB No. 9, Malvern, Pa. 19355; 215-251-2741.

**MAY 15. Roundtable on Insurance Conditions in Western Europe** in New York City, sponsored by the International Insurance Council; \$75 for conference; \$140 for luncheon. IIC, 1212 New York Ave. N.W., Suite 250, Washington, D.C.; 202-682-2345.

**MAY 15-19. 53rd National Assn. of Independent Insurance Adjusters** convention in Nashville, Tenn., sponsored by NAIIA; \$250 for NAIIA members; \$150 for spouses. NAIIA, 300 W. Washington St., Suite 805, Chicago, Ill. 60606; 312-853-0808.

**MAY 16-17. Risky Business:**

**Health Care & Retirement Planning in an Uncertain Time** conference in Washington, D.C., sponsored by the Assn. of Private Pension and Welfare Plans; \$500 for APPWP members; \$600 non-members. APPWP, 1212 New York Ave. N.W., Suite 1250, Washington, D.C. 20005; 202-289-6700.

**MAY 16-18. Workers' Compensation Conference 1990** in New Brunswick, N.J., co-sponsored by Rutgers University, Princeton University, Cornell University, Syracuse University, and the University of Connecticut; \$180; \$90 for one day. Donna Lebowitz, IMLR, Levin Building, Rutgers University, Kilmer Campus, New Brunswick, N.J. 08903-5062; 201-932-5830.

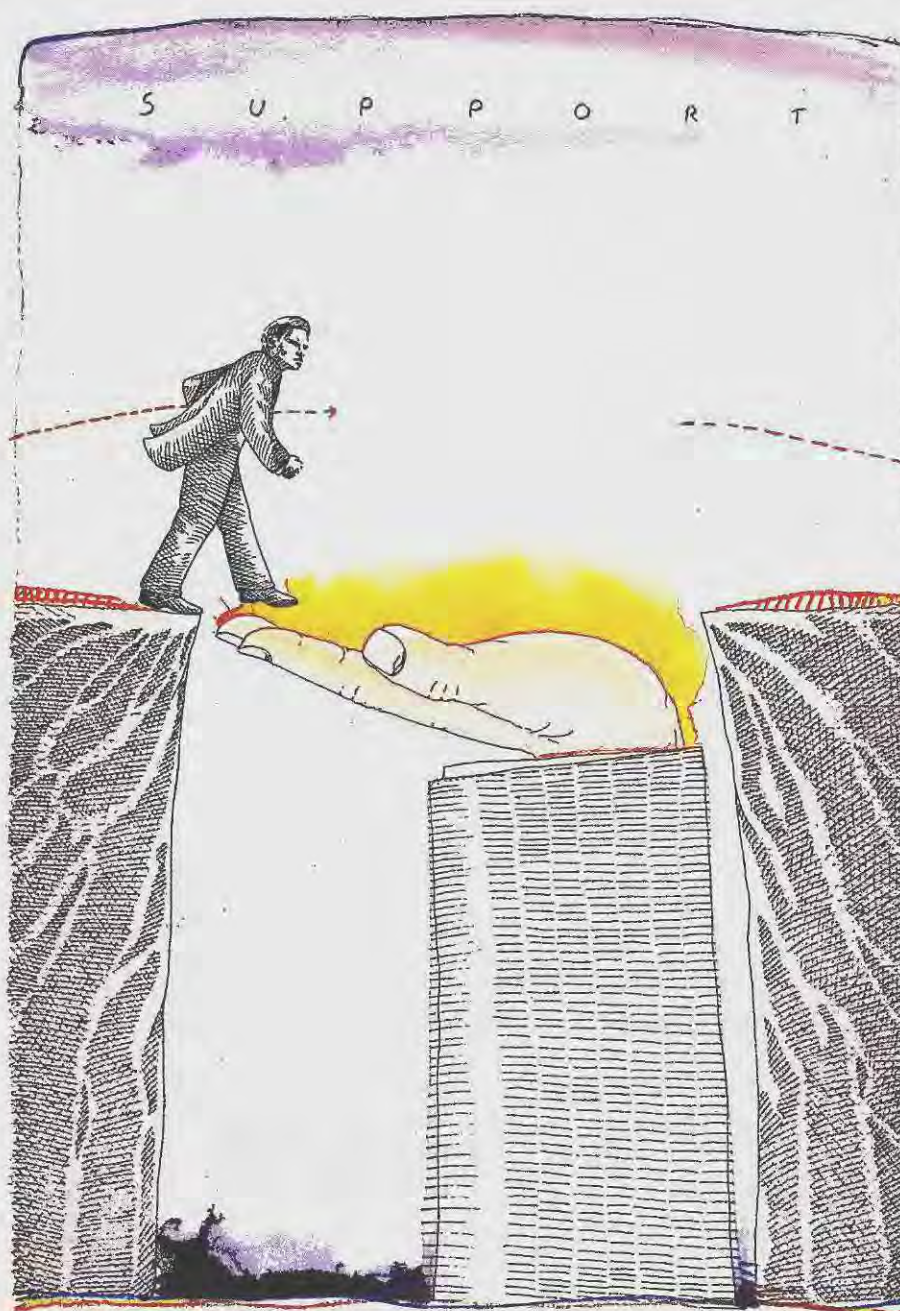
**MAY 17. 82nd Annual Meeting of The Surety Assn. of America** in New York City, sponsored by SAA; no charge. SAA, 100 Wood Ave. S., Iselin, N.J. 08830; 201-494-7600.

**MAY 17-18. Insurance in 2000-Where Will You Stand?** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 450 pounds (\$737). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**MAY 20-22. 22nd Annual Midwest Claim Conference: Entering the '90s, a Decade of Change** in Itasca, Ill., sponsored by the Chicago Claim Assn.; \$45 for one day; \$80 for two days. Midwest Claim Conference, c/o Patsy Howell, 1 Woodfield Lake, Schaumburg, Ill. 60173; 708-517-6041.

**MAY 20-22. Effective Management & Direction of Malpractice Insurers & Trusts** seminar in Kailua-Kona, Hawaii, sponsored by the Tillinghast division of  
*Continued on next page*

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## Datebook

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Towers, Perrin, Forster & Crosby Inc.; \$750; \$700 for each additional attendee from the same company. Mary Tschopp, Tillinghast Seminars, 1 Atlanta Plaza, 950 East Paces Ferry Road, Suite 1100, Atlanta, Ga. 30326-1119; 404-365-1642.

**MAY 21-22. Insurer Solvency: New Market Trends and Regulatory Directions** 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. Questions on the New CGL and CP Policies? Ask the Claims Department** workshop in Vienna, Va., sponsored by The Society of Chartered Property & Ca-

sualty Underwriters; fee for two workshops: \$140 for Society of CPCU members, \$175 for non-members; fee for one workshop: \$85 for Society of CPCU members, \$105 for non-members. Mari Jennings, Continuing Education Coordinator, The Society of CPCU, Kahler Hall, 720 Providence Road, CB No. 9, Malvern, Pa. 19355-0709; 215-251-2741.

**MAY 22-23. Environmental Pollution Liability Workshop** in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 420 pounds (\$688). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**MAY 22-23. Insurance Industry**

**Mergers and Acquisitions: 1990** 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. Basic Reinsurance Seminar** in Columbus, Ohio, sponsored by the National Assn. of Mutual Insurance Companies; \$349 for NAMIC members; \$279 for non-members. NAMIC Education Dept., P.O. Box 68700, Indianapolis, Ind. 46268-070; 317-875-5250.

**MAY 22-23. Successful Claims Management & Litigation Cost Control Strategies for the 1990s** conference in New York City, sponsored by Infoline Inc.; \$995. Infoline Inc., 633 Third Ave., Suite 2227, New York, N.Y. 10017; 212-557-3400.

**MAY 23. Introduction to Risk Management for Non-Insurance**

**Managers seminar** in Columbus, Ohio, sponsored by The College of Insurance; \$195 for college sponsors; \$225 for others. **Also Sept. 26** in New York City; and **Nov. 7** in Atlanta. Jane Wechsler, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-815-9201.

**MAY 23-24. Banks and Insurance Update: 1990** 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 23-25. Techniques of Loss Control** course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. RIMS, Continuing Education Program, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**MAY 23-26. Annual Physician Insurers Assn. of America** meeting in Kauai, Hawaii, sponsored by PIAA; \$290 for PIAA members; \$415 for non-members. Medit Associates, P.O. Box 9011, Winnetka, Ill. 60093; 312-446-3100.

**MAY 24. Controlling Legal Expenses** seminar in Dallas, sponsored by The Society of Chartered Property & Casualty Underwriters; \$95 for Society of CPCU members; \$120 for non-members. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, CB No. 9, Malvern, Pa. 19355-0709; 215-251-2735.

**MAY 29-JUNE 1. Reinsurance Accounting & Finance for Ceders & Assurers** seminar in Ossining, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,545 including lodging and meals. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 212-677-5974 Monday-Wednesday, 914-832-9384 thereafter.

**MAY 30-JUNE 1. Fourth Annual Health Benefits Conference: Health Challenges of the 1990s** in New York City, sponsored by New York State Public Sector Coalition on Health Benefits; \$150 members; \$200 non-members. Sharon Goldberg, Executive Director, New York State Public Sector Coalition on Health Benefits, P.O. Box 15, Albany, N.Y. 12260; 518-473-6217.

**MAY 30-JUNE 1. 10th Annual Midwest Business Group on Health Conference: Circles of Influence in Health Care Systems** in Chicago, co-sponsored by MBGH, Ford Motor Co. and Honeywell Inc.; \$385 MBGH members; \$485 for non-members. MBGH, 830 W. Higgins Road, Suite 200, Chicago, Ill. 60631-2941; 312-380-9090.

**MAY 30-JUNE 1. Recognition of Accident Potential in the Workplace Due to Human Factors** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$460. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**MAY. 31-JUNE 1. Managed Health Care in the '90s** conference in Palm Beach, Fla., sponsored by the National Assn. of Employers on Health Care Action; \$495 for NAEHCA members; \$595 for non-members. NAEHCA Foundation, P.O. Box 220, Key Biscayne, Fla. 33149.

### JUNE

**JUNE 4-5. Toxic Substance Control Act Compliance Course** in Washington, D.C., 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.

**JUNE 4-6. Fundamentals of Insurance** course in San Diego, sponsored by the Risk & Insurance Management Society Inc.; \$495 for RIMS members; \$595 for non-members. **Also Sept. 10-12** in Chicago and **Dec. 3-5** in New York City. RIMS, Education Dept., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 4-6. Fundamentals of Risk Financing** course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; \$495 for RIMS members; \$595 for non-members. RIMS, Education Dept., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

Continued on next page

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## HealthCare Services



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Continued from previous page

**JUNE 4-8. Reinsurance Practice** course in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 825 pounds (\$1,350). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 4-8. Certificate in Environmental Health & Safety Law** program in Washington, D.C., sponsored by the Institute for Applied Management & Law Inc.; \$1,475. Also **June 11-15** in Newport Beach, Calif.; **July 23-27** in Orlando, Fla., and **Sept. 10-14** in Las Vegas, Nev. IAML Inc., 610 Newport Center Drive, Suite 1060, Newport Beach, Calif. 92660; 714-760-1700.

**JUNE 5-6. Claims Reserving in Non-Life Insurance** course in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 440 pounds (\$721). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 5-6. Health Care Cost Containment** workshop in Milwaukee, sponsored by Health Research Institute; \$595. Also **June 26-27** in Hawaii, and **Aug. 7-8** in San Diego. HRI, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

**JUNE 6-7. Second Luxembourg Captive and Insurance Rendezvous** in Kirchberg, Luxembourg, sponsored by the Risk & Insurance Research Group Ltd.; 480 pounds (\$785) plus value-added tax. RIRG, 4 Henrietta St., Covent Garden, London WC2E 8PS; 01-836-0614.

**JUNE 6-7. Environmental Compliance at Federal Facilities** conference in Washington, D.C., 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.

**JUNE 6-8. CAOHC Approved Training Course in Occupational Hearing Conservation** in Kansas City, Mo., sponsored by Impact Hearing Conservation Inc.; \$325 for certification; \$150 for recertification. Impact Hearing Conservation Inc., 406 W. 34th St., Suite 400, Kansas City, Mo. 64111; 816-531-4848.

**JUNE 6-8. Techniques of Risk Management** course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. Also **June 11-13** in Denver; **Sept. 5-7** in Vancouver, B.C.; and **Dec. 5-7** in New York City. RIMS, Education Dept., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 6-8. Claims Management** course in New York City, sponsored by the Risk & Insurance Management Society Inc.; \$595 for RIMS members; \$695 for non-members; if registered six weeks prior to course, subtract \$50. Also **Sept. 12-14** in Chicago; **Oct. 24-26** in Scottsdale, Ariz.; and **Dec. 5-7** in Charlotte, N.C. RIMS, Educational Dept., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 7-8. Hazardous Waste Litigation: Advanced Tactics and Practice** seminar in New York City, sponsored by the Practising Law Institute; \$495. PLI, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-

5700, ext. 271.

**JUNE 8. Arbitration Disputes** seminar in Los Angeles, sponsored by the International Foundation of Employee Benefit Plans; \$175 for IFEBP members; \$200 for non-members. Also **June 15** in Chicago and **June 22** in New York City. IFEBP, Registration Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

**JUNE 10-13. 40th Annual Group Health Institute** in Los Angeles, sponsored by the Group Health Assn. of America; before May 11: \$495 for GHAA members, \$595 for non-members; after May 11 add \$90. Registrar, Group Health Assn. of America, 1129 20th St. N.W., Suite 600, Washington, D.C. 20036.

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**JUNE 10-13. 11th Annual Public Risk Management Conference** in Reno, Nev.; \$395 for PRIMA members; \$465 for non-members; \$290 for registrants from public entities. PRIMA, 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

**JUNE 11-12. American Bankers Assn. Risk Management Seminar** in Washington, D.C.; \$495 for ABA members; \$620 for non-members. Sandra Currence, ABA, 1120 Connecticut Ave. N.W., Washington, D.C. 20036; 212-663-5290.

**JUNE 11-12. Understanding Today's Property-Casualty Statutory Statement** 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.

**JUNE 11-12. Site Investigation and Remediation Liability Conference** in Washington, D.C., 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.

**JUNE 11-13. Trustees and Administrators Institute** in Anaheim, Calif., sponsored by the International Foundation of Employee Benefit Plans; \$525 for IFEBP members; \$600 for non-members. **Also Aug. 6** in Vancouver, B.C. IFEBP, Registration Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

**JUNE 11-13. Seventh Annual International Conference on Insurance Taxation** in Vienna, Austria, sponsored by the National Center for Tax Education & Research; \$945. Bernard B. Goodman, Executive Director, National Center for Tax Education and Research, 8 Vista Drive, P.O. Box 414, Old Lyme, Conn. 06371; 203-434-3044.

**JUNE 11-15. The 1990 Fundamentals of International Employee Benefits** course in Brookfield, Wis., sponsored by the Corporate Benefits Institute of the International Foundation of Employee Benefit Plans; \$1,000 for IFEBP members; \$1,125 for non-members. International Foundation of Employee Benefit Plans, Registrations Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

**JUNE 12-13. Earthquake Exposure Analysis-What is the State**

**of the Art?** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 420 pounds (\$688). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 12-15. Leaking Underground Storage Tank Workshop** in Atlanta, sponsored by the Georgia Institute of Technology; \$550; \$75 for optional exam. **Also Oct. 23-26.** Education Extension-R, Georgia Institute of Technology, Atlanta, Ga. 30332-0385; 404-894-2400; 800-325-5007.

**JUNE 13-14. Advanced Risk Management Analysis** course in New York City, sponsored by the Risk & Insurance Management Society Inc.; \$545 for RIMS members; \$645 for non-members. **Also Oct. 10-11** in Denver. Risk & Insurance Management Society Inc., Educa-

tion Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 13-14. Captive Forum '90** in Guernsey, Channel Islands, co-sponsored by the Guernsey Financial Services Commission-Insurance Division and Guernsey Insurance Co. Managers' Assn.; 50 pounds (\$81) for corporate insurance buyers; 100 pounds (\$163) for exhibitors; 150 pounds (\$245) for others. Captive Forum Coordinating Center, Studio Two, Pitronnerie Complex, St. Peter Port, Guernsey, Channel Islands; 0481-711676.

**JUNE 14-15. Leaking Underground Storage Tanks: Corrective Action Alternatives** course in Atlanta, sponsored by the Georgia Institute of Technology; \$295. Education Extension-R, Georgia Institute of Technology, Atlanta, Ga. 30332-0385; 404-894-2400 or 800-325-5007.

**JUNE 14-15. Underground Storage Tank Management Course** in Washington, D.C., sponsored by Executive Enterprises Inc.; \$1,045. **Also July 9-10** in Chicago. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 14-15. The Environmental Insurance Law Institute** 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.

**JUNE 14-15. Solving the Workers' Compensation Puzzle** in Ventura, Calif., sponsored by the University of California-Santa Barbara; \$145 for one day; \$250 for both days. Judy Weisman, University of California-Santa Barbara Extension, Santa Barbara, Calif. 93106; 805-961-4143.

**JUNE 18-19. New England Employee Benefits Council's 10th Anniversary Conference and Exhibition** in Boston; \$425 for NEEBC members; \$525 for non-members. New England Employee Benefits Council, 45 William St., Suite 225, Wellesley, Mass. 02181; 617-239-1767.

**JUNE 25-29. Environmental Litigation** course in Boulder, Colo., sponsored by the American Law Institute-American Bar Assn. Committee on Continuing Professional Education; \$725. Registrar, American Law Institute-American Bar Assn, 4025 Chestnut St., Philadelphia, Pa. 19104; 800-253-6397; 215-243-1661.

**JUNE 26. Directors' and Officers' Liability Insurance** seminar in San Francisco, sponsored by the Practising Law Institute; \$350. Practising Law Institute, Dept. 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

**JUNE 27. Environmental and Toxic Tort Claims: Insurance Coverage in 1990 and Beyond** seminar in San Francisco, sponsored by the Practising Law Institute; \$350. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 271.

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.

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NO. 36

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# Equitable names Crystal risk manager

**Ruth Crystal**, 32, has been promoted to risk manager at The Equitable Life Assurance Society of the United States in New York City. In this newly created position, Ms. Crystal is responsible for managing and administering the property/casualty insurance programs of the diversified insurance and financial services company. She reports to Helen B. Terry, vp-risk management. Before joining Equitable in 1987, Ms. Crystal was assistant insurance manager for Turner Construction Corp. and was a sales assistant at Liberty Mutual Insurance Co., both in New York. Ms. Crystal has a bachelor's degree in psychology from the State University of New York College at Purchase and holds the Associate in Risk Management designation.

**James A. Juergens**, 48, has been promoted to vp-risk management of Crowley Maritime Corp. of San Francisco. In this position, he has full responsibility for the corporation's risk management program, including property/casualty insurance, loss control, safety and claims administration. Mr. Juergens replaces **Charles N. Findlay**, who retired, and reports to Kevin O'Rourke, senior vp-legal and insurance. Mr. Juergens, who has been with Crowley since 1981, most recently was director-risk management for the company, which provides marine transportation and related services. Before joining Crowley, Mr. Juergens served in the risk management department of Sea-Land Service Inc. in Edison, N.J. He attended Golden Gate University in San Francisco. Mr. Juergens also is chairman of the Marine Index Advisory Board.

**L. Marilyn Gay**, 35, named assistant vp and benefits manager-human resources of KeyCorp in Albany, N.Y. In this newly created position, Ms. Gay is responsible for the financial services company's pension and welfare employee benefit plans. She reports to Wallace R. Demary, vp of benefits and compensation. Before joining KeyCorp in 1989 as a benefits officer, Ms. Gay was benefit manager at Buckman Van Buren & Fonner in Horsham, Pa. Prior to that, she was a sales consultant at the Prudential Insurance Co. of America, also in Horsham. She holds a bachelor of business administration degree in marketing and management from the University of Pennsylvania's Wharton School of Business in Philadelphia.

**Patricia S. Fisher**, named assistant treasurer of Amoco Corp. in Chicago. In this position, she directs the company's insurance purchasing, banking, short-term investment and borrowing and credit administration operations. She replaces **Steve Gates**, who was earlier named assistant treasurer of corporate finance, and reports to W.R. Hutchinson, vp-treasurer. Ms. Fisher, who joined Amoco as an attorney in 1981, had been a general corporate attorney in the company's law department since 1987. Before joining Amoco, she was an attorney at Isham, Lincoln & Beale in Chicago. She holds a bachelor's degree and a law degree

## Comings & goings: buyers

from Northwestern University in Evanston, Ill.

**Luis Lewin**, 41, named director of human resources operations at the New York Daily News in New York City. In this newly created position, Mr. Lewin is responsible for establishing human resource programs in four Daily News facilities, with an emphasis on the newspaper's plants. Mr. Lewin will be involved in employee benefits, compensation and training, as well as employee communications. He reports to John T. Sloan, vp-human resources. Mr. Lewin was manager of human resources at the Chicago Tribune before joining the Tribune

Co.'s Daily News unit. Before that, he was director of human resources at 7-Up Foods Inc. in Ventura, Calif. Mr. Lewin holds a bachelor's degree in psychology, secondary education and Spanish from Wilmington College in Wilmington, Ohio, and a master's degree in modern languages from Ohio University in Athens.

**Vincent R. Grande**, 27, named asset and risk specialist in the risk management department of Carnival Cruise Lines Inc. of Miami, Fla. In this newly created position, Mr. Grande is responsible for arranging workers compensation and property and liability insurance

for the company's hotels and ships. Mr. Grande, who reports to Michael S. Scheinblum, risk manager, has been with Carnival since 1989, most recently as a tax accountant in the payroll department. Prior to joining Carnival, Mr. Grande was a tax accountant at Weisberg, Brause & Co. in Miami. He holds a bachelor's degree in accounting from Utica College at Syracuse University in Utica, N.Y.

**Kenneth W. Spruell**, 42, named executive vp and general manager of the insurance division of mortgage banker Molton, Allen & Williams Corp. in Birmingham, Ala. In this newly created position, Mr. Spruell has overall responsibilities for the daily operations of the insurance division. He reports to Louis Kulovitz, executive vp. Mr.

Spruell first joined the company in 1985, then took a position in 1987 as managing vp at Alexander & Alexander Inc. in Chattanooga, Tenn. Mr. Spruell returned to Molton, Allen & Williams in January 1990 as executive vp-marketing and branch office operations. He holds a bachelor of business administration degree in real estate, insurance and finance from the University of Montevallo in Montevallo, Ala.

*We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.*

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# Changing times at small firms

## Risk managers delegate more: Survey

By JOANNE WOJCIK

Risk managers at small firms are taking a cue from their counterparts at large companies and delegating more tasks to their staff members, a new survey shows.

For example, fewer risk managers at small firms have direct, hands-on responsibility for benefits administration—what has been a typical duty for risk managers at small firms, the survey found.

Indeed, significantly fewer risk managers at small firms have direct, hands-on responsibility for such typical risk management duties as developing risk financing plans and negotiating coverages and instead have increasingly taken a supervisory role in these areas, according to the survey.

In addition, fewer risk managers at small firms have hands-on responsibility for corporate data security, safety and fire loss control engineering and claims handling, the survey reports.

Typically, large companies with diverse risks need risk managers to specialize and have large enough budgets to allow such specialization, observed Bill Perry, president of Logic Associates Inc., the New York-based executive recruiting

firm that conducted the survey.

But today, "even small companies are getting away from using risk managers as jacks-of-all-trades," he said.

In fact, Logic Associates has noticed a significant increase in demand for benefit managers at companies of all sizes, Mr. Perry noted.

Increasingly complex benefits laws and regulations have made benefit plan administration "much more complicated, and companies need someone" other than a risk manager to handle this area, Mr. Perry explained.

The 1989 Logic Associates survey, which details the varying responsibilities of risk managers at companies of all sizes, is based on the responses of 1,452 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 their counterparts at similarly sized companies (BI, April 30).

The survey respondents are categorized according to company size, with the smallest companies reporting annual sales of \$200 mil-

lion or less, and the largest reporting more than \$7 billion in sales.

The most significant finding in this year's survey was that fewer risk managers at smaller firms are responsible for employee benefits administration, according to Mr. Perry.

The survey found that 50% of risk managers at firms with annual sales of less than \$200 million had direct, hands-on responsibility for employee benefits administration in 1989, down from 57% in 1988, and 64% in 1987 (BI, April 17, 1989; Aug. 22, 1988).

And, 31% had supervisory or advisory responsibility for benefits administration, up from 29% in 1988, and 24% the year before.

An increased percentage of risk managers at the smallest companies had direct responsibility for pension and profit-sharing plan administration—32% in 1989, compared with 29% in 1988.

But, another 32% of risk managers at firms of that size said they were not involved in pension and profit-sharing plan administration.

At companies with between \$201 million and \$500 million in annual sales, 38% had direct, hands-on responsibility for benefits adminis-

### 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	52%	68	58	64	59	77	46
	23%	22	19	15	15	12	20
Negotiation of coverage placement	59	60	69	71	61	65	46
	27	27	18	14	17	15	5
Claims handling	56	57	61	46	37	38	29
	32	23	31	35	52	43	24
Safety/fire loss engineering	54	60	43	36	25	26	15
	36	23	27	39	54	55	44
Data security	50	21	16	10	9	11	5
	27	43	29	33	40	52	15
Benefits administration	50	38	15	17	9	2	5
	31	23	26	22	30	22	27
Pension/profit sharing administration	32	30	15	15	7	4	0
	37	36	13	15	25	8	15

Source: Logic Associates

BI/John Heiland

tration, down slightly from 39% in 1988.

About 28% of risk managers at these companies had either supervisory or advisory responsibility for benefits administration in 1989, compared with 24% the year before.

In addition, 30% of the risk managers at companies of this size

were directly responsible for pension/profit-sharing administration, the same as in 1988.

But a larger percentage—36% last year, compared with 33% in 1988—were responsible for pension/profit-sharing plan administration in either a supervisory or advisory basis.

Continued on next page

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# Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



## Radio, TV gain share of agency ad budgets

### Small agencies move past pencil and calendar ads

By LAURA MAZZUCA

More small agencies are creating formal, multi-media advertising budgets—whether they are located in a metropolis with competition on every corner or in a small town, where advertising traditionally has meant a handshake and a pencil and calendar.

Agents, driven by soft market conditions and increasing competition from direct writers and each other, are carefully directing their advertising dollars and creating formal ad budgets, consultants say.

For example, under increasing pressure from direct writers and New York and Philadelphia agencies, Buckelew & Associates in Toms River, N.J., recently began running television commercials.

"Things are getting tougher in our area, so we decided to advertise," said Brian Buckelew, vp of the \$25 million, family-run agency.

Most of the agency's new business still is generated through referrals, but "the advertising is important because it reinforces the agency's image with people who are already clients of ours," Mr. Buckelew explained.

But not all agencies are devoting more money to advertising.

About 20% of the nation's agencies now have mass media advertising programs, according to Kim Paterson, president of Creative Insurance Marketing, a marketing consultant in Red Bank, N.J.

And if direct-mail campaigns are included, 75% of agents have some kind of advertising campaign (see story, page 52C).

Most of those budgets are woefully inadequate, she says.

"It's true that more of them are formalizing their advertising budgets, but you don't always see the dollars going along with it," she said.

Still, "more agents are realizing that advertising on a hit-or-miss basis is not sufficient," Ms. Paterson said, referring to ads in the Yellow Pages or Little League team sponsorships.

Agencies need formal ad budgets because advertising must be repeated consistently to be effective, Ms. Paterson said.

"Some agents give up if they do not see a dramatic return right away," she said, noting that a formal advertising program is a new way of thinking for agents used to the old pencil-and-calendar method of advertising.

For example, Mr. Buckelew, whose father bought the agency in the late 1950s, was hard-pressed at first to persuade the senior Mr. Buckelew to advertise.

"His attitude was, 'It's a good idea, but it costs a lot of money,'" Mr. Buckelew recalled. "He's from the old school, when they never advertised because they didn't have to. But times have changed, and he realizes that."

Some agencies, aware of the importance of advertising, are increasing their budgets to expand into other mediums.

Capen, Frank, Proctor & Bowles, an agency in Bloomington, Ill., ran ads on a single radio station for 13 years.

Skippy advertising on that one station was a "pet peeve" for Joseph Weidner, operations manager for Capen Frank. Mr. Weidner recently became an agency principal.

The \$9 million agency recently began advertising for executives seeking personal financial services with commercials on cable television's Financial News Network.

Capen Frank's ad budget now has doubled to \$22,000—"still not adequate, but better than it was," Mr. Weidner said.

The agency also is advertising on another radio station. Response to the TV ads has been positive, though results have not been tracked formally, he said.

Billboard space, newspaper and magazine ads and radio and local cable television commercials are all popular outlets for smaller agencies that devote 2% to 6% of their annual revenues to advertising, Ms. Paterson said.

And as agencies become more creative and aware of how advertising dollars can be spent, they are mixing and matching various media, according to Ms. Paterson.

Rue Insurance Inc. in Trenton, N.J., for instance, advertises on a traditional talk/news and middle-of-the-road radio stations.

But the \$24 million agency also runs six different "humorous" spots on a New Jersey rock 'n' roll station, noted President William Rue.

"We're after all of the market," he said.

Northside Insurance Services Inc. of Atlanta spends most of its \$100,000 annual advertising budget on direct mail and cable TV. But part of the budget goes for shopping cart signs at a local gourmet market catering to the affluent, said agency President Jerry T. Hargrove, currently Insurance Marketing Services' Marketeer of the Year.

Northside's ad budget represents about 6% of its \$1.7 million of premium volume.

A likeness of Dennis Young on a huge billboard looming over the Texas-Arkansas state line is another example of agency creativity.

Mr. Young, president of Dennis Young Insurance, a \$2 million agency in Texarkana, Ark., also spends about \$1,000 a year on radio commercials during local high school football broadcasts and some National Collegiate Athletic Assn. basketball tournaments.

Agents need no longer rely solely on such conventional media, consultants say.

For example, with advances in affordable technology, agents can run direct-mail ad campaigns from their offices

*Continued on next page*



# Tracking success of agency advertising

So, your formal advertising budget is lined up, and you're running spots on the local cable TV station and in the local newspaper as well as sending out some direct mailings.

But how can you tell which of these methods is working—and working best?

One way to tell is by using a "tracking form," according to Kim Paterson, president of Creative Insurance Marketing in Red Bank, N.J.

With this method, a producer or customer service representative queries call-in or walk-in prospects on how they heard about the agency.

The reply is marked on a form listing each type of advertising an agency uses.

Producers and customer service representatives should further note on the form whether prospects develop into clients, what type of coverage was sold, and if no coverage was written, why not, Ms. Paterson said.

Ms. Paterson also advised agencies to briefly suspend ad campaigns to see if prospective clients contacting the agency during this period remember the agency from its suspended campaign. This tells the agency how strong an agency image the campaign is establishing.

She also recommended suspending ad campaigns during July and the Christmas holidays, when few people are looking to buy insurance.

Before an ad campaign, agencies should test name recognition with a "benchmark" survey, she said. Prospects in the area who meet an agency's target audience profile should be surveyed.

Once a campaign is underway, the group should be surveyed again, she said.

Referring to the benchmark surveys she conducted for an agency client, Mr. Paterson said: "You could see the increase in public perception, and it was dramatic. It's not 100% accurate, but it is quantifiable."

Agents agree that determining the success of any advertising campaign is difficult—and in some cases impossible.

"You either believe in advertising or you don't," observed Marcus Payne, executive vp and chief operating officer for Crump E&S Group in Dallas, which predominantly advertises in print.

The brokerage has tried several times to quantify its programs' success, but has never developed any substantive statistics—unless the advertising was for a specific program, Mr. Payne said.

In many cases, especially in small markets, the best way to determine a campaign's success is to just sit back and listen.

"My billboard must be working, because everybody says they're sick of it," quipped Dennis Young, president of Dennis Young Insurance in Texarkana, Ark.

In the nine months the billboard has been up, "we've had more calls than we've ever had about health insurance," Mr. Young noted. The agency sells health insurance, but it's advertised only in the Yellow Pages and on the billboard, he said.

—By Laura Mazzuca

## Direct mailings

*Continued from previous page*

At about 17 cents per piece, the 83,000 mailings cost the agency about \$14,000 a year.

Agent James Erskine used a direct mail campaign to drum up business when he was forced to start an agency from scratch in Wallingford, Conn., a town of about 100,000, when the cluster he was involved in failed two years ago and lost some contracts with insurers.

The three insurers that James Erskine & Co. represent are noted for their personal lines, so Mr. Erskine and his sole producer targeted homeowners coverage.

"I'm a dyed-in-the-wool commercial man, but when you're starting from scratch again, it's good to have personal lines as a base," he said.

Searching for leads in state listings of property transactions proved long, laborious and fruitless, he said.

But one day while Mr. Erskine and his producer were driving through a particularly attractive residential part of town, Mr. Erskine came up with the idea of taking photos of the houses and including them in a direct mail campaign.

Most of the homes were about 15 years old with insured values of between \$150,000 and \$200,000.

Letters—including a photo of each house—were sent to each homeowner.

The letter complimented the homeowner on the home's appearance and said the agency might be able to offer the owner less costly homeowner's coverage.

Producers were given photocopies of those pictures to use in fol-

low-up calls.

During those calls, producers ask prospects for coverage expiration dates and ask whether the agency can send them information.

Its success rate so far is almost 50%, since "we're only after an expiration date on that call," Mr. Erskine said.

Some 480 letters have netted 213 homeowners expiration dates and 190 auto coverage expirations dates.

While Mr. Erskine said he is "afraid to" determine the total cost of the campaign, he estimated that factoring out the producer's phone follow-up time, the campaign costs about \$3 per letter, or about \$1,200.

But the agency has generated about \$200,000 in premiums from the campaign, he said.

The agency's annual premium volume is now about \$386,000. Mr.

Erskine is optimistic that his unorthodox direct mail technique is helping to fill the coffers.

"Give me a call again in about a year," he quipped. "If I'm still here, you'll know it's working."

For many other agencies, though, direct mailing is part of a bigger print advertising campaign.

BRI Coverage Corp., a New York brokerage with 1988 gross revenues of \$31.9 million, uses a one-two punch.

Direct mail and trade journal ads promote new programs like coverage for asbestos abatement contractors, said partner Howard Miller.

Other agency advertising programs are designed to attract other potential insurance buyers, including demolition contractors and furriers.

BRI's annual ad budget is about \$100,000. ■



# Expert says results key, not desk clutter

By LAURA MAZZUCA

ORLANDO, Fla.—A lifetime of nagging parents, ruler-wielding teachers and tyrannical bosses have taught agency employees—and principals—to always “look busy.”

But employees who fill their working hours with busywork are actually wasting time that could otherwise be used to increase efficiency and profitability, according to Michael Fitzpatrick, president of Mullan Insurance Services Inc. in Toledo, Ohio.

Mr. Fitzpatrick discussed “Management by Breathing—or by Results?” at the 17th International Insurance Marketing Services annual convention April 18-22 in Orlando.

In what he calls “management by

breathing,” both managers and employees measure success and productivity not by what they do, but rather by “the number of deep sighs and clutter on the desk,” he said.

The manager in such an office becomes an “overseer,” stalking past desks and constantly demanding to know what everyone is up to.

But often when “overseers” ask employees to perform additional tasks like cold calling, staffers tell them that they “don’t have the time,” which is usually true because they are not only doing their jobs but trying hard to “look busy” the rest of the time, Mr. Fitzpatrick explained.

“We felt, assumed and guessed—but didn’t know—what was happening in our own office,” he said. “Man-

agement by looking busy becomes a game, and nobody knows the rules.”

The Mullan agency learned its lesson about promoting efficient work methods when its customer service representatives became irate in the mid-1980s with his “Mike the Terrible” management style, he said.

Since then, Mr. Fitzpatrick and his staffers have developed what he calls “management by results.”

Under this method, performance of individuals and the staff as a whole is tracked based on actual activity, not on whether they “look busy.”

Employees keep track of each daily task they perform and indicate how many times they perform each task.

Activities, tallied daily by each employee, are tracked on a weekly,

monthly and annual basis using a computerized spreadsheet system.

Agency principals are able to track employee productivity, and also to pinpoint peak seasons, spot work flow problems, and add staff when needed, Mr. Fitzpatrick said.

The system also can be adapted for principals and producers to track their own productivity by specific tasks, such as calls made and paperwork handled, Mr. Fitzpatrick said.

Under a “management by results” approach, the agency manager changes from Simon Legree to a “coach” in his staffers’ eyes, Mr. Fitzpatrick said. Under this system, “we want to score points and ensure that the other team doesn’t score more points than us.”

This is achieved by giving “players” specific instructions that they can understand and follow, as well as by tracking and reviewing their performance.

To determine how much time was being spent on various tasks, the Mullan agency’s staffers first defined the tasks that are performed by employees throughout the workday.

These include processing mail; taking incoming phone calls; talking with walk-in clients; securing expiration dates; processing claims and renewals; making quotes; tracking suspense items; making policy changes; increasing policy limits; and finding and noting insurer errors.

Staffers then estimated the average time it took to finish each task.

Processing mail, they estimated, took five minutes per piece. Telephone calls each took five minutes; walk-in clients took 15 minutes per transaction; and quotes took 30 minutes each, the staffers calculated.

Those times will vary from agency to agency, said Mr. Fitzpatrick.

Using these estimates, a manager or principal can determine how much employees are working each day by multiplying the average time per task by the number of tasks performed.

Although Mr. Fitzpatrick’s records indicate that Mullan employees work an average of 5.5 hours per day, he is happy to pay them for 7.5 hours because he asks them to fill in a portion of those two hours by making 10 cold calls daily. Once staffers do their regular work and make these calls, he says he does not care how they spend the rest of their day.

Mr. Fitzpatrick says his system also would help time management experts plan for “demand contact” phone calls—calls from clients needing immediate attention.

Planning agency work schedules around these unanticipated calls is difficult, he says. But Mr. Fitzpatrick said his own system takes these calls into consideration by counting each incoming call and then tracking the outcome of the call by the type of service provided.

“Management by results” works because the manager does not establish arbitrary goals—goals are set by the staffers themselves, he said.

It is also beneficial because it can be used to determine when to hire more personnel if the workload gets too heavy, he said.

Mullan’s rule of thumb is that if CSRs are handling more than 22 calls daily, another CSR should be hired. That figure probably will vary among agencies, he said.

The system also creates a good atmosphere in the office because it allows each employee to measure his or her own performance daily. “There’s some satisfaction in knowing that you accomplished all that in one day,” Mr. Fitzpatrick said.

However, he cautioned that the program cannot be used with an agency staff that already is suffering from the “management by breathing” malaise unless managers interested in using the system first meet with the agency’s staff to introduce it and explain why it is being launched.

Without that consultation, the result would be failure, resistance and resentment from staffers because they would take the attitude that “we don’t have time” to implement the system.

It is important to stress that the system is confidential and that only the manager knows each employee’s performance level, he said.

Employees also should be told that it only takes between four and six minutes each day to tally up their daily performance.

The system should be considered permanent, and it will provide useful comparative information, Mr. Fitzpatrick said.

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# Agent recounts disastrous buying spree

By LAURA MAZZUCA

ORLANDO, Fla.—Expansion through buying out even the most lucrative agencies can end in disaster unless good middle managers and standardized accounting and management hold the deals together, says an agency principal.

Once a disciple of high-profile acquisition, Charles Nielson is now chief financial officer of Collinsworth, Alter, Nielson, Fowler & Dowling Inc. of Miami Lakes, Fla.

He recounted how his highly successful agency, lacking a middle management layer, ran itself into the ground through rapid acquisitions during a speech at the 17th international Insurance Marketing

## Chastened principal touts slow growth

Services convention last month in Orlando, Fla.

The principals of that agency eventually joined another agency with \$30 million of annual premium volume.

But Mr. Nielson said he learned a lesson when his agency crumbled after acquiring and trying to absorb 60 agencies within 18 months during the soft market of the early 1980s.

"To absorb so many agencies in so short a time is suicide," he said.

Despite a growth program based on the aggressive approaches of

some alphabet houses, overexpansion hurt not only the purchasing agency and its partners, but "the good, honest agents who aligned themselves with us," he said.

The agency's problems began in 1978.

At the time, Mr. Nielson's agency—Stevenson, Collinsworth & Nielson—was "doing exceptionally well" with two offices and an annual premium volume of \$12 million. As one of three partners, he "very, very tightly managed" the agency.

SCN then embarked on an ag-

gressive acquisition program.

"We knew exactly where we wanted to go with the program and how we wanted to structure our purchases," Mr. Nielson said.

With \$250,000 in cash, the agency made down payments on 60 agencies with a total premium volume of about \$60 million a year.

SCN acquired agencies in California, Salt Lake City, Rhode Island, Illinois, Miami and other areas, Mr. Nielson said.

Acquired agencies were consolidated into 13 locations in eight territories.

For management purposes, SCN appointed one agent in each territory as supervisor of that region and made that agent a stockholder in SCN.

At first, things looked great.

Mr. Nielson hit the speakers circuit to spread the word on SCN's phenomenal growth. He addressed meetings of the IMS, the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America, where even more agents became interested in selling their businesses.

"I was like a kid in a candy store," Mr. Nielson recalled.

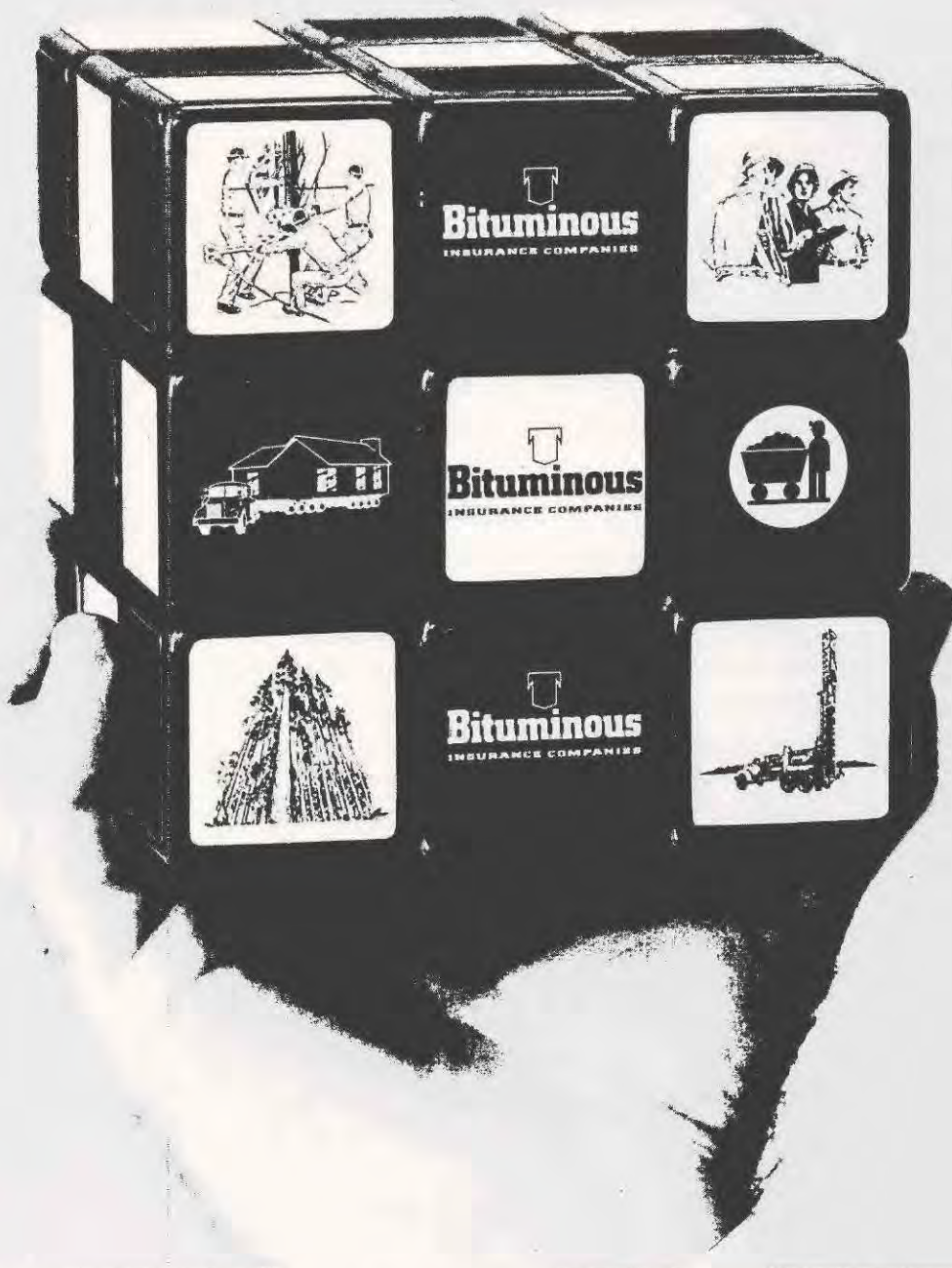
After 18 months of aggressive acquisitions, the numbers looked good: The expanded agency was producing \$70 million in annual premium volume and \$7.5 million in commissions.

Acquisition plans used by some alphabet houses served as a model. But SCN neglected to follow their management style after such acquisitions.

After a national brokerage acquires an agency, it typically sends in a middle manager to bring the accounting and management systems into line with the brokerage's standards, rather than expecting the former agency principal to do the job, according to Mr. Nielson.

Middle managers should spend at least two years getting acquired agencies into shape, he says now.

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**'To absorb so many agencies in so short a time is suicide,' says agency principal Charles Nielson.**

But SCN's main office then consisted of only executives and producers. The agency "virtually had no middle management" to run its many acquisitions, Mr. Nielson explained.

Territory managers were selected from some of the most successful acquired companies. Those agents, however, did not necessarily have the skills to manage an entire region, Mr. Nielson said he found out.

"You can't leave the management of a region to a person just because he has been there before," he observed.

Problems arose when these managers acted autonomously rather than conforming to SCN management policies, he said.

Another problem: Each regional headquarters was running on a different accounting system and all were different from the main office.

"You can't expect them to run a business for you without some firm procedures," Mr. Nielson said.

Producers at acquired agencies, many of whom held stock in their own agencies, also posed problems, Mr. Nielson said. Despite vows of allegiance to the new owners from many of these employees, he "could count on one hand how many of these people worked out."

Mr. Nielson said that agency ownership by several producers complicates management, "because you must assume that 80% of the producers will walk."

He suggests now that an acquiring company own at least 70% of the agencies it purchases.

Forced to travel between offices to help manage the acquisitions, Mr. Nielson had less time to take care of his own book of business, which centered on surety bonds for

Continued on next page

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Continued from previous page  
contractors.

He had to divide that business among four other producers who eventually stole it away, he said. Today, two of his major competi-

existing client base to "expand on what we have," he said.

It operates out of only two offices in Florida, one of which handles only the agency's bond business, Mr. Nielson said.

**'Real growth is a matter of going slow and realizing that whatever you have has to be managed,' says Mr. Neilson, whose agency now has only two offices. 'If that's stagnation, then it's working wonderfully for us.'**

tors are former SCN producers. "As if the expansion problem wasn't enough, I gave them my business," he said.

When newly acquired agencies began slipping, things really began to fall apart. Soon the new offices—especially in California—needed cash from SCN's successful Miami office, Mr. Nielson said.

Poor management and soft market conditions cost the once booming new acquisitions business. Premium volume was off by 50% at some offices, Mr. Nielson said.

Like a substance abuser, Mr. Nielson said, he still could not admit that he was in big trouble.

"It's a big setback to you personally to face the fact that you screwed things up," he said. "All I was willing to admit for awhile was that the market was bad. I was blaming it on that rather than admit that our structure was flawed."

Meanwhile, SCN Principal W. Meade Collinsworth in 1981 felt SCN was headed for trouble and left to open his own agency.

By 1982, it became apparent things were not working when the agency "ran out of cash."

After three years as a cash cow for the failing operations, the Miami office finally ran dry.

The agency's principals faced reality: They had to divest themselves of all the acquisitions, returning books of business to principals where possible.

In essence, the agency "gave back" the acquired agencies to the former owners. Ironically, agencies that had been struggling while they belonged to SCN became productive again after they were divested, he said.

With the acquisitions gone, Mr. Nielson went back to Miami thinking: "Maybe I can produce our way out of this hole."

He started over with a new book of business and kept in daily contact with his bank on how many premium checks came in and were cleared since the agency was operating at a "huge" deficit. "We knew to the penny what we had," he said.

The agency's insurers were "magnificent" and helped work out payment arrangements, he said.

Despite "producing like crazy," it was too late, he said. "The hole was just too deep, and we found that we found that we couldn't survive because of problems we had."

The bottom fell out in 1984 when a former SCN agency, since sold back to the original owners at a loss, sued, charging SCN still owed \$700,000 from the acquisition.

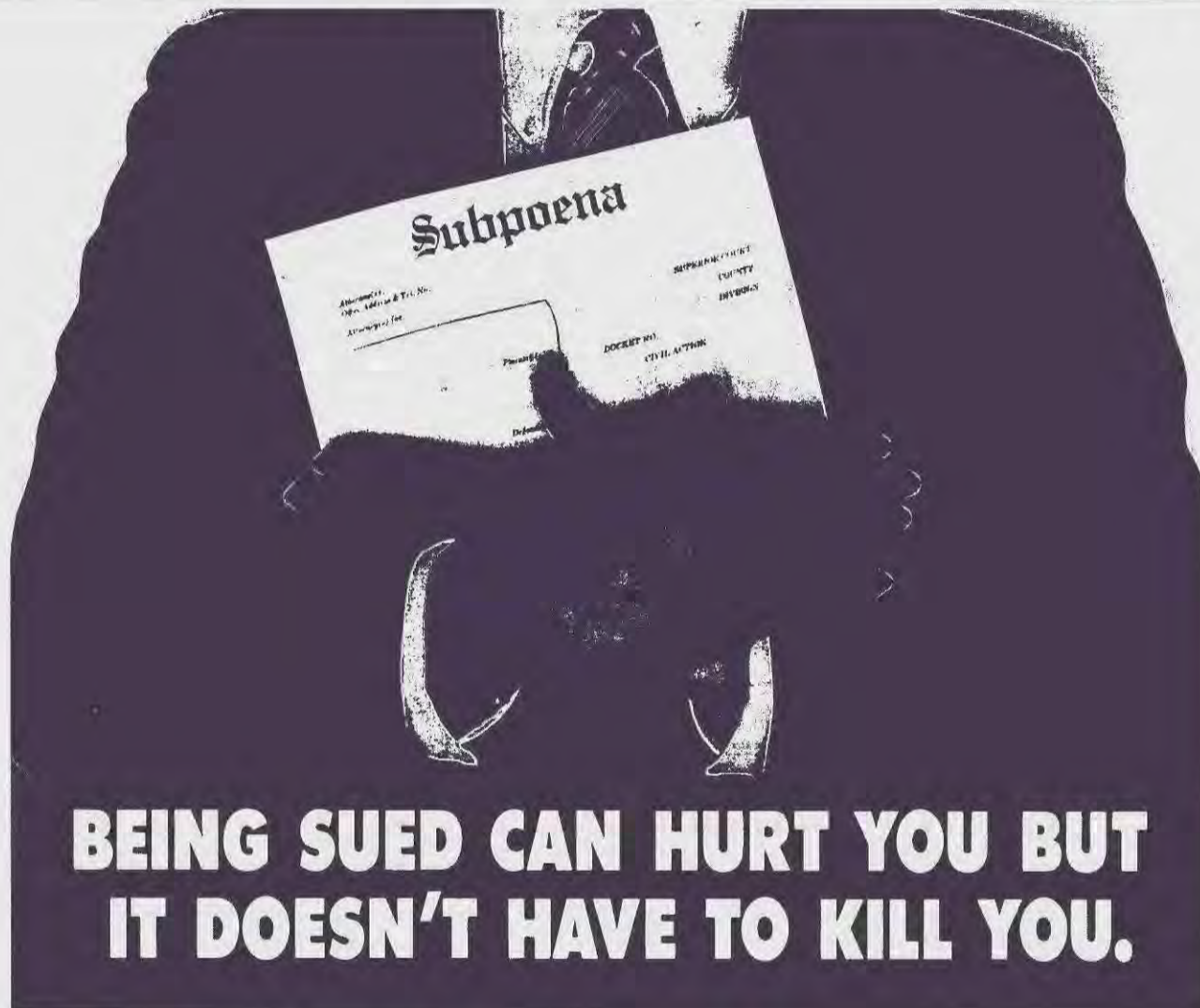
SCN declared bankruptcy. It arranged for another agency to handle its book of business, with SCN principals managing the business.

Eventually all insurers were paid and all clients taken care of, he said.

In 1986, the remaining principals of SCN reunited with Mr. Collinsworth, taking with them their \$1.2 million book of business.

Today, the Collinsworth agency is growing only through internal expansion, mining deeper into its

"We've learned that real growth is a matter of going slow and realizing that whatever you have has to be managed. We don't want to go anyplace. If that's stagnation, then it's working wonderfully for us," he said.



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# Buyers should exceed environmental laws: Expert

By LAURA MAZZUCA

CHICAGO—Agents and brokers must keep up with and understand changes in environmental laws to give clients the best advice possible, according to an environmental impairment liability consultant.

However, simply complying with environmental regulations is not enough to protect business owners from liability, said Richard Schlosser, vp and consultant with M&M Protection Consultants, a Chicago-based division of Marsh & McLennan Cos. Inc.

Insurance buyers should be encouraged to do more than regulations require on environmental concerns like underground storage tanks and hazardous waste, Mr. Schlosser said at the annual Chicago Insurance Day held April 26.

"Federal regulations should be used as a floor, not as a ceiling" when advising a client on environmental liability, he said.

For example, a small business with a heating oil supply stored in a small underground tank is not subject to the U.S. Environmental Protection Agency's financial re-

sponsibility rules for owners and operators of USTs, he said.

But such a tank may later create liability exposures because of leaks or other problems "if you haven't done whatever you need to do to control your own environmental risk," said Mr. Schlosser.

Increased awareness of environmental issues by society—coupled with a litigious society as a whole—has made people more likely to sue a business over environmental exposures in the 1990s, he said.

The good news, however, is that businesses are becoming increasingly aware of their environmental exposures and will take precautions to protect themselves against losses, especially if they are steered in that direction by an agent or broker, he said.

The three most common environmental liability exposures are asbestos, underground storage tanks and hazardous waste.

Under the 1986 Asbestos Hazard Emergency Response Act, or AHERA, asbestos in public and private schools must be controlled or removed.

Under that law, asbestos can be

"controlled" by encapsulating it and testing it regularly to determine whether it is a health risk, he said.

Some states also are passing legislation that requires building owners to notify tenants if airborne asbestos levels exceed specified limits, Mr. Schlosser said.

But he warned that the asbestos removal process can be risky because removal, if done improperly, can cause even higher airborne asbestos levels.

Agents and brokers should advise clients with possible asbestos liability exposures to determine the amount and condition of asbestos in any buildings they own, Mr. Schlosser said.

And agents and brokers should stress the importance of dealing with only reputable asbestos removal contractors—preferably those approved by the EPA under AHERA—and carefully monitoring all projects.

When asbestos is being removed, the business owner should document the contractor's job log.

This will indicate whether there was any leakage from the asbestos

work area, how any leaks were handled, the amount of asbestos removed, and the names and addresses of workers and supervisors involved, Mr. Schlosser said.

Regulation of underground storage tanks differs among the states, though state laws must incorporate the basic goals of federal EPA rules on preventing leaks and imposing financial responsibility on owners and operators of USTs.

Tank owners and operators must notify either the state or the federal government of the number and condition of any tanks on their premises.

An owner planning to close or abandon a tank must notify the federal EPA within 30 days.

As in asbestos removal, the UST owner must document any tank removal work done by a contractor.

And, if an owner or operator suspects a leak, a short- and long-term plan of action must be submitted to the federal EPA.

Again, the best rule of thumb is careful record keeping of any action taken, of repairs and of upgrading, Mr. Schlosser said. He suggested keeping at least a three-

year annual record of site assessment results.

Mr. Schlosser also stressed the importance of owners and operators establishing a written, formal tank management program, which should include an inventory of tanks and their condition; registration of each tank; action plans in the event of leaks; and closure and abandonment procedures.

UST owners and operators can meet those financial responsibility requirements through insurance, self-insurance, surety bonds, letters of credit from the business's bank, or state funds (*BI*, Nov. 20, 1989; Oct. 31, 1988).

Agents and brokers with manufacturing clients producing hazardous wastes should urge their clients to establish waste generation controls and consider replacing hazardous materials with non-hazardous substitutes whenever possible, Mr. Schlosser said.

Those companies also should develop a computer tracking system for their inventory of hazardous materials to ensure proper storage and stocking to avoid chemical contamination, he suggested. ■

# E&O manual available for independent agents

Agency management consultants Kurdziel & Associates and the Independent Insurance Agents of America have developed "E&O Risk Management," a procedures manual for independent agents.

It is designed for use by all agency personnel and constructed around a

## A/BT product & services

system for new business and renewal processing, as well as a single method for processing claims, renewals and endorsements.

Sections are included on errors and omissions and automation; E&O and insurers; how to use E&O controls; and monitoring controls.

Also included are sample forms, including an agency checklist for marketing a risk; quotation summary sheet; proposal checklist; binding authorization; and summary of current insurance coverage.

Cost is \$89.95 for members and \$149.95 for non-members.

For more information, contact Kurdziel & Associates, Interchange Suite 295, 5780 Peachtree Dunwoody Road N.E., Atlanta, Ga. 30342; 404-256-9199; or 800-458-2024, extension 7.

## Planning for profit

A new guide is designed to help agents better position themselves with insurers and ride out changing markets.

"Profitable Business Planning Guide: How to Build and Implement Your System," is put out by the National Assn. of Professional Insurance Agents.

The guide is designed to help lower expenses, increase income and chart a marketing plan to achieve goals both for agencies and for their insurers.

Agencies can analyze their strengths, weaknesses, various opportunities in the market, and their budget and management needs, as well as develop profit-building strategies and retain existing clients.

The trade group's planning guide costs \$149.

It was formerly offered as part of the Profitable Business and Financial Planning System, with computer software and videotape, which is also available for \$495.

For information, call the PIA at 800-742-6900, or FAX credit card orders to 703-836-1279.

## Sales training course

PML Marketing Group of Chicago, an independent marketing consulting firm, has developed a training course for health care insurance and insurance services marketing professionals.

The course, "Making Effective Presentations," is designed exclusively

for insurance agency marketing personnel who sell health care insurance and insurance-related services to corporate buyers.

The two-day program—an interactive, hands-on session conducted on-site—features role playing. Sessions are videotaped and reviewed by participants and leaders for comment and analysis.

The client agency retains all tapes after the course is completed.

The "Making Effective Presentations" program, which includes a 100-page manual and the videotapes, costs \$325 per person.

For more information, contact Paula Lundell, president, PML Marketing Group, P.O. Box 9113, Winnetka, Ill. 60093; 312-446-5155.

## E&O loss control

IGS Educational Software of

Bryan, Texas, has released an Errors & Omissions Loss Control program for insurance agents on a self-paced training diskette usable on IBM-compatible personal computer systems.

The program, which emphasizes E&O recognition and control, reviews major client and insurer responsibilities, examines 20 specific problem areas, offers examples and case studies and suggests how to prevent E&O claims.

The E&O program also includes review questions.

The program is available through Agency Management Services Inc. for \$120 for a single user and \$150 for multiusers.

For more information and a listing of other IGS programs, contact Agency Management Services Inc., P.O. Box 1009, Bryan, Texas 77805; 800-456-5272. ■



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However, risk managers at larger companies were no less likely to handle benefits administration.

For example, 15% of risk managers at companies with \$501 million to \$1 billion in sales had direct, hands-on responsibility for benefits administration, up from 13% in 1988. Benefits administration was handled on a supervisory or advisory basis by 26% of risk managers at these companies, the same as 1988.

But, the percentage of risk managers at these firms that reported direct responsibility for pension/profit-sharing administration dropped to 15% last year, from 16% in 1988.

About 13% of risk managers at firms in this category had supervisory or advisory responsibility for pension/profit-sharing plan administration in 1989, up from 11% in 1988.

Of those at companies with \$1 billion to \$2 billion in annual sales, 17% reported direct, hands-on responsibility for benefits administration, the same as 1988.

Twenty-two percent of risk managers at companies of this size had supervisory responsibility of benefits administration in 1989, up from 21% in 1988.

The percentage of risk managers at firms of this size that were directly responsible for pension/profit shar-

## Survey finds risk managers like exercise

To relieve stress, risk managers don their running shoes or hit their exercise bikes, according to a new lifestyle survey.

Risk managers appear to need such relief, since the overwhelming majority work long hours and regularly take their work home, according to Logic Associates Inc.'s first survey on U.S. risk managers' lifestyles.

About 64%, or 930, of the 1,452 respondents to the poll on compensation and responsibilities say they exercise regularly.

Most of them, 72%, prefer running.

And, nearly two-thirds reported using stationary bicycles.

Less common activities include racquetball, cited by 26%; outdoor bicycling, 10%; tennis, 7%; and golf, 2%.

Twenty-three percent of the risk managers surveyed have fitness centers at their workplace.

"Other methods utilized to reduce or relieve stress included listening to music and reading," said Bill Perry, president of Logic Associates, a New York-based recruiting firm that specializes in risk management.

On average, risk managers work 50 to 55 hours a week, the survey found. And 53% regularly take work home with them.

In fact, so many risk managers are taking work home that home computers have become a recruiting perk, Mr. Perry said.

"A lot of companies are paying for risk managers' home PCs, with a modem and second phone line to use in case of snow days" or other times when they cannot get to the office, he said.

Risk managers on average receive three to four weeks of paid vacation annually, but the survey found that only 65% of them took that entire amount.

Despite the long hours, risk managers appear to be happy with their jobs: Only 8% of those surveyed have changed employers in the last year.

The survey also reported that:

- 18% smoke.
- 2.3% have lost their jobs due to a merger, acquisition or buyout.
- 80% are married.
- 28% have been divorced at least once.
- 53% consider themselves proficient in the use of a personal computer.

—By Joanne Wojcik

ing plan administration also remained unchanged, at 15%.

Another 15% of risk managers in this category handled these duties in either a supervisory or advisory capacity in 1989, up from 14% the previous year.

Nine percent of risk managers at companies with \$2 billion to \$4 billion in annual sales were responsible for benefits administration in 1989, up from 7% in 1988.

And 30% of risk managers at these firms played either a supervisory or advisory role in benefits administration last year, up from 29% the previous year.

In addition, 7% of these risk managers had direct responsibility for pension/profit-sharing administration in 1989, compared with 6% the previous year. Pension/profit sharing plan administration was handled on either a supervisory or advisory basis by 25% of risk managers in this category, up from 24% in 1988.

At companies with annual sales of

*Continued on next page.*

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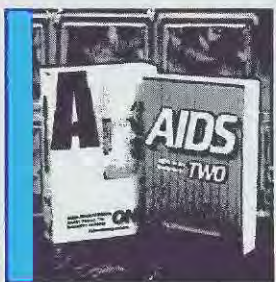
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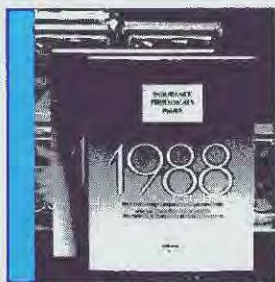


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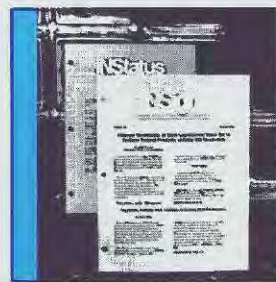
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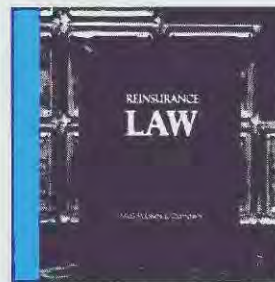
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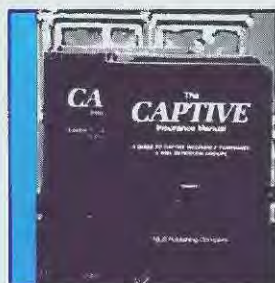
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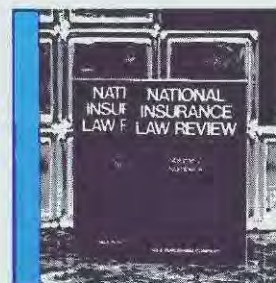
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## Risk exec survey

*Continued from previous page*

\$4 billion to \$7 billion, 2% of risk managers reported having direct responsibility for benefits administration, up from 1% in 1988.

About 22% of these risk managers took either a supervisory or advisory role in benefits administration during 1989, up from 20% the previous year.

Four percent of these risk managers were directly responsible for pension/profit sharing administration in 1989, the same as in 1988.

This duty was handled on either a supervisory or advisory basis by 8% of risk managers responding to the survey, up from 5% last year.

And fewer risk managers at the largest companies—those with sales exceeding \$7 billion—were directly responsible for benefits administration last year, the survey found.

At these firms, 5% reported having direct involvement in this area during 1989, compared with 7% in 1988. In addition, 27% reported su-

perisory or advisory involvement in benefits administration in 1989, down from 33% the previous year.

None of the risk managers at the largest companies reported direct, hands-on responsibility for pension/profit sharing administration last year, the same as in 1988. Fifteen percent reported having either a supervisory or advisory role in pension/profit sharing administration during 1989, down from 22% in 1988.

While arranging risk financing mechanisms and negotiating commercial coverage continue to be risk managers' predominant responsibilities, Logic found that significantly fewer risk managers at smaller firms were directly responsible for each of the five risk management functions about which they were surveyed (see chart, page 52).

For example, at firms with less than \$200 million in annual sales, 52% of risk managers had direct responsibility for risk financing, compared with 55% in 1988. But, risk financing was handled by 28% of

these risk managers on a supervisory or advisory basis in 1989, compared with 23% the previous year.

About 68% of the risk managers at firms with \$201 million to \$500 million in annual sales had direct, hands-on responsibility for risk financing in 1989, down from 72% in 1988. But 22% of these risk managers handled this responsibility in either a supervisory or advisory capacity last year, up from 19% in 1988.

The change at large firms for direct, hands-on responsibility of risk management duties was also down.

For example, risk financing was the direct responsibility of 77% of risk managers at companies with \$4 billion to \$7 billion in annual sales, down from 81% the previous year.

This duty was handled on either a supervisory or advisory basis by 12% of risk managers in 1989, up from 9% in 1988.

Significantly fewer risk managers at small companies also were directly responsible for negotiating with commercial insurers, the survey found.

At firms with less than \$200 million in annual sales, 59% of risk managers were directly responsible for coverage placement in 1989, down from 68% in 1988.

At companies with \$201 million to \$500 million in sales, coverage negotiations were handled directly by 60% of risk managers in 1989, down from 62% in 1988.

And at companies with \$4 billion to \$7 billion in sales, 65% of risk managers were directly responsible for commercial coverage negotiations, down from 67% in 1988.

Many risk managers at small companies also shifted from direct supervision of claims handling to a supervisory role.

For example, 56% of risk managers at companies with less than \$200 million in sales had direct, hands-on responsibility for claims handling in 1989, compared with 65% in 1988. But 32% of these risk managers reported supervisory or advisory responsibility for claims handling, up from 24% the prior year.

Direct responsibility for claims handling rested with 57% of risk managers at companies with \$201 million to \$500 million in 1989, down from 59% in 1988. Another 28% of these risk managers reported having supervisory or advisory responsibility for claims handling, up from 27% in 1988.

At larger companies, where fewer risk managers have hands-on responsibility for claims, there was little change from the previous year.

For example, at companies with \$4 billion to \$7 billion in annual sales, 38% of risk managers were directly responsible for claims handling, the same as in 1988.

Another area in which risk managers of small companies are becoming less directly involved is safety/fire loss control engineering, the Logic Associates survey shows.

More risk managers at small firms are delegating that responsibility, the survey found.

For example, at companies with less than \$200 million in sales, 54% reported direct responsibility for safety/fire loss control engineering, down from 59% in 1988.

And, 36% of risk managers at these companies played either a supervisory or advisory role in safety/fire loss control engineering last year, up from 24% the previous year.

At companies with \$201 million to \$500 million in sales, 60% of risk managers said they were directly responsible for safety/fire loss control engineering, down from 62% in 1988.

About 23% were involved on either a supervisory or advisory capacity, up from 22% in 1988.

Only at the smallest companies did a significant portion of risk managers—50%—still have direct responsibility for corporate data security, the survey found.

Copies of the survey are available for \$60 each from Logic Associates, 70 Broadway, Suite 1208, New York, N.Y. 10038; 212-227-8000.

## More women managers seen

Women are continuing to make inroads into the risk management profession, a new survey shows.

"The numbers (of women risk managers) are going up each year," said Bill Perry, president of Logic Associates Inc., which conducted the survey.

In addition, women risk managers are relatively common at financial service companies, the survey showed.

However, there has not been a significant increase in the number of women breaking into the ranks of risk management with the "big boys"—firms with more than \$4 billion in annual sales, Mr. Perry pointed out.

Women accounted for more than 19%, or 278, of the 1,452 risk managers responding to the 1989 survey, up from 18% the previous year, he said.

Most women risk managers are employed by smaller companies, Mr. Perry noted.

For example, 22%, or 58, of the risk managers at companies with less than \$200 million in sales were women, up from 20%, or 42, in 1988, the survey showed.

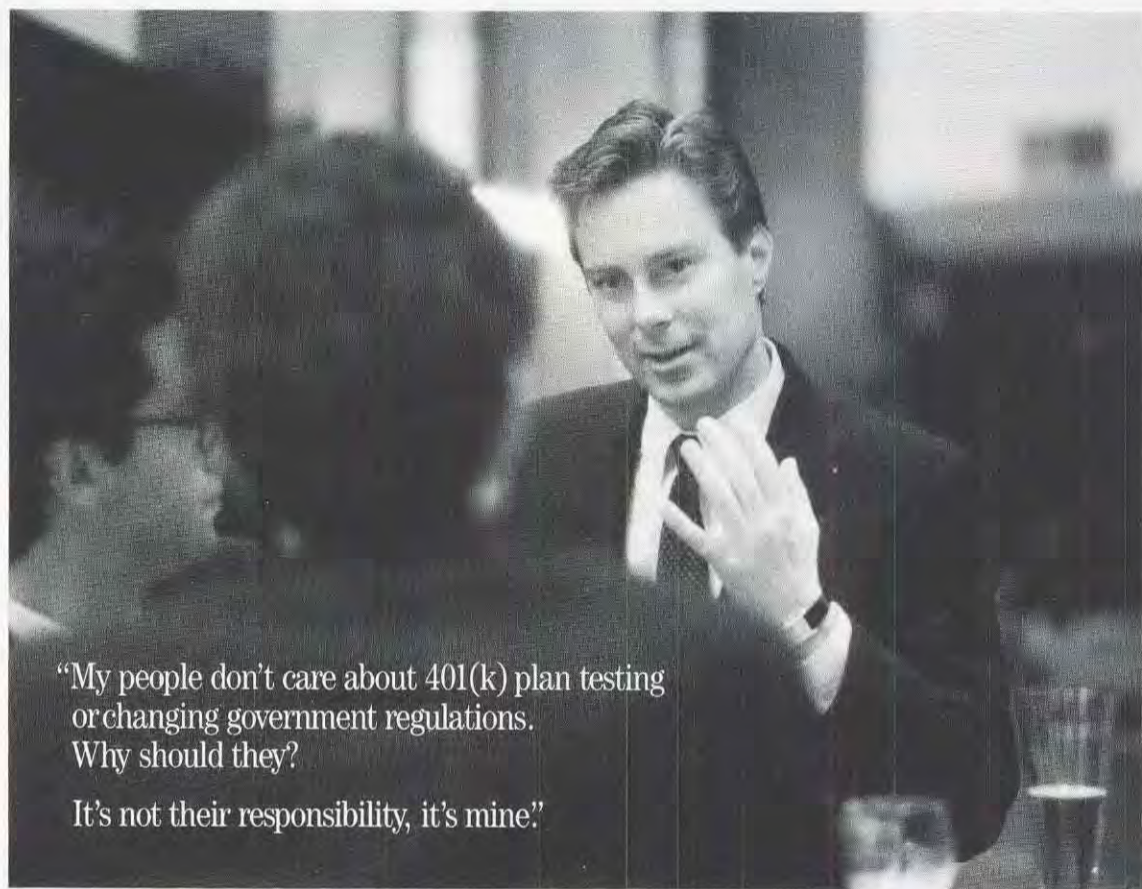
And, at companies with between \$201 million and \$500 million in sales, 26%, or 85, were women, up from 24%, or 71, the previous year.

Women are more likely to find risk management jobs at large companies in the financial services industry, according to the survey.

Risk management posts were held by women at 26%, or six, of the surveyed financial services companies with sales exceeding \$7 billion in annual sales.

However, there are no year-to-year comparisons since 1989 was the first year this data was collected, he explained.

—By Joanne Wojcik



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## Fraud probe

Continued from page 1

While the North Carolina Insurance Department cannot require Travelers to honor the claims, it would like to see the insurer do so and has held two meetings with Travelers' representatives to discuss the problem, said Tony Higgins, senior deputy insurance commissioner.

Mr. Higgins said he feels Travelers should honor the claims because it allowed the program to run for several months without adequate funding from Cap Staffing. He added that promotional literature, claim forms and other material used by Cap all bore Travelers' name and logo.

"I feel for (Travelers) for the \$860,000 they're out, but I feel more for the people with \$1.3 million in (unpaid claims) outstanding," Mr. Higgins said. "The Cap insureds cannot be expected to know the intricacies of the insurance business.

"It's very frustrating to us to feel as impotent as we do on this," he added, explaining that the most the Insurance Department has been able to do to help Cap insureds is to suggest they sue Travelers.

So far, three lawsuits have been filed against Travelers in North Carolina state courts by workers stuck with unpaid medical bills or by employers suing on workers' behalf, according to A. Todd Brown, a lawyer with the Raleigh, N.C., firm of Hunton & Williams, who represents the insurer.

Two of the lawsuits have also named Cap Staffing, while one names Cap's principal officers, Mr. Brown said.

Travelers, however, maintains that it has no liability for the claims.

"Travelers obviously feels it is just as much a victim as anyone else," Mr. Brown said. "Travelers did nothing wrong and according to the (contract) has no obligation to pick up those claims."

Meanwhile, Travelers' lawsuit against Cap Staffing also alleges that Cap officials fraudulently collected several hundred thousand dollars in contributions to an Individual Retirement Account program that supposedly was invested with Travelers. Travelers, though, was not involved in the IRA program, the suit says.

According to the suit, the Cap officers diverted IRA investments for their own use.

The charges in the Travelers complaint are among the subjects of the federal and state criminal inquiry, which also involves the Internal Revenue Service, the U.S. Postal Service and the federal Social Security Administration, regulatory and legal sources say.

A federal grand jury is hearing evidence from the inquiry, sources say.

The Cap case is also expected to be one of the subjects covered in hearings before the Senate Permanent Subcommittee on Investigations, tentatively scheduled for next week.

The subcommittee, chaired by Sen. Sam Nunn, D.-Ga., has been investigating the Cap Staffing case and other instances of alleged abuse of employee benefit plans.

Cap Staffing and an affiliate, Cap Programs Inc., were ordered into Chapter 7 bankruptcy liquidation in November 1989, according to James Ward, a Charlotte certified public accountant who serves as the companies' bankruptcy trustee.

Mr. Ward said he has been unable to identify all the companies' creditors or fix Cap's liabilities because the companies' records were seized by the IRS and the FBI in September 1989, before the bankruptcy petition was filed. These records have been sealed pending the outcome of the grand jury investigation, he said.

However, Mr. Ward said he has compiled a list of more than 100 people who invested \$10,000 to \$500,000 each with Cap Staffing. Most of these investors rolled over IRA accounts into Cap Staffing in exchange for promissory notes, he said.

A North Carolina state agency

seized most of Cap Staffing's assets last August to satisfy a tax lien, and the company's only remaining asset may be \$1,900 in a bank account in Greensboro, N.C., Mr. Ward said.

With the company's records under seal, little progress has been made in the bankruptcy proceedings since November, he said.

Travelers filed its fraud suit in U.S. District Court in Charlotte on Oct. 13, 1989. The complaint also names:

- Cap Programs and another affiliate, Cap Leasing of North Carolina Inc.

- Robert W. Long, Cap Staffing's former president.

- Michael Spieles, who succeeded Mr. Long as president in 1989.

- D. Ron Harris, former secretary of Cap.

- Michael Krebsler, who succeeded Mr. Harris as secretary.

- D.G. Smith, former controller of Cap.

- Jerry M. Wolicki, described as an "assistant to the president" of Cap.

- Steven Loflin, Cap's former vp-insurance administration.

According to the complaint, Cap Staffing entered into contracts with small employers under which the companies' workers became employees of Cap. Cap then "leased" the workers back to the employers, assuming responsibility for the workers' payroll, employee benefits and other administrative functions.

Mr. Harris initially approached Travelers' representatives in Charlotte about providing life, accidental death and dismemberment and health insurance for Cap's leased employees. Travelers submitted a proposal for the coverages, which Cap rejected, the suit says.

Mr. Long and Mr. Harris later went to Travelers' Hartford, Conn., headquarters to discuss other coverage arrangements, and as of Nov. 1, 1988, Cap Staffing entered into an administrative services only contract with Travelers for the health portion of the benefits program, the complaint says.

Under the ASO contract, Travelers

was to process claims for a self-funded health insurance plan set up by Cap Staffing. Travelers did not assume any liability for claims under the contract, which provided that Cap would establish a bank account for payment of benefits and make sure enough money was in the account to reimburse Travelers for claim payments the insurer made on Cap's behalf, according to the suit.

Cap collected fees from employers and made payroll deductions from employees' paychecks, purportedly to fund the health benefit program, the suit says.

The insurer also agreed to underwrite life and AD&D coverage for Cap's leased employees.

To attract business to the newly established leasing program, Cap and Messrs. Long, Harris and Wolicki fraudulently represented that Travelers was also underwriting the health coverage available rather than just administering claims, the suit alleges.

While the self-funded health in-

surance program was intended only for employers leasing their workers from Cap Staffing, the three Cap officials also started offering the coverage to other employers that did not have full-service leasing agreements with Cap.

Cap's self-funded health program covered workers at about 80 companies that had either full-service leasing agreements or other contracts with Cap Staffing, according to the Insurance Department's Mr. Higgins.

Cap initially provided Travelers with a list of 330 covered workers, but the list had grown to more than 3,000 by April 1989, the suit says.

Despite repeated requests, Messrs. Long, Harris and Wolicki failed to update these lists of covered employees or provide Travelers with copies of full-service leasing contracts that would allow the insurer to verify that claims were being submitted by bona fide Cap employees, the suit alleges.

Cap also failed to fund the program with the money it had col-

Continued on next page

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## Fraud probe

*Continued from previous page*  
lected, the suit charges.

Travelers received one check for \$4,994.85 in December 1988. A second check for \$21,000, sent five months later, bounced, the complaint says. When Travelers threatened to cancel its contract in June 1989—six months after its inception—Messrs. Long, Harris and Wolicki wired \$215,000, the suit says.

Travelers—which did cancel on Aug. 1, 1989—is trying to recover \$864,770.84 in claims it paid on Cap's behalf without reimbursement, the insurer charges.

An additional \$1.3 million in claims has gone unpaid since Travelers bailed out, according to the department's Mr. Higgins.

Asked why Travelers paid so much without reimbursements from the Cap fund, Mr. Brown said Travelers was lulled by assurances from Cap.

"When we were continually getting assurances that 'the check's in the mail,' we sort of believed that these people were on the straight and narrow," he explained.

Meanwhile, Messrs. Long, Harris and Wolicki took money from numerous investors between February and July 1989 in a fraudulent IRA scheme, the complaint also charges.

Cap letters told investors that money contributed to the "Cap Staffing Individual Retirement Custodial Account Plan" was invested with Travelers and would produce a 12% yearly return.

The suit charges that Messrs. Long, Harris and Wolicki falsified an IRA plan submitted to Cap by a local bank, substituting Travelers' name for the bank's name to make it appear the insurer offered the plan.

The three men then converted the IRA money—along with the money intended for the health insurance fund—for their personal use or to

their other businesses, the complaint charges.

Mr. Smith, Mr. Spieles, Mr. Krebsler and Mr. Loflin all joined Cap in early 1989 and participated in the fraud with other defendants, the complaint charges.

All defendants except Mr. Long and Mr. Harris have denied the charges in answers to the complaint, said Travelers' lawyer, Mr. Brown.

Neither Mr. Harris nor Mr. Long could be reached.

Entries of default were made against Mr. Long and Mr. Harris after they failed to respond to the lawsuit within the required period. A motion by Mr. Long to set aside the default entry is pending.

In an affidavit supporting his motion, Mr. Long says he relied on Mr. Harris, who he believed to be a former chairman of Travelers.

Mr. Brown noted that Mr. Harris was never chairman of Travelers.

Mr. Long also denied that Cap ever executed an administrative services contract with Travelers and said he could not remember whether Cap's "understanding" called for Travelers to administer or to underwrite the health benefit program.

Mr. Long said Cap entered into a June 2, 1989, merger agreement with Gold Equity Management Co. of Palm City, Fla. Cap transferred "a substantial sum of money" to GEMCO, and GEMCO took over responsibility for collecting payments from Cap clients and forwarding them to Travelers, according to Mr. Long. He adds in the affidavit that he does not know if GEMCO ever made any payments to Travelers.

The merger was rescinded on July 31, 1989, as part of a GEMCO plan to set up a new entity, Universal Staffing Associates Inc., the affidavit says.

Mr. Wolicki and Mr. Spieles, who work at Universal Staffing in Palm City, could not be reached for comment.



# PROPERTY LOSS CONTROL

**PUBLISHING: May 28**

**AD CLOSING: May 15**

Traditional safety methods coupled with technological innovations are helping risk and loss control managers evaluate and prepare for disasters before they strike.

Business Insurance will devote the May 28 issue to the important area of property loss control, and will provide readers with a single source of information on the best property protection methods available. The topics to be covered will range from cutting-edge technology to traditional methods — from data processing and computers used to locate disasters... to the more familiar alternatives of sprinklers and firewalls. Editors will also talk to some of the experts — architects and engineers — about loss control procedures including structural engineering and earthquake preparedness.

### DIRECTORY

The Directory of Loss Control Consultants, also contained in this issue, provides the information and the resources needed by risk and loss control managers to do their jobs better.

### DISTRIBUTION

In addition to reaching over 155,000\* regular readers, this issue will also be distributed at the National Association of Insurance Brokers conference on Sea Island, Georgia. Advertisers in BI reach industry leaders wherever the industry takes them.

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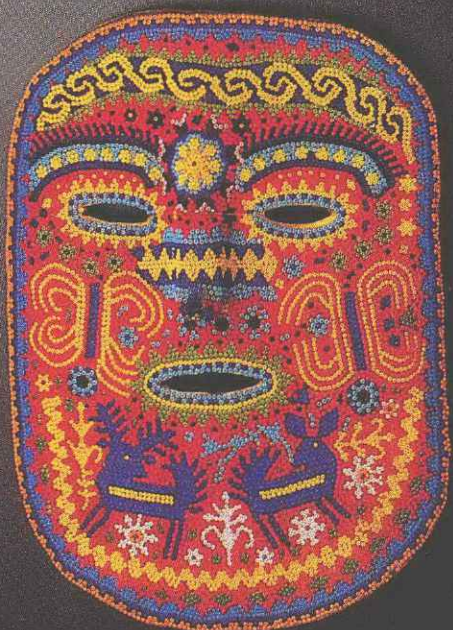
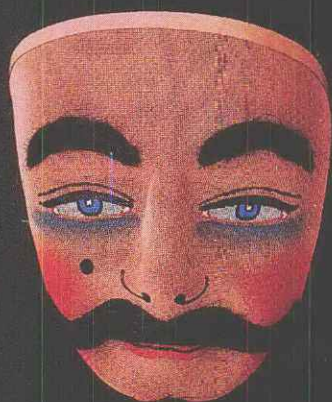
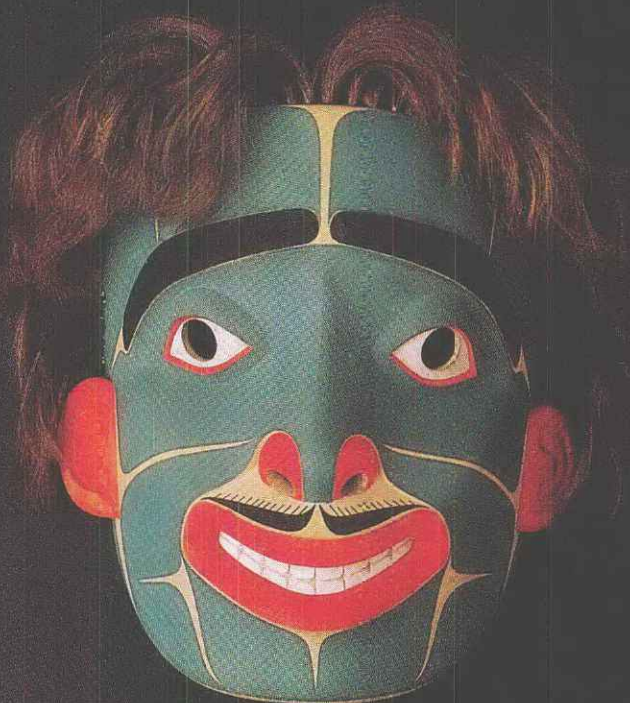
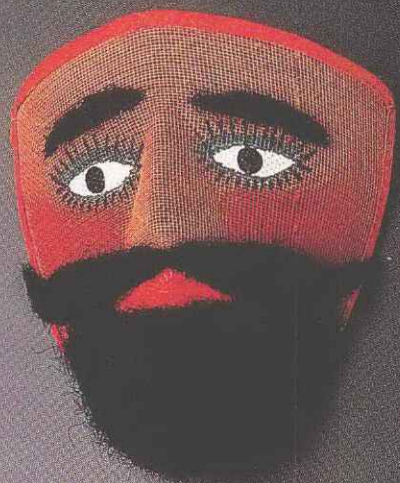
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# Aon elects Ryan chairman, replaces W. Clement Stone

## Comings & goings: industry

**Patrick G. Ryan**, president and chief executive officer of Aon Corp. of Chicago, was elected chairman of the insurance holding company at its annual shareholders meeting late last month. As chairman, he replaces **W. Clement Stone**, Aon's founder, who retired as chairman in February.

**In other insurer changes:**  
**G. Fred DiBona** elected president and chief executive officer of Independence Blue Cross of Philadelphia.

**Peter C. O'Connor** named vp-international at The Home Insurance Co. of New York, a unit of AmBase Corp.

**David R. Jahn** elected vp and appointed regional manager in San Antonio, Texas, for Nationwide Mutual Insurance Co. of Columbus, Ohio. Nationwide also announced the retirement of two senior vps: **Bernard E. Guinan** and **J. Richard Harmon**.

The Hartford Steam Boiler Inspection & Insurance Co. of Hartford, Conn., announced these promotions: **Robert W. Trainer** to senior vp for investments and the financial department; and **Keith S. Hynes** to senior vp for underwriting.

**Renee E. Torobin** elected vp of Unigard Inc., the holding company

of Unigard Security Insurance Co. of Seattle.

**Marshall N. Swann** named vp of the Western regional office of Industrial Risk Insurers, a property insurance pool in Hartford, Conn.

**O. Linwood Perry Jr.** and **Robert Briganti** named senior vps at Continental Guaranty & Credit Corp., a subsidiary of Continental Corp. in New York.

**Ronald E. Wolust** named senior vp of United States Fidelity & Guaranty Co. of Baltimore.

**Adrian M. Meyers** appointed vp of engineering for Royal Group Inc. of Charlotte, N.C. He previously was a regional loss control manager with Crum & Forster Commercial Insurance Co.

**David R. Tourangeau**, a senior vp with UNUM Corp. of Portland, Maine, appointed to direct the company's reinsurance business operations and manage a planned entry into the Pacific Rim. He had been head of the retirement products division.

Benefit consultant A. Foster Higgins & Co. Inc. announced the following appointments as managing consultants in its Washington, D.C., office: **Robert W. Coburn**, **Kenneth A. Kent** and **Michael F. McAllister**.

**Kim Brizer** appointed manager of the Yuma, Ariz., office of R.L. Gresham & Co., an adjusting and appraising firm based in Las Vegas, Nev.

Consulting firm Martin E. Segal Co. of New York announced these promotions to senior vp: **Bruce J. Cerabone**, **A.H. Higgs**, **Mark Meltzer** and **Jonathan A. Parker**. Segal also announced these appointments to vp: **Henry Brownstein**, **Leonard B. Comberiate**, **Randy G. DeFrehn**, **Peter A. Driscoll**, **Robin J. Dusang**, **Diane Gleave**, **Jeffrey L. Johnson**, **Albert LaCasse**, **Eileen Lazar**, **Robert Libertto**, **Irene Potapenko** and **Steven T. Seide**.

**Deborah L. Trout** named director of utilization review and network programs for United Behavioral Systems Inc., a managed care subsidiary of United Health-Care Corp. of Minneapolis.

### Agents/brokers

**Donald R. Moore** elected vp at Adams & Porter Inc., a New York brokerage.

Rollins Burdick Hunter Co., an Aon Corp. brokerage subsidiary, announced these promotions: **Erick L. Johnson** named senior vp and chief operating officer at RBH of Arizona Inc. in Phoenix; **Myles McDonald** also appointed vp at the Arizona subsidiary; and **Joyce T. Howard** and **Michael S. Calhoun** named vps in the national aviation division, based in Chicago.

Corroon & Black Corp. announced these changes: **Robert Reak** joins C&B of California Inc. as senior vp in San Jose, Calif.; **Daniel E. Obler** named vp and manager of property engineering, also in San Jose; **Raymond R. Veit** named senior vp and marine manager with Corroon & Black of Louisiana Inc. in New Orleans; and **Robert Pendergast** named senior vp-international; and **Ann Hoppe** named vp-international and unit manager at C&B of New York Inc.

**Leslie G. Moore** elected regional vp and area marketing manager in Atlanta for Hobbs Group Inc., a brokerage subsidiary of Arkwright Mutual Insurance Co. of Waltham, Mass.

**Gordon St. John** elected chief executive officer with Bosquett & Co., a Detroit agency. He had been executive vp.

### Other suppliers

**Robert Johnson** named chairman and chief executive officer of PCS Inc., a vendor of prescription drug card programs in Scottsdale, Ariz. Mr. Johnson, formerly executive vp of the California Pharmacists Assn., replaces **John Pfeiffer**, who retired.

**Carole L. Kennedy** will continue as president and chief operating officer of PCS, titles she has held since December.

PCS also announced the appointment of **Robert E. Abrams** to the newly created post of vp-special products.

**Judi L. Wallace** promoted to vp with Boone & Co., a compensation and benefits consulting firm in Winston-Salem, N.C.

**Jack D. Williams** named president and chief executive officer of National Benefit Services Inc. of Phoenix, Ariz., a managed care company. He previously was executive vp and chief operating officer of Beacon Corporate Benefit Services Inc. Also, **Foster R. Drury** named executive vp with NBS.

**John M. Barry** appointed principal with Barry, Evans, Josephs & Snipes Inc., a Charlotte, N.C.-based consulting firm specializing in benefit packages for executives.

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## INTERNATIONAL

## Cover offered for high malpractice awards

By CAROLYN ALDRED

## LONDON

LONDON—A new medical malpractice liability insurance line slip is available in the London market to protect U.S. hospitals and clinics against unusually large medical malpractice awards.

Lloyd's of London broker Lloyd Thompson Ltd. put together the line slip, which provides \$3 million of medical malpractice liability insurance per claim excess of a minimum of \$2 million, said Lloyd Thompson Director Charlie Pearch.

The coverage, written on a claims-made policy form, has a maximum aggregate limit of \$9 million.

The facility, which is accessible through Lloyd's brokers, is designed to protect policyholders against single, unusually large awards rather than accumulated smaller awards, he explained.

The facility is led by:

- Lloyd's underwriter Ken Barrett of syndicate 1066, managed by Merrett Underwriting Agency Management Ltd.

- Lloyd's underwriter David Mann of syndicate 435, managed

by D.P. Mann Underwriting Agency Ltd.

- Unionamerica Insurance Co. Ltd., a unit of New York-based Continental Corp.

- CNA Reinsurance of London Ltd., a unit of Chicago-based CNA Financial Corp.

Once at least \$5 million in medical malpractice liability coverage has been obtained through the facility, clients should be able to access additional liability limits in the London market, Mr. Pearch said.

Total capacity of \$20 to \$25 million excess of \$5 million is available throughout the London market for medical malpractice coverage, he estimated.

## U.S., Lloyd's tax pact

After more than a year of intense negotiations, Lloyd's of London and the U.S. Internal Revenue Service signed a new agreement last month concerning taxation of Lloyd's members' U.S. income.

Under the new agreement, income from the underwriting of U.S. risks will be taxed at U.S. corporate tax rates instead of personal income tax rates beginning in 1991.

Corporate tax rates in the United States range from 15% to 39%, while personal income tax rates range from 15% to 33%.

Income from the underwriting of non-U.S.-based risks underwritten in U.S. dollars will continue to be taxed at the personal income tax rate.

The new agreement, which replaces a 1980 agreement, continues to recognize that the taxable entity is the individual member of Lloyd's.

And, the new agreement continues to recognize Lloyd's three-year accounting methods and reserving practices, which had been questioned by a U.S. Treasury Department report (BI, Feb. 27, 1989).

For U.K. names, there also will be no change in the principle of tax

credit relief in the United Kingdom.

Lloyd's is preparing material to be sent to members and managing agents shortly.

The new agreement, Lloyd's said in a statement, achieved "consistency and fairness."

Negotiations to review Lloyd's special closing agreement with the IRS began last February after the U.S. Treasury Department issued a report recommending that Lloyd's syndicates be taxed more like corporations (BI, Feb. 27, 1989).

## Manager appointed

Clive Pracy has been named manager of risk management services for the international accounting and consulting firm of KPMG Peat Marwick in London.

Prior to joining KPMG Peat Marwick, Mr. Pracy established a technical and advisory claims department for Munich Reinsurance (U.K.) Co. Prior to that he served in the risk management department of New York-based Exxon Corp. for 13 years.

KPMG Peat Marwick "has developed a risk management consul-

tancy practice in response to a growing need in both the public and private sectors for informed and independent advice about the appreciation and treatment of the risks that all organizations face," the firm said in a statement.

## Chubb name change

The Chubb Group of Insurance Cos., an international unit of Warren, N.J.-based Chubb Corp., is trading under a new name in preparation for the single European market.

On April 1, Chubb offices in the United Kingdom, Ireland, Denmark, France, Belgium, West Germany, Italy, Spain and The Netherlands began trading under the name Chubb Insurance Co. of Europe S.A.

"With the advent of a single market in Europe fast becoming a reality, we needed a single name to promote and develop our pan-European products and services," said Lawrence Grant, chairman of the London-based subsidiary.

From its London offices, Chubb has been operating in Europe for

Continued on page 63

## Complex program covers tunnel project in Sydney

By KATE McILWAINE

SYDNEY, Australia—A sophisticated package of marine and property policies covers two new

tunnels being constructed beneath Sydney Harbor.

The construction of the two, 2.3 kilometer-long tunnels beneath Sydney Harbor was commissioned

by New South Wales to alleviate traffic on the Sydney Harbor Bridge (see photo). The tunnels, which pass under the front of the Sydney Opera House, will link North Sydney with an expressway on the south side of the harbor.

The tunnels are being constructed by the Sydney Harbor Tunnel Co. Ltd., a joint venture of Sydney-based Transfield Group, a construction and heavy engineering company; and Kumagai Gumi Co. Ltd., an Australian subsidiary of Tokyo-based Kumagai Group.

The contract price is \$553.8 million Australian (\$413.1 million) and the tunnels are expected to be finished by August 1992. Upon their completion, the joint venture will operate the tunnels until the year 2022, whereupon responsibility will transfer to New South Wales. Lowndes Lambert Australia Ltd., a Sydney-based subsidiary of Lowndes Lambert Group P.L.C., arranged the insurance package for the project.

Continued on next page



Two tunnels now under construction beneath Sydney Harbor, site of the Sydney Opera House, are expected to be completed in 1992.

## West German market Less restrictive insurance rules urged

By DON LEWIS KIRK

BONN, West Germany—West Germany is under pressure from within and outside its borders to deregulate its insurance market.

A recent report by the West German National Deregulation Commission cites "conditions no longer reflecting the reality of modern insurance markets" as a reason to end the country's strict regulation of insurance products.

In addition, West Germany's finance minister has met with his U.K. counterpart to negotiate a common, less-restrictive regulatory standard in light of the European Community's move to allow cross-border trading of insurance.

"The individual insurer has few incentives to develop new policies if everyone has to adhere to the same conditions," said Juergen Donges, chairman of the National Deregulation Commission, referring to the current regulatory climate in West Germany. "It

makes West German insurers less competitive by international standards."

The National Deregulation Commission was appointed by the government to report on possible candidates for deregulation in West German industry.

The West German Federal Insurance Supervisory Authority in Berlin, which oversees regulation of insurance, currently must approve the wording of all insurance contracts. Any innovation in policy wording is introduced throughout the market.

"It ends up being a general condition," Mr. Donges said of new contract wordings. "It would be better if insurers had complete freedom to determine the provisions of a policy. That's not the case right now," he said.

The commission also recommends an end to regulation of insurance pricing.

"The freedom to set tariffs individually will lead to a large drop in prices," Mr. Donges said. "Lower prices

Continued on page 63

## Industry harmed by competition, ACE exec says

By ROGER SCOTTON

HAMILTON, Bermuda—Bermuda's growing liability insurance industry is on the brink of entering a round of competition that could harm the industry, warns a prominent insurance executive.

Bermuda's liability insurers are "headed down the road of antagonism" and, if they compete among themselves, the market "will end up on the path to destruction," warned John Cox, chairman of Bermuda-based ACE Ltd.

In a hard-hitting and provocative speech during a seminar sponsored by Bankers Insurance Co. Ltd. in Hamilton on April 26, Mr. Cox—who is a director of BICL—called for a collective effort to create a stronger, more united liability insurance market on the island.

Bermuda has evolved into a proper risk transfer market, he said. "But the real test is only just now beginning," Mr. Cox warned.

"The strategy of Bermuda companies should be collective, there should be a joint effort on this island to create a stronger market, rather than one divided and competing against itself," he said.

"And this market is in danger of losing control of its own destiny, which is one of the main advantages it had when it started," Mr. Cox warned.

Increased regulation is not an answer, he said. Although the Bermuda government has a part to play in improving the market, Mr. Cox said after the meeting, any change ought to be voluntary.

"Regulation could harm this market," he said.

Liability insurance brokers—whom Mr. Cox called the worst enemy of liability insurers—are partly responsible for creating this competition, he said.

Mr. Cox likened these brokers to "thorns" impeding the growth of a business that was "taking root" in rich, heavily capitalized "soil."

Rather than giving out advice like doctors, "to make sure the body, or in this case, the company, survives," brokers are motivated by price alone "as the ultimate solution," argued Mr. Cox.

"The broker should be showing his client all the alternatives," he said. "The brokers are the essential intelligence of this business. They are a necessary and vital part of it. But they should be showing all alternatives."

The future of the Bermuda liability insurance market will be determined only by insurers deciding their own future, he added.

Mr. Cox is expected to step down from his post as chairman of ACE by the end of this year. ACE Ltd. is the parent of policyholder-owned excess liability insurer A.C.E. Insurance Co. Ltd., which is based in Bermuda.

BICL is a policyholder-owned facility that writes directors and officers liability insurance and financial institution bonds for commercial banks.



Mr. Cox

## INTERNATIONAL

## Sydney tunnel

*Continued from previous page*

The package involves contract works insurance, which is a type of construction all-risk policy, and marine hull policies to cover prefabricated sections of tunnels as they are towed into the harbor from the dry docks where they are manufactured.

Each tunnel is composed of eight sections and each section is towed individually, said Phillip J. Roy, Deputy Managing Director—Construction of Lowndes Lambert.

It is the first time the broker has negotiated insurance cover for such a large marine towing operation in open seas, he said, noting the tunnel sections are towed to Sydney in the Tasman Sea from Kembla, which is 78 kilometers down the New South Wales coast.

Mr. Roy said the contract works and marine hull policies were negotiated separately because contract works underwriters were unprepared to accept the marine exposures involved in the project.

Mr. Roy said he had experienced "no problems in placing the risk, but some underwriters did not want to participate because of the nature of the risk."

He said it was the largest construction package negotiated by Lowndes Lambert in terms of the complexities of the risk involved, but was not the biggest in terms of cost.

Mr. Roy would not comment on the price structure or limits of the insurance package.

"It was a very interesting job and still is," Mr. Roy said. Because the risk involved "land and water construction, we had to coordinate both sides. It was a path not encountered before."

The concrete tunnels are constructed in sections at a dry dock in Port Kembla, then towed individually into the harbor.

Each of the tunnel units is 120 meters long, 26 meters wide, 7.5 meters high, three meters thick and weighs 23,000 metric tons. The first four units were towed into place in Sydney Harbor last Octo-

ber and November. The others are still under construction.

For the towing operation, steel bulkheads were installed at either end of the tunnel units to seal them off. Mooring lines were attached and the dry docks were filled with water.

"From the time of the first ingress of water into the dry dock, the insurance cover changed from the contract works policy to the marine hull policy," Mr. Roy explained.

In addition, the marine policy will respond if one of the sections should sink in Sydney Harbor and block shipping, he noted. It would reimburse the Sydney Port Authority for any loss of income from blocked shipping as well as any shipping companies with business interruption claims, Mr. Roy explained.

Once the units are floated out, the dry docks are drained in preparation for construction of the next four units, which are due to be completed and towed to Sydney later this year.

"In the assessment of the marine risk associated with the ocean tows (a consulting firm) was required to check all relevant risks, including meteorological conditions, stability, the towing method and structural conditions," Mr. Roy said.

"The marine hull policy ceases when the tow line is disconnected at the tunnel sites where the units are positioned for sinking. The contract works insurance then recommences," he said.

It takes six hours to sink the units onto the floor of Sydney Harbor, he noted.

The contract works insurance is

led by London-based Excess Insurance Co. Ltd., according to Mr. Roy.

He said 62.5% of the tunnel's construction coverage is placed in London and Europe; 7.5% with a Japanese insurer; with the rest in Australia. According to Mr. Roy, the largest Australian insurer participating on the risk is C.E. Heath Underwriting & Insurance (Australia) Pty., a Melbourne-based underwriting subsidiary of C.E. Heath P.L.C.

Mr. Roy said he was disappointed with the response from Australian insurance companies, but noted that the Australian market had chosen not to compete with the London market for contract works risks in recent years.

The marine hull policy is shared by British and American insurers with Lloyd's syndicates and other British insurers taking 50% and Australian companies taking the remaining 50%.

The lead insurer for the Australian portion of the marine policy is Sydney-based Switzerland General Insurance Co. Ltd., a unit of Swiss Reinsurance Co., which writes 20% of the coverage.

"We wanted to reserve 50% of the marine cover for Australia. Even though we are a British broking house, we like to place business locally if we can," Mr. Roy explained.

"But if the price is not right, we will obviously go to London to place it," he added.

When the project is commissioned—scheduled for Sept. 1, 1992—an industrial property policy comes into force for the tunnels, according to Mr. Roy. ■

## Attacks on mine prompt dropping of reinsurance

MELBOURNE, Australia—The property reinsurers of Bougainville Copper Ltd. are planning to cancel the mining company's coverage because of ongoing civil strife near the company's mine on the Pacific island of Bougainville.

In a statement read to shareholders at BCL's annual meeting late last month, Chairman Don Carruthers said: "On April 2, lead reinsurers of the company gave 90 days' notice of withdrawal of insurance cover consequent to our contractors being prevented from carrying out surveillance duties at Panguna (Bougainville). Discussions are taking place to try to reinstate some cover."

A spokesman for Mr. Carruthers said he could not elaborate on the comments made at the meeting because the company is negotiating with its reinsurers.

The mining firm, partially owned by the government of Papua New Guinea, operates one of the world's largest gold and copper mines on the tiny South Pacific island. Rebel forces that want the island to secede from Papua New Guinea have attacked the mine repeatedly over the past year, causing hundreds of millions of dollars in damage (BI, Dec. 4, 1989).

There have been no BCL employees on the island since March, when rebel activities by the Bougainville Revolutionary Army worsened. The mine has been closed since May 1989.

Between 40 and 50 companies, led by Royal Insurance Ltd. of Melbourne, a unit of Royal Insurance Holdings P.L.C. in London, reinsure BCL's primary property and business interruption coverage.

Some 88.5% of that coverage is written by Metals & Minerals Pte. Ltd., a Singapore-based captive of its parent company, Melbourne-based CRA Ltd. Three other companies write the remainder of the primary coverage.

BCL received a \$102.5 million Australian payment (\$78.6 million) from its four primary insurers on April 5 in an out-of-court settlement of its dispute over property and business interruption coverage for losses stemming from the civil commotion (BI, March 5).

Ross Bovill, managing director of Sedgwick James Management Services in Singapore, which manages the captive, and a director of Metals & Minerals, said BCL's reinsurance is still in force.

He added that discussions were being held with reinsurers about the current situation on Bougainville.

"Certain reinsurers are concerned and have indicated a variety of responses," Mr. Bovill said. "We're working hard to ensure that cover remains," he said.

Mr. Bovill would not name the reinsurers involved nor comment on responses under consideration.

Sedgwick James Ltd. in Melbourne, BCL's reinsurance broker, also is "heavily involved" in the negotiations, confirmed Andrew Smith, national operations director for Sedgwick.

Mr. Smith declined to elaborate on the discussions.

Mr. Bovill said the "fluidity" of the situation on Bougainville was a problem in the negotiations.

"Obviously reinsurers are going to be nervous about the position there," he said.

—By Kate McIlwaine

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## INTERNATIONAL

## LONDON

Continued from page 61  
more than a decade.

It has branch offices in Brussels, Belgium; Copenhagen, Denmark; Paris; Dublin, Ireland; Madrid, Spain; Milan, Italy; Rotterdam, The Netherlands; and Dusseldorf, West Germany.

Chubb also plans to open other European offices.

"The advent of the single European Market in 1992 and the removal of trade barriers brings many opportunities in the European insurance market," the insurer said in a statement.

"In 1989, revenues from international operations approached \$500 million," Chubb said in its 1989 annual report. "Over the longer term, we aim to increase our international activity so that it ac-

counts for 25% of our business by the year 2000."

## Broker results

Lloyd's of London broker Nicholson Chamberlain Colls Group Ltd. reported revenues increased 50% last year to 15 million pounds (\$24.6 million) from 10 million pounds (\$18.1 million at year-end rate) in 1988.

"This has been achieved through new business totaling in excess of 6 million pounds (\$10.86 million), said Chairman Alan Colls in the company's 1989 annual report.

New business "has more than offset the reduction in income on the existing portfolio," he added, referring to reduced commissions on existing business that has ren-

ewed at lower premiums.

In only its second full year, the brokerage also boosted pretax profits 82% to 3.1 million pounds (\$5.1 million) in 1989, from 1.7 million pounds (\$3.1 million at year-end 1988 rate) the previous year.

The United States continues to be Nicholson Chamberlain Colls' largest source of revenue, representing 6.1 million pounds (\$10 million) in 1989. Another 5.4 million pounds (\$8.9 million) came from the United Kingdom and 1.4 million pounds (\$2.3 million) from other European nations, the broker reported.

"Although historically the insurance business has been cyclical, none of us can remember a time when market conditions have been as soft across so many classes as those experienced in 1989," Mr. Colls noted in the report.

While "there are signs of a hard-

ening market in some areas, this is unlikely to have an effect before 1991," he said.

## Creditors to get checks

Creditors of Mediterranean Insurance & Reinsurance Co. Ltd. will receive a claims dividend of 70 cents on the dollar this week, according to the accountants managing the company's rehabilitation.

A cash reserve of 15.4 million pounds (\$25.3 million) has been put aside to meet agreed claims of about 9.5 million pounds (\$15.6 million) as well as estimated claims and incurred-but-not-reported losses, said Philip Singer, an associate director of accountant Cork Gully, a unit of Coopers & Lybrand.

The insurer's outstanding claims and IBNR claims total 22 million pounds (\$36.1 million).

Checks for 70 cents for every

dollar of agreed claims are being sent to creditors by Cork Gully partner Malcolm London, chairman of Med Re's creditors committee.

Meanwhile, Cork Gully hopes to pay a final dividend—resulting in full payment for all claims—by 1994, said Mr. Singer.

Med Re was put into a "scheme of arrangement," which is a British form of rehabilitation, in 1987 (BI, May 11, 1987).

Under such a scheme, a plan of rehabilitation has to be approved by 75% (in value) and 50% (in number) of all classes of creditors.

Med Re's financial difficulties primarily "arose in connection with three reinsurance treaties between Med Re and Kuwait Re, where Kuwait Re's liabilities exceeded the amount which Kuwait Re was able to pay," said a Med Re memorandum issued in 1987. ■

## West Germany

Continued from page 61  
and fairer risk-cost ratios (rates for consumers are among the most important consequences." Premiums should be free from regulation in every branch except health insurance, the report contends.

The report also criticizes the West German insurance industry for its "principle of conformity."

However, insurers insist that regulation and "running surveillance" of contract conditions protects the consumer. Prudent standards are "the best guarantees for order in the market," said Jorn Badenhop, director of the association in Bonn.

Foreign insurance companies also find West Germany's insurance market restrictive, according to the commission's report. Foreign insurers are discriminated against and should be given greater access to the market, according to the report. Freedom of services in West Germany is too strongly regulated by the Federal Insurance Supervisory Authority, making it too difficult for foreign insurers to establish themselves in West Germany, the report said.

"Consumers are unaware of policies offered by a foreign insurer at a better price," Mr. Donges said.

A study of West German insurance prices conducted in 1988 by the EC Commission shows that premiums in certain branches of the West German insurance market are higher than in other EC countries. In particular, premiums for commercial general liability, industrial fire and theft insurance are much greater than in other countries, the EC study found.

In addition, the National Deregulation Commission's report calls for the creation of a guaranty fund to protect consumers from insolvent insurance companies.

The European Community's move toward a single European market for insurance services has also put pressure on West Germany to change its tight regulation of insurance from other EC nations.

At recent talks with U.K. Trade and Industry Secretary Nicholas Ridley, West Germany's Finance Minister Theodor Waigel showed willingness to move on several key issues, including freedom for insurance product innovation as well as more competitively priced products.

The two nations still have no agreement on insurance regulatory standards, which has been a major obstacle to harmonization.

Anticipating EC directives enabling insurance companies established in one country to offer a full range of services in another, Mr. Waigel issued a joint statement at the conference between the two ministers calling for "mutual recognition of (a) supervisory standard."

However, he also acknowledged a need for consumers to have the "widest possible choice between different competitively priced insurance products." ■

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# Work comp benefits to rise in Georgia

ATLANTA—Workers compensation benefits in Georgia will increase 28.6% after July 1, but workers or their families will be denied benefits if a worker is injured or killed while under the influence of drugs or alcohol.

Georgia Gov. Joe Frank Harris has signed five workers comp reform bills passed during the Legislature's 1990 session, and all go into effect July 1.

S.B. 464—signed by Gov. Harris on April 11—increases the maximum weekly workers comp benefit for total disability or death to \$225 from \$175 and for temporary partial disability to \$150 from \$117.

The law also extends to 21 days from 14 days the deadline by which benefits must be paid after an employer has knowledge of an injury or death.

It also increases to four from three the number of physicians in the "panel of physicians" employers must contract with and make accessible to injured workers.

S.B. 464 also requires insurers to update their workers comp rate filings at least once every two years, with the initial two-year period commencing on July 30.

But, H.B. 1168—signed April 1—denies workers comp benefits for workers who are injured or die as a result of being under the influence of alcohol or drugs, unless those drugs were prescribed by a physician and were taken in accordance with the physician's instructions.

H.B. 1421—signed April 4—creates the Self-Insurers Guaranty Trust Fund "to provide for the continuation of workers compensation benefits due and unpaid—excluding penalties, fines and attorneys' fees—when a self-insured employer becomes insolvent."

Each fund participant will be assessed \$4,000 in 1990. In subsequent years, each participant will be assessed up to 1.5% of benefits paid during the previous calendar year to a maximum of \$4,000, or \$1,000, whichever is greater.

After the funding level reaches \$3 million, assessments will cease for participants who have paid at least three prior assessments until the fund is depleted to less than \$2 million.

H.B. 1421 also stipulates that money held in the fund is not the property of either the state or the fund's participants.

The fund is to be governed by a seven-member board elected by participants. But, the initial board will be appointed by the governor.

And, S.B. 693—signed April 10—exempts employers that self-insure their workers comp risks from state and local premium taxes.

H.B. 1753—signed March 28 and effective on policies issued, delivered or renewed on or after July 1—requires workers comp insurers to offer deductibles either as a part of their policy or as an optional endorsement to the policy.

Insurers must offer in writing deductibles of \$100, \$200, \$300, \$400, \$500 or increments of \$500 up to a maximum of \$2,500 per compensable claim.

Insurers must determine premiums based on those deductibles before applying any experience modifications, premium surcharges or other premium discounts.

—By Linda J. Collins

## California spill bill

SACRAMENTO, Calif.—Oil companies and shippers would have to maintain minimum liability coverage and improve their cleanup preparations for spills off the California coast under legislation proposed in late April by Gov. George Deukmejian.

The proposal was prompted by a Feb. 7 spill of Alaskan crude oil off

## Around the states

Huntington Beach, Calif. About 300,000 gallons of oil spilled through a three-foot hole ripped in the hull of the tanker American Trader (BI, Feb. 12).

Under Gov. Deukmejian's plan, oil companies and shippers bringing oil to California will be required to:

- Submit new, updated spill contingency plans that include greater use of booming equipment and skimming vessels.

Such equipment will help ensure that a spill is contained "before it hits our shores and beaches," Gov. Deukmejian said last week.

- Join an oil spill cleanup cooperative or prove that they have the

individual capacity to clean up a serious spill.

- Demonstrate that they have a minimum of \$500 million in oil spill liability protection, whether through an insurance or a self-insurance program.

American Trading Transportation Co., owner of the American Trader, had up to \$400 million in cleanup coverage written by Norwegian protection and indemnity club Assurance Foreningen Gard.

However, shipowners can now purchase as much as \$750 million in pollution liability coverage through P&I clubs (BI, Jan. 8).

Gov. Deukmejian's plan also calls for establishing an Office of

Oil Spill Response in the state's Department of Fish and Game to develop ongoing spill prevention and response measures.

In addition, the state will finance a \$30 million oil spill response fund through a 5-cent-per-barrel fee on companies shipping crude oil into California. The fund is to pay immediate cleanup costs when the responsible party is not quickly identified.

These measures "will ensure that the industry bears the burden of the cost of oil spill prevention and cleanup," the governor asserted.

The proposal is to be merged into AB 3941, a similar measure introduced by state Assemblyman Eric Seastrand, R-Salinas. A hearing is scheduled for today before the Natural Resources Committee.

—By Joanne Wojcik

## Work comp benefit

INDIANAPOLIS—Husbands in Indiana now have the same rights as wives to receive workers comp death benefits.

The benefit becomes effective July 1 under an amendment, S.B. 62, to the state's workers comp code signed by Gov. Evan Bayh.

Previously, only a husband who was "both physically and financially incapable of self-support" was eligible for these benefits from his wife's employer.

The amendment also allows children to collect workers comp death benefits to age 21, up from age 18.

The governor also has signed an amendment to Indiana's insurance code that raises civil penalties for unfair claim settlement practices.

Continued on next page

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## Around the states

Continued from previous page

S.B. 211—also effective July 1—increases the maximum civil penalty a commissioner can levy against an insurer for unfair claim practices to \$25,000 for each act or violation, up to a 12-month aggregate of \$100,000.

The commissioner previously could fine insurers \$2,000 for each act or violation, up to \$10,000 in a six-month period.

However, if it is determined that the insurer knew or should have known it was violating the state's insurance code, the commissioner can fine the insurer up to \$50,000 for each act or violation, up to \$200,000 aggregate in any 12-month period.

Formerly, the commissioner could fine insurers \$5,000 for each intentional act or violation, up to \$50,000 aggregate in a six-month period.

—By Linda J. Collins

## Medical malpractice

AUGUSTA, Maine—Medical malpractice awards in Maine beginning next year may be offset by amounts that plaintiffs already have received from collateral sources, under a law signed by Gov. John McKernan Jr.

The law, which takes effect Jan. 1, 1991, could save policyholders up to about 7% of the \$40 million in annual medical malpractice premiums written in the state, said Steven Michaud, director of government relations and regulatory affairs for the Maine Hospital Assn. He said he expects insurers to pass savings on to policyholders, but the law does not require it.

The legislation also:

- Establishes a five-year medical liability demonstration project to develop practice parameters and risk management protocols for anesthesiologists, emergency medi-

cine specialists, obstetricians and gynecologists.

Risk management protocols "must establish standards of practice designed to avoid malpractice claims and increase the defensibility of the malpractice claims that are pursued," the bill says.

Under the law, physicians could use their participation as a defense in a malpractice suit.

- Calls for the insurance superintendent to determine the savings from the collateral source rule and the demonstration project and order insurers to assess their policyholders 50% of that total, up to \$500,000. These funds would be used to cut malpractice premiums for physicians providing obstetrical and prenatal services in rural areas.

—By Judy Greenwald

## Illinois health care bill

SPRINGFIELD, Ill.—Revolutionary legislation in Illinois would establish a system of state-paid health care and ban private insur-

ers from selling basic health insurance to groups and individuals.

The Universal Health Care Act, introduced last month in the Illinois General Assembly, would prohibit insurers and health maintenance organizations from writing health care insurance for residents after 1993.

In addition, providers of basic health care services would be reimbursed only through the universal health care system.

Those basic services include: inpatient and outpatient hospital care; services by licensed health care professionals, including doctors; substance abuse treatment; long-term care; prescription drugs; and services that promote health and prevent illness and injury, including prescription eyeglasses. Cosmetic surgery is excluded, unless it is considered reconstructive.

However, insurers may offer coverage for other benefits.

Under the proposed system, the state would pay providers according to an unspecified reimbursement plan, which would be

developed by board appointed by the governor.

In addition, the proposals, which amend the state Insurance Code and the Health Maintenance Organization Act, call for creating two task forces to advise the board on containing costs and promoting efficiency and quality care.

H.B. 3291 and S.B. 1587 seek to establish a single, non-profit insurance system that negotiates directly with health providers and thereby "eliminates the waste and inefficiency that plagues our current multi-payer patchwork system," said Robert Creamer, executive director of Illinois Public Action, a consumer group.

Under the current system, insurers are "inefficient middlemen" that have benefited from rising health care costs, he said.

A single-payer public insurance system, like Canada's national health care system, which inspired the legislative proposals, is needed to bring health care costs under control, Mr. Creamer said.

—By Meg Fletcher

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All bids or proposals must be submitted on the bid specification proposal sheets in duplicate and shall be based upon and in conformity with the specifications listed.

Bid specifications packages are to be requested from the Housing Authority City of Pittsburgh, 200 Ross Street, Pittsburgh, PA 15219. Phone #: (412) 456-5022, Comptrollers Department. Questions should be directed to David Arnold, Comptroller.

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A pre-bid conference will be held for all interested parties at 707 North First Street, St. Louis, Missouri 63102 at the specified dates and times listed above.

Proposals will be received in the Purchasing Department of the Bi-State Development Agency, 707 North First Street, St. Louis, Missouri 63102 at specified dates and times listed above. Any proposal received after the time referred to above will not be considered and will be returned to the sender unopened.

The Agency reserves the right to accept any bid or any part of parts thereof or to reject any and all bids. Acceptance of any bid is subject to concurrence by the United States Department of Transportation and the Illinois Department of Transportation (IDOT). Any contract resulting from bids is subject to financial assistance between the Agency and the United States Department of Transportation and the Illinois Department of Transportation (IDOT).

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# Berkshire report

Continued from page 1

ence enough disappointments doing transactions we believe to carry an expectation of profit," Mr. Buffett noted in the report.

Berkshire's "method of operation, incidentally, makes us a stabilizing force in the industry. We add huge capacity when capacity is short and we become less competitive only when capacity is abundant," he added.

"Of course, we don't follow this policy in the interest of stabilization—we follow it because we believe it to be the most sensible and profitable course of action," Mr. Buffett pointed out in the report.

After a record crowd of 1,000 filled the Joslyn Art Museum auditorium to capacity in 1989, the Berkshire annual meeting was moved this year to the Orpheum Theatre in downtown Omaha to accommodate about 1,600 requests for tickets.

Berkshire shareholders traveled to Omaha from around the world to glean investment tips from Mr. Buffett, whose 45% shareholding in Berkshire now exceeds \$3.2 billion in value.

Berkshire stock—the highest-valued stock traded on the New York Stock Exchange—was trading at \$6,700 on April 30, the day of the meeting, down from a high of \$8,900 in the fourth quarter of 1989.

Undaunted by this change, Mr. Buffett said at the meeting that the stock "was selling at a different relationship to its intrinsic value at the end of 1989 than at the beginning of 1989." The stock reached a high of \$5,025 in the first quarter of 1989.

In 1965, when Mr. Buffett took over the company, Berkshire stock was selling for about \$12 per share.

As the meeting commenced, Mr. Buffett referred to himself and Berkshire Vice Chairman Charles T. Munger—the other controlling shareholder—as the "Berkshire Hathaway version of Bartles & Jaymes."

The two sat casually at a simple table in straight-backed chairs on the stage of the theater facing the audience.

And, while the business portion of the Berkshire annual meeting, which began at 9:30 a.m., lasted only about 10 minutes, a question-and-answer period with Mr. Buffett and Mr. Munger continued until about noon.

After this formal question-and-answer period was adjourned, Mr. Buffett and Mr. Munger invited those with additional questions to remain. However, Mr. Buffett was forced to call an end to those questions at 1 p.m. so he and Mr. Munger could attend Berkshire's annual board meeting.

"We only have one (board) meeting a year, so we should show up," Mr. Buffett quipped.

Mr. Buffett has ample reason for good humor. Berkshire's total assets rose nearly 38.8% to \$9.46 billion in 1989 from \$6.82 billion in 1988.

And, while its 1989 revenues rose only 0.8% to \$2.48 billion from \$2.46 billion in 1988, net earnings increased 12.1% to \$447.5 million from \$399.3 million in 1988.

Berkshire's insurance group, which insures primarily commercial casualty risks, wrote \$296.1 million in net premiums in 1989, down 38.9% from \$484.7 million in 1988 and 60.6% from \$751.3 million in 1987.

But, net earnings from the 12 companies that comprise Berkshire's insurance group—which includes National Indemnity Co., National Fire & Marine Insurance Co., Columbia Insurance Co., Cornhusker Casualty Co. and Wesco-Financial Insurance Co.—rose 23.7% to \$347.1 million from \$280.7 million in 1988.

Of that \$347.1 million, \$243.9 million, or 70.3%, represented net investment income, which included dividends from Berkshire's well-publicized holdings in companies like Capital Cities/ABC, Inc.; Champion International Corp.; The Coca-Cola Co.; GEICO Corp.; The Gillette Co.; Salomon Inc.; USAir Corp.; and The Washington Post Co.

Berkshire's insurance underwriting operations recorded an after-tax underwriting loss of \$12.3 million in 1989, compared with a \$1 million underwriting loss in 1988. In 1987, those operations recorded a \$20.7 million underwriting loss.

Besides the insurance group and its famed investment portfolio, Berkshire's other holdings include: The Buffalo News; the publisher of encyclopedias and reference materials such as World Book Encyclopedia, Childcraft and Early World of Learning; Fechheimers, a uniform manufacturer and distributor; See's, a candy manufacturer; The Nebraska Furniture Mart, the country's largest home furnishings store; home cleaning systems man-

ufacturers, including Kirby Co.; and numerous other operations in various industries.

Mr. Buffett's comments in Berkshire's annual report more fully explain the reasoning behind his prediction that a turn in the competitive commercial property/casualty insurance cycle is not immi-

**'We're a long way from' improved profits in insurance, warns Berkshire's Warren Buffett.**

nent.

Mr. Buffett said he expects the insurance industry's incurred losses will continue to "grow by about 10% annually, even in years when general inflation runs considerably lower."

And, "if premium growth meanwhile materially lags that 10% rate, underwriting losses will mount, though the industry's ten-

dency to underreserve when business turns bad may obscure their size for a time," he stated.

Currently, premium growth is running "far below" the 10% increase that would be required simply to stabilize insurers' combined ratios at current levels, Mr. Buffett said in the report.

In fact, the industry's written premiums grew only 2.1% in 1989 to \$206.6 billion from \$202.3 billion in 1988, according to Insurance Services Office Inc. statistics (BI, April 2). Meanwhile, the industry's aggregate combined ratio hit 109.7% in 1989, compared with 105.5% the previous year, according to ISO.

Mr. Buffett noted "some analysts have argued that the more onerous taxes recently imposed on the insurance industry and 1989's catastrophes—Hurricane Hugo and the California earthquake—will cause prices to strengthen significantly. We disagree," he said in the report.

"These adversities have not destroyed the eagerness of insurers to write business at present prices. Therefore, premium volume won't grow by 10% in 1990, which means

the negative underwriting trend will not reverse," he added.

Mr. Buffett warned: "Insurance profitability will improve only when virtually all insurers are turning away business despite higher prices. And we're a long way from that point," he stressed.

During the annual meeting, Mr. Buffett described the investment philosophy he and Mr. Munger employ.

"We look for good businesses with good economics run by very able and honest people," he said.

"Essentially we've got a bunch of stars, and we have stars because we set out to join with stars," Mr. Buffett added.

Regarding the company's insurance operations, Mr. Buffett said Berkshire prefers casualty business because it has a longer "float." Since casualty losses take longer to develop than do property losses, Berkshire can use that float to make investments and generate income.

"Our insurance companies, over the last couple of years, have been holding roughly \$1.5 billion" in

Continued on next page

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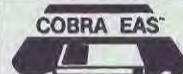
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## Berkshire

Continued from previous page float. "In essence, you can look at their annual underwriting loss as the cost of holding that money," he said.

This represents "a very unusual amount of float as compared to" their current premium volume, Mr. Buffett said.

"We like 'float' business and we do seek it out, not that there isn't a cost attached to it," Mr. Buffett said. He observed, for example, that "you can lose your shirt on medical malpractice" insurance if it generates enough claims over a long period of time.

He noted that Berkshire is also holding roughly \$300 million in loss reserves from its former reinsurance arrangement with Fireman's Fund.

Berkshire would be interested in entering into other quota-share reinsurance arrangement, similar to the one it had with Fireman's

Fund, with the right insurers. For example, he said that Berkshire would love to write a quota-share treaty for GEICO Corp., of which Berkshire holds nearly 6.9 million—or 45%—of the shares.

GEICO writes a full range of personal lines coverages, primarily for preferred risks.

However, "that isn't going to happen, or it's not likely to happen, because there's a lot of capital now" on the market, Mr. Buffett said.

"A quota-share opportunity is more likely to come along when, generally, there is fear in the industry. We'll be more likely to do it then, as we did the last time" insurers were faced with substantial underwriting losses and capacity was shrinking, he predicted.

Mr. Buffett was quite satisfied with the treaty reinsurance arrangement. He noted in the report, however, that "there was some good luck in the selection, years ago, of a termination date for the

Fireman's Fund contract. The date, Aug. 31, 1989, happened to be just before the occurrence of both Hurricane Hugo and the San Francisco earthquake."

When questioned about consumer revolts against the high price of auto insurance, both in California—with Proposition 103—and in other states, Mr. Munger, referring to the insurance industry in general, observed that such movements have dimmed "the prospects of writing (personal lines) insurance in states that have this sort of consumer rebellion."

But, Mr. Buffett predicted that there will still be markets for personal lines business in those states. And, he also noted that GEICO, for example, "could benefit" from the unwillingness of some insurers to write personal lines business in those states.

"GEICO is a low-cost operator" and, as such, has "some advantages" over other personal lines insurers, he noted. ■

## Washington

# Bill would allow 401(k)s for tax-exempt groups

By ADRIENNE C. LOCKE

WASHINGTON—Tax-exempt organizations would once again be able to form 401(k) plans under a bill recently introduced in the House of Representatives.

H.R. 4287—co-sponsored by Reps. Sander Levin, D-Mich.; Dan Archer, R-Texas; and Bill Frenzel, R-Minn.—would restore the ability of tax-exempt organizations to establish new 401(k) plans. The Tax Reform Act of 1986 prohibited tax-exempt groups from setting up new 401(k) plans, but existing plans were allowed to continue (BI, Aug.

25, 1986).

"The revenue consequences of the proposal is relatively small," Rep. Levin said when introducing the bill. However, he conceded that "in this time of continuing deficits, offsetting revenue sources will have to be found."

The bill, which is pending before the House Ways and Means Committee, may be included in the committee's budget reconciliation package later this year, a spokesman for Rep. Levin said.

Meanwhile, a new group formed late last month to lobby for passage of such legislation.

The Washington, D.C.-based 401(k) Coalition, which has 30 non-profit organizations as members, says the Bush administration has signaled it favors extension of 401(k) plans to the non-profit sector.

## Vaccination required

Employers must provide free hepatitis B vaccinations to all health care industry workers who are at substantial risk of exposure to the virus, the Labor Department said.

The requirement is one of several contained in the Occupational Safety and Health Administration's revised directive health care facility inspections.

Previously, vaccination was one of several ways OSHA recommended an employer could protect workers from the hepatitis B virus.

Among those at risk of infection, according to the agency, are: physicians, pathologists; dentists and dental technicians; emergency room, intensive care and operating room nurses and technicians; and laboratory and blood bank technicians.

Other health care workers who may be exposed to the hepatitis B virus include: housekeeping personnel; laundry workers; orderlies; morticians; research laboratory workers; paramedics; and medical examiners, the directive says.

Any workers exposed to body fluids are considered to be at substantial risk, the directive warns.

Single copies of the revised enforcement procedures are available from the Labor Department. Send a self-addressed, stamped envelope to OSHA Publications, Room N-3103, 200 Constitution Ave. N.W., Washington, D.C. 20210; or contact local or regional OSHA offices.

## New OSHRC chief

Edwin G. Foulke is the new chairman of the Occupational Safety and Health Review Commission in Washington, D.C.

He was sworn in following his confirmation by the Senate Labor and Resources Committee. He was nominated by President Bush in Sept. 1989 to fill the vacancy left by Ross Buckley, whose six-year term expired in April 1989.

Mr. Foulke is a lawyer with experience in labor relations, employment, and occupational safety and health law.

He previously was a partner at Constangy, Brooks & Smith, a Columbia, S.C., law firm.

The Senate Labor and Resources Committee is expected to fill the two remaining posts on the three-member commission during its May executive session, a committee spokeswoman said.

The OSHRC—an independent federal agency—rules on job safety and health disputes resulting from workplace inspections and penalties for safety violations proposed by OSHA. ■

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## HYATT LEGAL PLANS

## Weavers slip

*Continued from page 1*

in the London press that the six LUI insurers faced a 1 billion pound (\$1.64 billion) reserve deficit. Mr. Wilson labeled the reports erroneous.

Following those reports, Mr. Wilson said last week that the six LUI insurers likely had a reserve deficiency of between 75 million to 100 million pounds.

Sources told *Business Insurance* that total undiscounted outstanding claims and reserves for incurred-but-not-reported losses—rather than the reserve deficit—of Walbrook and the six LUI subsidiaries may reach 1 billion pounds.

Mr. Wilson said he could not give a total loss figure at the moment.

He said his estimate was based on preliminary figures given to LUI by Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc., which is preparing the actuarial report on the LUI insurance subsidiaries. The 75 million to 100 million pound estimate "is a ballpark figure based on the information we have to date," he said.

"We don't have the final Tillinghast numbers yet, but I don't think the numbers will change a great deal," he said.

Estimates similar to Mr. Wilson's have been circulated in the London market since the problems at the six LUI insurance companies came to light late in March, but neither Mr. Wilson nor Tillinghast would comment on them publicly.

For example, "figures of that region" were specifically mentioned to about 30 brokers and interested parties at an April 18 meeting to discuss how to keep the runoff of the Weavers business alive, Mr. Wilson confirmed, though he was not at the meeting.

"This range is not out of line," he said, adding that the brokers have been very helpful in coming up with financial information needed for the rescue effort.

"What's been produced is a range of numbers of the sort that is as near as we are going to get" to meet the aggregate liabilities of the LUI companies and Walbrook in particular, according to David Palmer, chairman of the BIIBA. "It is the total amount guesstimated" to meet future claims.

The final Tillinghast report will be presented to the LUI and Walbrook board but will only be made public if the board agrees.

However, LUI will have to publish its 1989 annual report to its shareholders at some point, though the release of the report already has been delayed by the problems with the six LUI insurers.

LUI, which suspended trading when Walbrook stopped underwriting, must submit its financial statement to the British Department of Trade and Industry by July unless an extension is allowed.

Last year, Tillinghast endorsed Walbrook's loss reserves as of year-end 1988. Walbrook and its subsidiaries reported year-end 1988 loss reserves of 231 million pounds (\$418.1 million at applicable exchange rates), a 57% increase from 147 million pounds (\$276 million) at year-end 1987 (*BI*, May 22, 1989; May 8, 1989).

Walbrook's subsidiaries are Desert Insurance Co. Ltd. of Bermuda and El Paso Insurance Co. Ltd.

However, last year's Tillinghast report did not assess the adequacy of the loss reserves of four other insurers owned by LUI: Kingscroft Insurance Co. Ltd. (formerly Kraft Insurance Co. Ltd.), Lime Street Insurance Co. Ltd. (formerly Louisville Insurance Co. Ltd.) and Mutual Reinsurance Co. Ltd., all of which were bought by LUI in 1988; and London United Reinsurance Co. (Bermuda) Ltd.

LUI reported that loss reserves for all of its insurers totaled 485.9 million pounds (\$879.5 million) as of year-end 1988. The reserves were discounted, based on a 7.5% interest rate and assuming claims

would be paid on average in 4.9 years, according to the accounts.

Tillinghast may now recommend that the discounted reserves of Walbrook and its two subsidiaries be increased 73% to around 400 million pounds as of year-end 1989.

The increase in reserves reflects business written by Walbrook last year and does not represent a substantial deterioration in prior years' business, *Business Insurance* learned.

Tillinghast also may recommend that the reserves of all LUI insurance subsidiaries be increased by 65% to around 800 million pounds.

Meanwhile, discussions are continuing among brokers and interested parties to "produce an orderly runoff" of the Weavers participants, Mr. Palmer said.

But, "whether it can be achieved, we will have to wait and see," he said.

Marsh & McLennan Cos. Inc. and Sedgwick Group P.L.C. are leading discussions to assist in an orderly runoff of the Weavers participants.

"We are trying to see if we can do something to be the facilitators (of an orderly runoff) rather than for the companies to face liquidation," Sedgwick Chairman David Rowland said last week.

Discussions have taken place between the brokers and cedant reinsurers, and the Association of British Insurers, Mr. Rowland said.

"Discussions will continue for a number of weeks, and it will take a couple of months before anything can be put together," Mr. Wilson said.

Meanwhile, in other developments:

- Brokers in the London market led by C.T. Bowring & Co. Ltd. are trying to put together a U.S. casualty line slip to replace the Weavers slip.

The slip, if completed, would provide \$20 million in limits excess of \$5 million for U.S. casualty risks. Underwriters would use the

## British fund may cover Weavers policyholders

LONDON—Professional liability insurance policyholders of H.S. Weavers (Underwriting) Agencies Ltd. might be entitled to recoveries under a British guaranty fund if some of the former insurers on the Weavers line slip are declared insolvent.

The Policyholder Protection Act of 1976, which has never been tested in U.K. courts, says that if an insurer approved by the British Department of Trade and Industry becomes insolvent, individual policyholders would receive 90% of all claims not paid by the insolvent insurer.

The payments would be funded through a 1% levy on premiums written by British insurers related to the class of business that the insolvent insurer underwrote.

The act is designed to protect the British public if an insurer becomes insolvent and specifically excludes "bodies corporate," so major U.S. corporate policyholders would not be entitled to recoveries under the act.

But brokers and others who are interested in the orderly runoff of the Weavers line slip say that individuals who are members of partnerships could be entitled to recover under the act. That would include many of the accountants and lawyers that purchased professional liability coverage from the Weavers line slip; individual executives whose directors and officers liability insurance was placed with the slip; or doctors who purchased medical malpractice insurance from Weavers.

That is "a big chunk" of Weavers business, a London source said.

"There is an extremely good chance that if" insurers that participated on the Weavers slip "failed, there would be claims under the Policyholder Protection Act which would be administered by the Policyholder Protection Board and paid by the British insurance market," the source said.

That would help protect the reputation of the British insurance market, the source added.

—By Stacy Shapiro

policy form currently used by X.L. Insurance Co. Ltd.

Lloyd's of London underwriter Stephen Merrett has agreed to write 20% of the slip.

- The Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee, chaired by Rep. John Dingell, D-Mich., will hold hearings to investigate Weavers' problems, said John B. Chesson, the subcommittee's counsel.

The hearings could be held as early as June, he said.

- The two LUI syndicates on the Illinois Insurance Exchange will be purchased by their underwriter, Richard Foss and five other investors.

The investors are led by Jeffrey Beresford-Wood, owner of the Classic Syndicate on the IIE.

The sale, which is expected to close next week, is subject to regulatory approvals. ■

## Case management savings

*Continued from page 2*

and is expected to live another two years in the nursing home.

Dow Corning, which implemented its case management program in July 1985, has saved \$150,000 to \$175,000 per year, said Larry Muzzy, manager of benefits administration.

The chemical company, spends \$10.5 million on health care for its 3,500 covered employees, he said.

Metropolitan Life Insurance Co. underwrites the benefit plan.

- Houston-based Cooper Industries saved thousands of dollars when it arranged home health care for a child who had been hospitalized with a severe respiratory dysfunction. The company paid for a filtration system to be installed in the child's home.

Case management helped save Cooper Industries a total of \$700,000 in the last half of 1989, according to Nathalie Woolfrey, assistant director-group insurance.

The diversified manufacturer, which has used case management on and off since 1984, spends \$99 million annually on health care for its 37,000 active employees and 12,500 retirees, Ms. Woolfrey said.

These figures do not include recent acquisitions by Cooper, which will increase the workforce by 20,000 employees, she noted.

The company's health care plan is underwritten by Aetna.

And, in addition to the savings mentioned above, General Mills Restaurants Inc. has documented cost savings of \$750,000 since it implemented its case management program in January 1985, said Director of Benefits John Reiker.

The Orlando, Fla.-based restaurant division of General Mills Inc. covers 19,340 employees that work at 700 Red Lobster and Olive Garden restaurants nationwide. Each year the company spends \$40 million on health care.

General Mills Restaurants, Kawneer, Dow Corning and Cooper Industries are among the employers identified by the National Assn. of Manufacturers as employers that have been able to control health care costs through case management.

Other employers are fighting rising health care costs by: analyzing claims data (*BI*, April 30); adopting comprehensive health management programs (*BI*, April 16); working with labor unions (*BI*, April 2); and operating in-house medical clinics (*BI*, March 5).

Even small employers have developed special health care cost management strategies (*BI*, March 19).

Although catastrophic cases make up only about 20% of all health care claims, those cases are responsible for 80% of all costs, according to Jacqueline Mazoway, product manager of medical case management for Intracorp in Berwyn, Pa., the case management division of CIGNA Corp.

In a typical medical case management program, a registered nurse acts as a case coordinator and liaison between the employer, patient, family, primary physician and medical facilities to:

- Ensure that the patient receives quality, cost-effective health care.

- See that the patient and family are informed about all of their options and receive support throughout the illness.

- Promote the appropriate use of health care resources.

Medical case management usually involves four major phases: early identification, assessment, coordination and ongoing evaluation, Ms. Mazoway explained.

Conditions that are frequently identified as potential medical case management cases include cancer, major trauma, psychiatric disorders, substance abuse, heart disease, neurological disorders, immune deficien-

cies, high-risk pregnancies, premature births, organ transplants and diseases of the digestive, respiratory and musculoskeletal systems.

"Eventually all employers with an eye toward cost control will have some form of case management services incorporated in their plans," predicted Ken Sperling, a Hewitt Associates consultant in Rowayton, Conn.

"Employers have extracted what they can from pre-certification review," Mr. Sperling said. "The big dollar savings in the future will come from case management."

Among employers that have implemented case management programs, 70% reported the programs helped generate savings, the Hewitt survey found.

The average savings for an employer that implements a case management program is 2% of total medical costs, according to the survey.

However, consultants say that potential savings from a case management program can be even greater.

Peter LeBrun, managing consultant of benefit consultant A. Foster Higgins & Co. Inc. in Chicago, estimated that case management can save an employer an average of 3.5% of its total health care costs.

"Case management savings represent true dollar savings," Mr. Sperling said. "Fewer dollars are going into the health care system."

And, the big advantage of case management is that "there is no cost shifting" to employees, he said.

In addition to saving money, case management can ensure that employees and their dependants receive the most appropriate care, said JoAnn Fritsch, a consultant with The Wyatt Co. in Washington, D.C.

"These cases are very complicated," Ms. Fritsch said. "The case manager coordinates between specialists and looks at the whole body."

But, case management goes beyond arranging immediate medical needs for a patient.

For example, Dow Corning, through its case management program, was able to help an employee that could not afford a wheelchair purchase one at half the normal price, Mr. Muzzy said.

Ms. Woolfrey of Cooper Industries says an important aspect of her company's case management program involves treatment for permanently disabled children.

"Many employees don't want their children in a hospital for the rest of their life," she said. Through case management, the company is able to arrange home health care for many of these children, Ms. Woolfrey said.

Mr. Reiker of General Mills Restaurants recalled a case in which an employee was in a total body cast for eight weeks. While hospital care was not necessary, the doctor would not release the employee because it was summer and the employee's house was not air-conditioned.

General Mills Restaurants intervened and saved \$20,000 in hospital costs by installing air-conditioning in the employee's home, Mr. Reiker said.

Every employer can turn to case management to control health care costs, but case management is most successful when an employer also has a pre-certification review program in place, according to consultants. Through a pre-certification review program, the employer is best able to identify those cases needing case management, they say.

According to the Hewitt survey, 62% of employers with case management programs use pre-certification review to identify which cases will be managed.

For example, at both Dow Corning and Kawneer, Intracorp pre-certifies all employee hospitalizations to

identify those cases most appropriate for case management in addition to providing case management services, said Messrs. Muzzy and Rehm.

Each year, Dow Corning has between 20 and 40 catastrophic cases, Mr. Muzzy said.

Kawneer has approximately 15 catastrophic cases per year, Mr. Rehm said.

General Mills Restaurants has an in-house staff of four registered nurses who conduct pre-certification review and case management.

"We talk to 95% of all employees that go into the hospital," said Mr. Reiker.

Each year General Mills Restaurants manages about 2,000 cases.

But, even with a pre-certification review program, identifying all of the potential cases for case management can be difficult, said Cooper Industries' Ms. Woolfrey. Aetna handles both the pre-certification review and case management for Cooper Industries.

In the third and fourth quarter of 1989, Cooper Industries had 38 cases under case management, according to Ms. Woolfrey.

Another important ingredient for successful case management is having a benefit plan flexible enough to accommodate a case manager's recommendations, say companies that use case management.

"To the extent the case manager's recommendation is not covered by our benefit plan, we would try to accommodate the situation," said Mr. Muzzy of Dow Corning.

On a case-by-case basis, Dow Corning extends plan benefits to cover the form of alternative treatment recommended by the case manager, he explained.

For example, Dow Corning might extend the limits of psychiatric care coverage to accommodate an em-

*Continued on next page*

## Case management

Continued from previous page

employee's needs, he said. "We are a family-oriented company," Mr. Muzzy said. "To the extent we can help our employees, we will bend the rules."

Similarly, Cooper Industries extends its benefit plan to cover the recommendations of the case manager on a case by case basis, Ms. Woolfrey said.

For example, the company has paid for residential day treatment programs for employees suffering from mental disorders, she said. Normally, residential day treatment is not a covered benefit under Cooper Industries' insured benefit plan.

Because General Mills Restaurants conducts its case management program in-house, it is readily able to adapt the benefit program to the recommendations of the case manager, said Mr. Reiker.

"An in-house program allows us greater flexibility in determining treatment and makes it easier for us to adjust our (benefit) program," he said.

Employers generally experience very favorable responses from their employees after implementing case management.

Workers usually have the option to have their cases managed, and most employers achieve a very high participation rate, according to companies.

"Our plan has been reviewed very favorably by our employees," said Mr. Muzzy of Dow Corning.

A whopping 99% of employees or dependents with medical conditions that Dow Corning has identified for management have agreed to case management, he said.

"Individual employees who have experienced case management like it," reported Ms. Woolfrey of Cooper Industries.

"It is a win-win situation. Since our employees pay a portion of their health care costs, they save and we save," she said.

"Most employees feel it is nice to have a third party to talk to," said Mr. Rehm of Kawneer. He estimated that more than 80% of the Kawneer employees with serious medical conditions have agreed to participate in the case management program.

At General Mills Restaurants, 98% of employees with serious medical conditions have agreed to case management, Mr. Reiker said.

The company also randomly surveys one-third of its employees who have had managed medical condi-

tions and has found that 95% of the employees favored the program, he said.

"We have had phenomenal success from an employee relations standpoint," he said.

He noted that the company invests \$100,000 annually on educational materials explaining the case management program to employees undergoing case management.

Each time an employee is identified as having a medical problem appropriate for case management, the company creates a personalized pamphlet explaining the medical procedures the employee is facing and his options.

"This is a very high-touch as well as high-tech program," Mr. Reiker said.

"Half the battle is making the employee feel cared for."

Through its case management program, General Mills Restaurants was able to identify that pre-term births and low birthweight babies were a particular health care problem for the company. As a result, the company is developing a 15-minute video in conjunction with the March of Dimes and TPF&C, a division of Towers, Perrin, Forster & Crosby Inc., on the importance of pre-natal care, Mr. Reiker noted. ■

## Update

### Maine rules cleanup uninsured

Continued from page 2

"This is an unfortunate decision that is not in line with the trend in most jurisdictions," said Lido attorney Lynn Dondis of Skelton, Taintor & Abbott in Auburn, Maine.

This case will influence numerous other state supreme courts poised to review this issue, predicted Frederick Ansell, of Wiley, Rein & Fielding in Washington, D.C., who filed an amicus curiae brief in the case.

Attorneys for Fireman's Fund could not be reached for comment.

### Champion officers lose suit

MONTGOMERY, Ala.—A federal judge has ordered former officers of the defunct Champion Insurance Co. to pay \$115.5 million in damages related to state guaranty fund losses caused by Champion's collapse.

U.S. District Judge Robert Varner last week awarded the damages in a racketeering lawsuit brought by the state against John Eicher and other Eicher family members who were officers of Baton Rouge, La.-based Champion.

The award represents a tripling of the \$38.5 million in guaranty fund losses caused by the demise of the state's fourth-largest auto insurer.

Judge Varner entered a default judgment against the Eichers last month after they failed to respond to the complaint charging violations of the Racketeer Influenced and Corrupt Organizations act.

Mr. Eicher and six family members are also charged with theft related to their operation of Champion after being indicted by a Montgomery County grand jury in March.

Champion was ordered liquidated in Louisiana in June 1989 (BI, June 12, 1989).

### Risk manager convicted in theft

NEW YORK—A former Citibank risk management officer has been convicted of four felonies for allegedly embezzling \$25 million worth of securities from the banking giant.

Mario Rios Pinochet was convicted by a federal jury last week of taking five \$5 million bearer securities from a Citibank vault on Jan. 25 and delivering them to a PaineWebber office in Stamford, Conn., claiming he had received them from three owners in Spain and Brazil.

He instructed PaineWebber to sell the securities and wire the proceeds to a Bermuda bank account, prosecutors said.

Mr. Pinochet, who will appeal the verdict, is scheduled to be sentenced July 19. He faces up to 50 years in prison and \$1.75 million in fines.

### CIGNA alters benefit operations

HARTFORD, Conn.—CIGNA Corp. is restructuring its employee benefits operations in the wake of its acquisition of EQUICOR earlier this year.

During the next two months CIGNA plans to:

- Divide national benefits operations into three regional operating groups—Eastern, Central and Western—which will be responsible for sales, underwriting and health care services.

- Form a National Accounts unit to underwrite and service its largest customers.

- Form a Health Management Services unit to develop health care policy. The unit also will manage Intracorp, a rehabilitation and medical cost control unit; Corporate Healthcare Management, a similar unit of EQUICOR; MCC Cos. Inc., a managed mental health and substance abuse unit; and CIGNA Dental Health.

CIGNA says the changes are intended to make its vast benefit operations more responsive to customers.

Presidents of the groups are: Stephen H. Matheson, Eastern; James P. Murphy, Central; and David G. Devereaux, Western.

### Briefly noted

**California antitrust law guidelines** for the insurance industry will prohibit insurers in the state from sharing prospective loss cost information to determine rates and also suggest that two or more unrelated insurers using standard policy forms or certain exclusionary language may be violating state antitrust law. Draft guidelines were issued last July (BI, July 31).

**Texas Employers Insurance Assn.**, the state's second-largest workers compensation insurer, has been placed into conservatorship by the State Board of Insurance. As of March 31, TEIA reported assets of \$307.3 million and liabilities of \$297.9 million, not including \$57.6 million in assessments payable to the Texas Workers Compensation Assigned Risk Pool over the next three years.

**Random drug testing** of private transportation employees in safety- and security-related jobs will continue after the U.S. Supreme Court last week let stand a U.S. appeals court ruling upholding the Transportation Department testing program (BI, Dec. 25, 1989).

**Reliance Group Holdings Inc.** said it completed the sale of its **General Casualty Cos.** subsidiary to Winterthur Swiss Insurance Co. for \$630 million in cash, giving Reliance a pretax gain of about \$380 million in the second quarter (BI, March 19).

**American General Corp.** last week put itself up for sale. Company officials say it will bring at least \$700 million more than Torchmark's \$6.3 billion offer. American General stock was selling for \$47.75 late last week.

**National health care expenditures** rose 10.4% to \$539.9 billion in 1988, the last year for which figures are available, reports the Department of Health and Human Services.

**Baltimore City Circuit Court Judge Marshall A. Levin** has consolidated approximately 5,000 asbestos cases, creating the **largest asbestos personal injury case** in history, attorneys say.

**Lincoln National Corp.** said it completed the sale of **National Acadia Reinsurance Co.** to Robert M. Bass Group Inc. and affiliate Acadia Partners in a transaction valued at \$390.6 million (BI, Sept. 4, 1989).

Truckers can continue to automatically limit their liability for **cargo lost or damaged** in transit after the U.S. Supreme Court last week let stand an Interstate Commerce Commission ruling.

## Aetna lawsuit

Continued from page 2

auto insurers as well as commercial property/casualty insurers.

In its suit, Aetna seeks to prevent the insurance commissioner from requiring an eight-year assessment to withdraw from the private passenger auto market and from revoking its licenses to write other business.

Aetna charges that the two laws unconstitutionally restrict its freedom to move capital between states and that requiring the assessments amounts to taking property without due process.

The company wants to withdraw from the state auto market, but continue writing other lines in the state. Aetna is currently licensed to write general liability, workers compensation, commercial property, accident, health, marine, fidelity and surety, fire, theft, personal property and homeowner's insurance in Massachusetts, the lawsuit notes.

"The current auto insurance system in Massachusetts operates to the detriment of consumers and insurance companies alike," said John J. Martin, president of Aetna's personal financial security division.

"The insurance commissioner sets the prices so price competition is non-existent. Worse still, an insurer that decides to leave the private passenger auto insurance market in light of such conditions confronts a massive hurdle to any orderly exit from

that market because it must pay what amounts to extortion or lose all its licenses to do any other insurance business," Mr. Martin said.

Mr. Gailey said he believes the court will uphold the constitutionality of the state laws. "The law gives the insurance commissioner the ability to prevent market disruptions. I am confident that that authority will be upheld," he said.

States "have to have the ability to prevent unreasonable disruptions in the marketplace," he said.

If Aetna considers private passenger auto rates inadequate, the company could challenge those rates in state court, Mr. Gailey said.

He also noted that Massachusetts is reforming its residual auto market to cut the number of policyholders and lower insurer assessments to the assigned risk pool. By the time Aetna's lawsuit is resolved, "the economics of a decision to stay or leave will have changed dramatically," the commissioner said.

In 1988, approximately 64% of all private passenger auto policies were insured through the state risk pool—Commonwealth Automobile Reinsurers. Aetna paid about \$40 million—or 7.75%—of the state pool's \$534 million assessment to insurers in 1988, the suit says.

Aetna writes \$250 million annually in gross private passenger auto insurance premiums in Massachusetts, the

spokesman said. Aetna writes \$560 million a year in gross premiums for all property/casualty lines, excluding group health, in Massachusetts, he said.

In 1987, Massachusetts allowed Fireman's Fund Insurance Corp.—now known as Fund American Cos. Inc.—to make a one-time payment of \$45 million to the state's assigned risk pool and withdraw entirely from the state's insurance market (BI, Nov. 23, 1987).

Fund American re-entered the state in September 1988 by purchasing Lisle, Ill.-based Warner Insurance Co., which is licensed in Massachusetts but does not write auto insurance.

The insurance department is challenging the Warner acquisition, claiming it violates the 1987 settlement.

Fund American can write property/casualty insurance in the state pending a state Superior Court ruling on whether the acquisition violates the 1987 settlement, the Massachusetts Supreme Court ruled earlier this year (BI, Jan. 15).

*The Aetna Casualty & Surety Co. vs. Timothy E. Gailey, Commissioner of Insurance of the Commonwealth of Massachusetts and Commonwealth Automobile Reinsurers, U.S. District Court for the District of Massachusetts, No. 90-1051MC.*

## Insider trading

**AmBase Corp.**: David Barran, director, disposed of gift 1,900 shares of common stock at an unreported price per share on Feb. 7. Mr. Barran also indirectly acquired by gift 1,900 shares of common stock at an unreported price per share that same day, and now directly and indirectly holds 1,900 shares.

AmBase stock was trading at \$6.88 per share on April 27.

**American International Group Inc.**: Houghton Freeman, director, disposed of gift 100 shares of common stock at an unreported price per share on Jan. 24, and now directly and indirectly holds 3,118,757 shares.

AIG stock was trading at \$89.38 per share on April 27.

**Belvedere Corp.**: Robert M. Huggins, president, purchased 3,000 shares of common stock at between \$5.00 and \$5.25 per share from March 1 to March 5, and now directly holds 6,200 shares.

Belvedere stock was trading at \$4.13 per share on April 27.

**Chubb Corp.**: Philip J. Sempier, vp, sold 700 shares of common stock at \$94.00 per share on Feb. 6, and no longer holds any shares in the company.

Chubb stock was trading at \$85.63 per share on April 27.

**Corroon & Black Corp.**: Robert F. Corroon, director, sold 4,181 shares of common stock at an unreported price per share on Feb. 28, and now directly and indirectly holds 146,295 shares.

Corroon & Black stock was trading at \$28.88 per share on April 27.

**Continental Corp.**: John F. McGillicuddy, director, purchased 1,000 shares of common stock at \$28.75 per share on Feb. 16, and now directly holds 5,000 shares.

John P. Mascotte, chairman, disposed of gift 1,698 shares of common stock at an unreported price per share from Dec. 29, 1989, to March 17, and now directly and indirectly holds 14,666 shares.

Continental stock was trading at \$28.25 per share on April 27.

**Fund American Cos.**: John J. Byrne, chairman, purchased 60,000 shares of common stock at \$31.13 per share on Feb. 21, and now directly holds 100,000 shares.

Fund American stock was trading at \$30.25 per share on April 27.

**Arthur J. Gallagher & Co.**: Richard W. Kieffer, shareholder, exercised an option for 14,150 shares of common stock between \$4.97 and \$19.50 per share on Feb. 19, and now directly holds 24,212 shares.

Gallagher stock was trading at \$2.50 per share on April 27.

**General Re Corp.**: Jerry S. Wilbourn, vp, sold 6,000 shares of common stock at \$85.55 per share on Feb. 26, and now directly and indirectly holds 7,544 shares.

General Re stock was trading at \$77.13 per share on April 27.

**Marsh & McLennan Cos. Inc.**: Richard E. Heckert, director, indirectly sold 20,000 shares of common stock at \$86.90 per share on Nov. 13, 1989, and now directly and indirectly holds 500

shares.

M&M stock was trading at \$67.75 per share on April 27.

**NAC Re Corp.**: Donald Kramer, chairman, sold 100,000 shares of common stock at \$35.00 per share on Feb. 15, and now directly and indirectly holds 376,938 shares.

NAC Re stock was trading at \$32.50 per share on April 27.

**Ohio Casualty Corp.**: Vaden Fitton, director, indirectly acquired by gift 800 shares of common stock at an unreported price per share on Jan. 23, and now directly and indirectly holds 171,592 shares.

Ohio Casualty stock was trading at \$40.25 per share on Apr. 27.

**The St. Paul Cos. Inc.**: James F. Duffy, vp, exercised an option for 930 shares of common stock at \$28.31 per share on Feb. 26, and now directly and indirectly holds 8,100 shares.

St. Paul stock was trading at \$56.25 per share on April 27.

**USF&G Corp.**: Paul W. Schlough, vp, exercised an option for 1,534 shares of common stock at \$21.19 per share on Feb. 20, and now directly holds 5,804 shares.

USF&G stock was trading at \$27.75 per share on April 27.

*Insider Trading, prepared by Invest/Net Group of Miami from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry director and officers.*



# Ready to say Uncle?

Frustrated by the failure to hold the line on soaring health care costs, many business leaders are calling for some type of national health plan. Who can blame them?

As it stands, we now spend *131% more* per citizen on health care than Japan. For every \$2 of operating profits, U.S. corporations pay close to \$1 for health benefits.



At the CIGNA companies, we believe a national health plan is not the answer. But we do agree a fundamental change is needed. And we've responded with Integrated Managed Care.

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Through a long-term partnership with each of our clients and local providers of medical services, it helps to both check skyrocketing medical costs and deliver quality care. One of our clients, for example, projects a savings of \$200 million over three years.

For information write the CIGNA Companies, Dept. RC, 1600 Arch Street, Philadelphia, PA 19103. You'll find we have many interesting things to say. Uncle isn't one of them.

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