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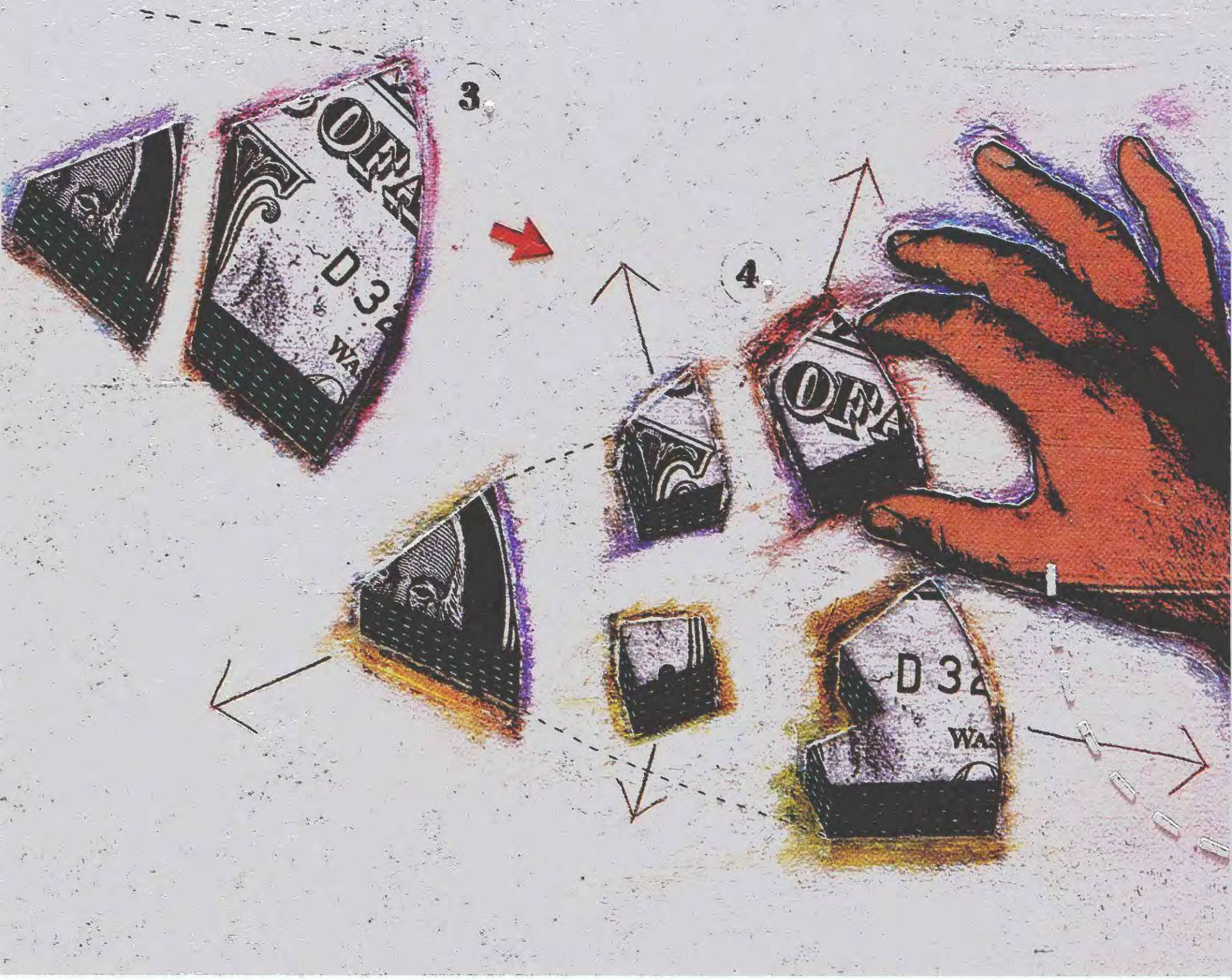
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Update

Sweeping House bill includes state pools, higher PBGC rates

WASHINGTON—The House last week approved a major budget reconciliation bill that will force sweeping changes in flexible benefit plans, boost employers' pension costs and require employers to subsidize state health risk pools for uninsured individuals.

The legislation, H.R. 3545, would place a $500 cap on the amount of pretax salary that employees in flex plans could contribute toward uncovered benefit expenses, like deductibles. And, em-

Continued on next page

State of the exchanges

New York extends deadline for syndicates to withdraw

By DOUGLAS McLEOD

NEW YORK—The New York Insurance Exchange may lose additional syndicates because the exchange's board of governors has extended the deadline until Nov. 10 for syndicates to file withdrawal petitions.

Under exchange rules—which the board has now waived—syndicates seeking to pull out by 1988 had to file notices of their intent to withdraw by Sept. 1 and submit more detailed withdrawal petitions by Oct. 1.

No separate notices of intent will be required under the board's extension of the filing deadlines.

Several exchange members had asked the board to consider waiving the timing requirements, according to an Oct. 23 letter to members and associate brokers from A. William Urquhart, the exchange's vp, general counsel and secretary.

The letter does not name the syndicates or explain the reasons for the requested extension.

However, exchange officials explained at a recent members' meeting that some members were unhappy that the recent $25 million security fund drawdown was announced two days after the Sept. 1 deadline for filing notices of intent to withdraw, according to members who attended the meeting.



Photo: David Lubarsky

Mr. Fahys

The directors of NYIE Security Fund Inc. voted to draw down the exchange's deposit fund after reviewing a preliminary actuarial report by the Tillinghast Division of Towers

Continued on page 99

IEA, state regulator meeting to decide fate of exchange

By MICHAEL BRADFORD

MIAMI—A meeting this week between officials of the Insurance Exchange of the Americas and the Florida insurance commissioner probably will determine whether the Miami marketplace can be resuscitated or will be allowed to die.

However, IEA observers indicate the prognosis for the exchange's survival is poor.

"I think the end is near," said a syndicate investor who asked not to be identified.

"There's not really a broker community left," pointed out Daniel Vaisman, president of the IEA Brokers Assn. and president of Miami Brokers Inc. "Even we know it's bleak."

Exchange President Nicholas Cross said last week that IEA directors probably would meet with Insurance Commissioner Bill Gunter by the end of this week to discuss the fate of the exchange, which has been closed since huge reinsurance losses were discovered in February.

"That meeting will determine the future direction of the exchange more than anything else," Mr. Cross said.

Last summer, the Florida exchange had targeted Sept. 1 as the date it would reopen its doors as a market strictly for excess and surplus lines insurance.

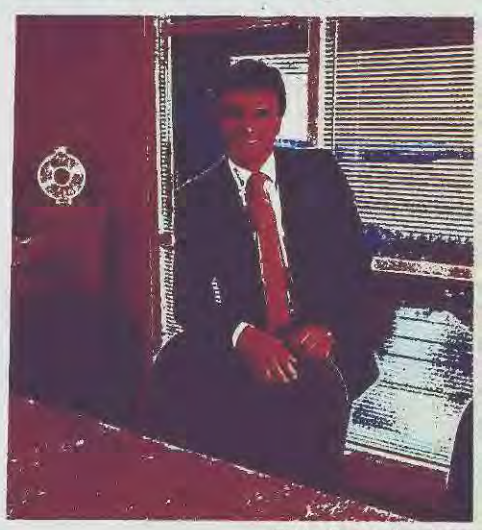


Photo: George Contorakas

Mr. Cross

When that target date was missed, the opening was reset for Oct. 1, but it quickly became clear that the facility would not be ready to open its doors by then, either.

Continued on page 96

Governor appeals Cal/OSHA ruling

By GLENN HUNTLEY

SACRAMENTO, Calif.—Gov. George Deukmejian is appealing a state court ruling that reactivated the state's workplace safety program, thus leaving the federal Occupational Safety and Health Administration in charge of worker safety in the state.

The state 3rd District Court of Appeals in Sacramento ruled Oct. 27 that Gov. Deukmejian exceeded his authority last June when he vetoed $7 million to fund Cal/OSHA, the state's worker safety agency.

California took authority over the workplace inspection and safety enforcement role from the federal Occupational Safety and Health Administration in 1974, but responsibility was transferred back to the federal agency at Gov. Deukmejian's insistence when the new fiscal year started in July.

Gov. Deukmejian announced last week he would appeal the ruling to the state Supreme Court.

"This was a decision of first impression made without legal precedent, and we have no option but to pursue an appeal," he said in a statement released Oct. 27.

Officials of California Rural Legal Assistance, petitioners in the court case, were "delighted" with the lower court victory. said Ralph Abascal, the group's attorney.

California Rural Legal Assistance, which filed the case on behalf of six farm workers, successfully argued that the governor violated state law when he cut off money for the program.

When the governor proposed shifting Cal/OSHA's responsibilities to the federal agency to save money, he left intact Cal/OSHA's role in public sector safety enforcement (*BI*, Feb. 23).

Gov. Deukmejian persists in his campaign to keep Cal/OSHA out of private sector safety issues despite opposition from labor unions,

Continued on page 99

House eases penalties for COBRA violations

By JERRY GEISEL

WASHINGTON—Congress is filing down COBRA's penalty fangs, but COBRA's bite still could be painful and expensive for some employers.

New penalties approved last week by the House of Representatives would require an employer to pay an excise tax of $100 for each day it failed to extend coverage to a beneficiary.

For example, if the violation lasted 60 days each for five people, the employer would be liable for an excise tax of $30,000.

However, if the COBRA violation were inadvertent and corrected within 30 days, the employer generally would be exempt from the excise tax.

But in certain situations—such as the Internal Revenue Service uncovering an uncorrected COBRA violation during a plan audit—the employer could be slapped with an excise tax of at least $18,000 for each person to whom it failed to extend coverage.

The $18,000 per-beneficiary excise tax, which some consultants say is overkill, could be more costly—if the violations involve several beneficiaries—than the amount some small companies pay for health insurance.

However, the secretary of the Treasury would be given the authority to waive part or all of the excise tax if the violation was due to "reasonable cause" and if the tax would be "unduly burdensome in light of the seriousness of the failure," according to a House Ways and Means Committee legislative report.

Even an $18,000 penalty, though, pales in comparison with the penalties employers face under the current COBRA statute, which the House legislation would modify.

Current IRS regulations implementing the Consolidated Omnibus Budget Reconciliation Act of 1985—under which most employers must extend health care continuation coverage to former employees for up to 18 months and to widowed or divorced spouses and dependent children for up to 36 months—would strip an employer of its annual tax deduction for health care expenses if the employer violated COBRA's health care continuation provisions for only one day.

The same penalty applies regardless of whether the violation was willful or inadvertent and quickly corrected.

In addition, under the current penalties, which have triggered a wave of employer protests, all of a company's highly compensated employees would be taxed on the cost of their employer-provided health care coverage if the company violates COBRA.

Legislators concede that the current penalties, agreed to behind closed doors and without any public discussion, are too harsh and should be modified.

"The sanction for failure to satisfy the health care continuation rules is too harsh in certain circumstances. The sanction should be tailored so that it takes into account the period of the violation, the employer's (or other responsible party's) knowledge of the violation, and the number of qualified beneficiaries affected," the Ways and Means Committee report says.

"The committee also believes that it is important to

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Update

Budget bill affects benefits

Continued from previous page
sions approved by the House Education and Labor and the Ways and Means committees.

The Education and Labor proposal would: boost the annual premium employers pay the Pension Benefit Guaranty Corp. to $19 per plan participant from $8.50; slap a $200 per-participant fee on employers terminating defined benefit plans; require employers that terminate overfunded plans to give participants a share of the excess assets. The proposal also toughens pension funding rules.

Under the Ways and Means proposal, PBGC premiums would range from $14 to $50, depending on how well a pension plan is funded. Pension funding rules would be toughened and a 20% excise tax would be imposed on pension plan reversions.

These differences, and the differences between the House bill and a similar bill winding through the Senate, will be ironed out by a congressional conference committee.

The bill also would allow states that set up health care pools for the uninsured to force employers to subsidize those pools.

Market plunge drains surplus

NEW YORK—The net result of the stock market's wild fluctuations over the past two weeks is a 10% drop in property/casualty insurers' surplus to about $98 billion, said Sean F. Mooney, senior vp and economist with the Insurance Information Institute in New York.

"You should see, particularly in the commercial liability area, the markets tighten" as a result, Mr. Mooney said.

Gloria Vogel, associate director at Bear, Stearns & Co. in New York, agreed. "Basically, I think it will put an end to the pricing competition, or at least moderate it," she said.

Overall, most observers do not expect the reduction in surplus to trigger another tight market but they predict it could constrain insurer competition (*BI,* Oct. 26).

NCCI forecasts comp ratio drop

NEW YORK—The National Council on Compensation Insurance predicts the combined ratio for workers compensation insurers will dip to 117.8% at year-end from 122% last year.

And, the NCCI predicts the improved results will continue during the next three years with combined loss ratios (after dividends) of 111.8% in 1988, 109.7% in 1989 and 108.1% in 1990.

"Significant" rate level increases are needed before workers compensation insurance can be written on a profitable basis in most of the United States, said NCCI President Kevin Ryan.

Work comp costs are increasing at 10% annually, while wages, which serve as the basis for calculating premiums, have been rising only 6% annually. Insurers need 1988 rate increases equal to that difference just to keep pace with rising costs, he said.

However, NCCI spokesmen declined to comment on the average percentage increase that insurers will seek in 1988.

Rate increases averaged about 10% in 1987 and 13% in 1986.

Group's aviation rates slashed

LONDON—The world's second-largest insurance-buying group of airlines received a 56% rate cut on hull insurance and a 20% liability rate cut as world aviation rates continue to plummet.

The KSSAF group—led by KLM Royal Dutch Airlines, Scandinavian Airline System and Swiss Air Transport Co. Ltd. and including Austrian Airlines and Finnair—renewed its hull and liability insurance Oct. 1, said Frans Husmann, KLM's risk manager.

Hull rates were reduced 56% for the group, while the insured value of its fleet grew to $8 billion from about $7 billion, he said, making it the world's second-largest insurance-buying fleet after Texas Air. Liability rates for KSSAF dropped 20%, while the liability limit increased to $1 billion from $700 million, he said.

All of KSSAF coverage was placed with the group's mutual captive in Guernsey, Polygon Insurance Co. Ltd., which is managed by Transglobe Underwriting (Management) Ltd., Mr. Husmann said. Polygon then reinsured some of the coverage to the London, U.S. and French markets.

Polygon also ceded about 2.5% of the hull and liability coverage to the International Air Transport Assn.'s new mutual insurer, Airlines Mutual Insurance Ltd. in Bermuda, and all five airlines in the KSSAF group joined the AMI mutual, Mr. Husmann confirmed.

Thirteen airlines now belong to AMI but none are American.

Jury rules against R.I. Blues

PROVIDENCE, R.I.—Rhode Island Blue Cross/Blue Shield must pay $2.9 million in damages for interfering with contracts between the Ocean State Physicians Health Plan, an HMO, and its physician members, a federal court jury says.

On Oct. 24, the jury found Rhode Island BC/BS liable for tortious interference of the contracts and federal antitrust law violations. The jury awarded no damages for the antitrust violations and awarded $250,000 for punitive damages.

"We are convinced the case was really too complex for a jury trial," said Ronald Battista, senior vp for Rhode Island BC/BS.

Mr. Battista said that the Blues will file a motion asking the judge in the case to rule in its favor despite the jury's verdict. Any judgment it ultimately has to pay would come from Rhode Island BC/BS and not insurance, he said.

"We've been saying for more than a year that Blue Cross' actions

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18 new syndicates to add capacity at Lloyd's in 1988

By CAROLYN ALDRED

LONDON—U.S. insurance buyers can expect additional insurance and reinsurance capacity from many of the 18 new Lloyd's of London syndicates that will begin writing in 1988.

However, many of those syndicates are limiting the amount of capacity earmarked for U.S. liability risks, and several syndicates will not write any U.S. liability business.

At least 18 new syndicates, with a total capacity of 124 million pounds ($211.2 million), have been authorized so far by Lloyd's to start underwriting for the 1988 underwriting year.

Ten of the new syndicates will write non-marine risks, six will write marine risks and one each will write bloodstock and aviation risks.

Four additional syndicates also are being formed from existing syndicates splitting up. For example, syndicate 799, managed by Merrett Underwriting Agency Management Ltd., will split into three separate syndicates (*BI,* May 4).

Underwriters and managers of several of the new syndicates, noting that Lloyd's is overlooking a less risky market in its own back yard, say they plan to devote a greater percentage of their capacity to U.K. risks than many existing syndicates currently commit.

"Our research has revealed that small commercial risks in the U.K. are not placed, to any great extent, in the Lloyd's market. U.K. property insurance premiums for the top 16 companies exceed some 2.7 billion pounds in 1985 ($3.9 billion at year-end 1985 exchange rates), and the Lloyd's premium income amounted to only 153 million pounds ($221.85 million)," says the prospectus for new non-marine syndicate 1104, managed by Merrett Underwriting Agency Management Ltd.

"Lloyd's lacks a substantial presence in the U.K., and there is a great opportunity here," said John Hallet, secretary of Lambert Brothers (Underwriting Agencies) Ltd., manager of new non-marine syndicate 1086. The syndicate is earmarking only 40% of its capacity for North American risks.

However, "capacity for the U.S. buyer is still going to be as great at Lloyd's as it has always been. There are substantial syndicates operating at Lloyd's with a primarily U.S. account," Mr. Hallett added.

Stephen Merrett, chairman of Merrett Holdings P.L.C., agreed. Lloyd's "has substantial continuing commitments" to U.S. insurance buyers, he said.

"Many lessons were learned from the last cycle, and I feel that there is still a tremendous amount of opportunity to make some good underwriting profits from the North American continent in the next few years," said underwriter David Thomas in a prospectus for new non-marine syndicate 1034, managed by R.M. Pateman Underwriting Agencies Ltd.

However, Mr. Thomas also said that U.S. insurers still face several problems, including underreserving

Continued on page 99

Benefit directory forms due

Business Insurance will publish the annual directory of employee benefit consultants in the Dec. 21 issue, which also will contain a spotlight report predicting trends in the employee benefit market in 1988.

The directory is published as an editorial service; there is no charge for companies to be included. However, to be listed, consultants must fill out and return a questionnaire provided by *BI.*

If your company provides benefit consulting services and you have not yet received a questionnaire, please request one by writing Marilou Jones, Directory Editor, 740 N. Rush St., Chicago, Ill. 60611; or call 312-649-5279.

The deadline for returning completed questionnaires to *Business Insurance* is Nov. 16.

Industry must tame cycles: McCormick

By DONNA DiBLASE

SAN FRANCISCO—The property/casualty insurance industry is not in the good shape many industry officials and observers believe, says one insurance company executive.

"These are thought by many to be good times in the industry. The balance sheets are stronger and there are profits. However, the cycle is still untamed and in fact, the current cycle is heading south quickly," asserts William M. McCormick, president of Novato, Calif.-based Fireman's Fund Insurance Cos.

"We can and must find a way to stop the devastating price cycles. The forces driving the cycle are bigger than any one company" so the insurance industry must work to find a solution, he told attendees of a Coopers & Lybrand insurance industry seminar in San Francisco on Oct. 23.

"It's time for us to acknowledge that at least some of our troubles are of our own making—that some of the blame rests with the industry," Mr. McCormick said.

If the industry's self-regulation does not improve, state insurance departments and the federal government will be forced to implement their own controls over the industry, he warned.

"An increasing number of states have adopted or are considering adopting strict rate regulations. The message is very clear that the government thinks we are an industry totally out of control and I think the governance of our industry is at stake," he contended.

"The choice is simple: will we as an industry continue to govern ourselves with the states or will the federal government do it for us," Mr. McCormick said.

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Maine maps comp revamp

By MEG FLETCHER

AUGUSTA, Maine—Employers generally support proposals by Maine Gov. John R. McKernan Jr. to avert a mass exodus of commercial insurers from the state's workers compensation system at year-end (*BI,* Sept. 28).

"We are very, very supportive of the approach the governor has taken," said John Melrose, an official of both the Workers' Compensation Reform Committee, an employer coalition, and the Maine Council of Self-Insurers.

However, even if the proposals—which include slashing some benefit levels—are adopted, employers expect an increase in workers compensation rates, Mr. Melrose said. "Our aim is to soften the extent of the increase."

Observers would not estimate how much of a rate increase regulators would allow if the proposals are adopted.

Gov. McKernan, a Republican, called legislators into special session Oct. 21 to consider a two-bill package that was drafted with the help of state Insurance Superintendent Joseph A. Edwards. The bills, which Democratic legislators already are seeking to amend, would cut the cost of the state work comp system by:

- Slashing permanent partial benefits.
- Modifying ratemaking procedures, including abolishing the current 10% cap on work comp rate increases in 1988.
- Emphasizing workplace safety by requiring some employers to assume deductibles and by increasing funding for an existing safety commission.
- Making the work comp system less adversarial.

"There appears to be a real recognition on the part of decision makers in the state of Maine that something needs to be done prior to Jan. 1," said Joseph DiGiovanni Jr., vp of the New England region for the 171-member American Insurance Assn.

Insurers contend that workers compensation insurance in Maine is highly unprofitable because of inadequate rates and substantial losses from the state's assigned risk plan, through which most employers buy coverage.

The assigned risk plan is critical to Maine's workers compensation market because no insurer has written policies in the voluntary market since June.

Contributing to insurers' complaints is a 1985 law that decreased rates 8% that year, froze rates in 1986 and mandated a maximum 10% increase in 1987 and 1988. Insurers say that rates are now about 290% below what they should be.

The legislative proposals were introduced as a last-ditch effort to stop 24 insurer groups that wrote 93.4% of the workers compensation insurance premiums in Maine in 1986—including Liberty Mutual Insurance Cos., the largest work comp insurer in the state—from withdrawing from the state after Dec. 31. However, the insurers must continue accepting assigned risk plan

Continued on page 97

Rise to respectability

Benefit management gains sophistication

By JERRY GEISEL

Employee benefit managers and benefit programs have risen from corporate backwaters, gaining a sophistication, importance, respect and visibility few could have imagined 20 years ago.

In 1967, benefit programs often were lodged in corporate personnel departments and were administered by employees who often lacked a direct connection to senior management.

"Twenty years ago, employee benefit managers basically were people who were technicians and were involved in the area of administration," said Joseph Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J.

"In the '80s, benefit managers are businessmen who understand financial, legal and human resources areas, and they run those areas as a business," Mr. Duva said.

Employee benefits "was not a profession 20 years ago," said Fred Hamacher, vp of compensation and benefits with Dayton-Hudson Corp. in Minneapolis. Many of those responsible for benefits in the late 1960s were "those who did not hack it," he said.

"Benefit managers now are professionals who have been in the business for a long time," Mr. Hamacher pointed out.

"The benefit manager was personnel-oriented" in the late '60s, noted Thomas Paine, a partner in the Rowayton, Conn., office of Hewitt Associates.

In other cases, corporate risk and insurance managers handled benefits as a part-time responsibility.

"Property/casualty managers took on benefits as an extra assignment," said Lloyd Kaye, a managing director with William M. Mercer-Meidinger-Hansen Inc. in New York. He added that benefit programs occasionally were administered by burned-out executives assigned to the benefits department as a last resort.

Regardless of who ran benefit departments, the job itself was viewed as passive or reactive.

"A benefit manager would implement programs rather than design benefit programs," said Douglas Stegner, Mercer's chairman in New York. "It was not a dynamic job. It was not viewed as a

Continued on next page

Government shapes 20 years of events

By ALISON KITTRELL

Government regulation was by far the biggest factor shaping employee benefits during the last 20 years, according to benefit professionals.

Legislative action dominated six of the 10 stories rated the top events of the past two decades by a group of employee benefit professionals surveyed by *Business Insurance*.

The runaway choice for the most-important occurrence in the benefits arena since 1967 was the passage of the Employee Retirement Income Security Act of 1974, which included numerous provisions to protect workers' pensions and regulate benefit plans.

The benefit panel gave the passage of ERISA 33 votes as the most-important story of the last 20 years. In addition, three ranked it second, one ranked it third, two ranked it fourth, two ranked it fifth, one ranked it sixth, one ranked it eighth, one ranked it ninth, and two ranked it 10th.

Business Insurance assigned a value of 10 points for each first-place vote, nine for each second-place vote, and so on, with a 10th-place vote worth one point. The passage of ERISA garnered 403 points, ranking far ahead of any other story.

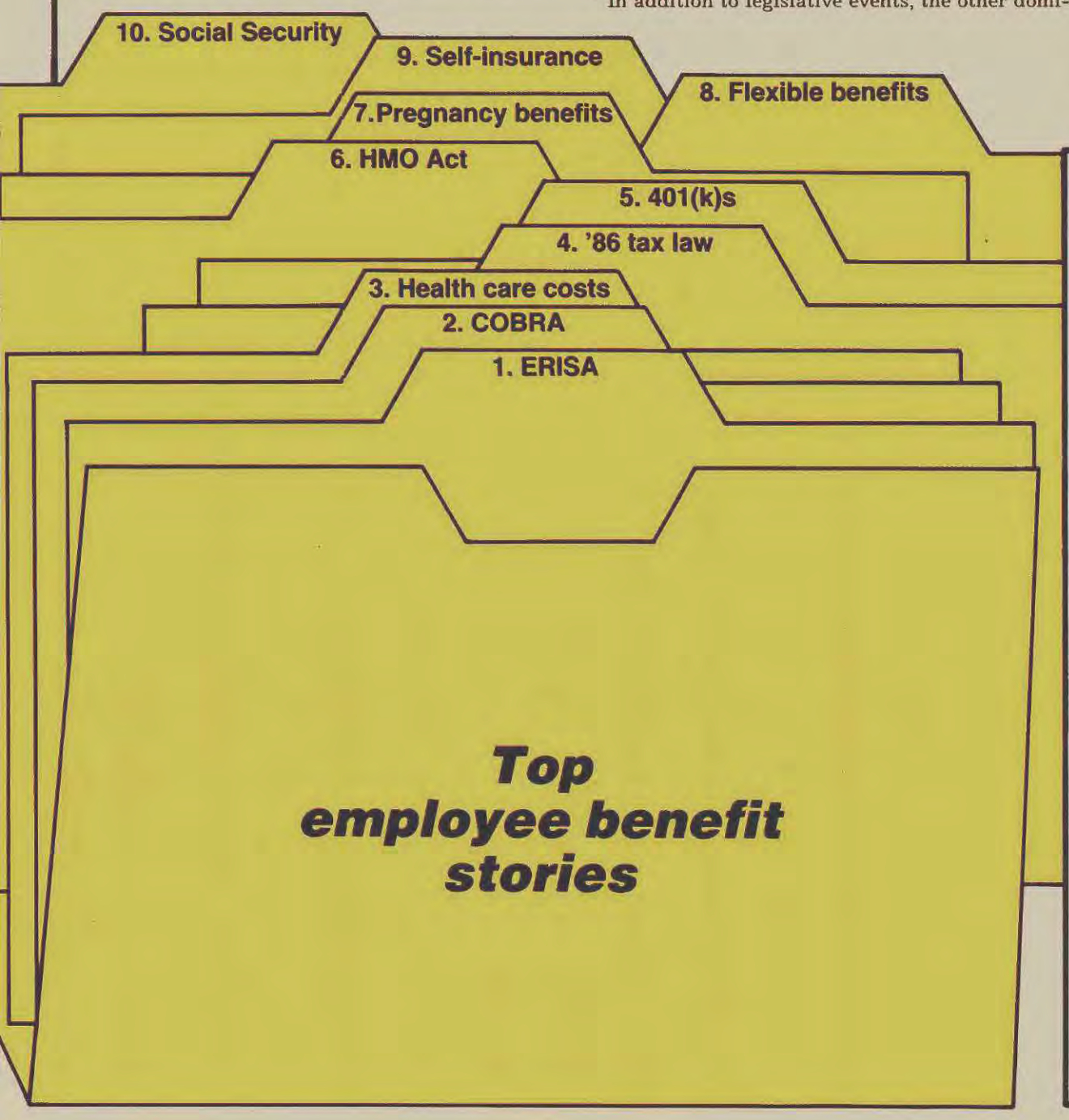
In addition to legislative events, the other dominant trend of the last 20 years was the introduction of new types of benefits, such as 401(k) plans, alternative delivery health care systems and flexible benefits, according to the panel.

In fact, the consensus of the survey group was summed up in a comment by the benefits manager for a research and consulting firm with $210 million in annual sales, who said that during the last 20 years in the benefits field: "The pace of change has accelerated, particularly on the legislative side. Benefits management has also had to respond to the needs of a changing workforce."

Following ERISA, the panel's other choices for the Top 10 stories of the last 20 years were:

- The passage by Congress of the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires employers to extend health care coverage to former workers and to the divorced, separated or widowed spouses of employees; a total of

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BI chronicles 20 years of benefit milestones

This issue of *Business Insurance* recaps the many innovations in employee benefit management since *BI's* first issue in October 1967.

As a special feature, the *BI* staff selected 20 people who have left their mark on benefit management during the past two decades to predict what innovations will develop in their areas of expertise during the next 20 years. These essays begin on page 33.

In addition, we have created "time capsules" that summarize interesting employee benefit management events and trends from each of the past 20 years. These time capsules begin on page 12 and continue throughout the issue.

Other features in this anniversary issue include:

BI speaks out on benefit issues ..... Page 10
Dental plans make employees smile ..... Page 20
Benefit costs explode over two decades ..... Page 24
Managed care programs still evolving ..... Page 70
Employers turn to self-insurance ..... Page 72
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Some innovations gain little popularity ..... Page 77
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Drug plans stem rising benefit costs ..... Page 95
State laws mandate parental leave ..... Page 95
Have insurers learned from past gaffes? ..... Page 100

Managing benefits

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position having an impact on the corporate bottom line."

As a result, the corporate attitude toward benefits discouraged creativity and innovation.

"Years ago, everyone was concerned with the next company. . .of matching benefit increases, regardless of what was right or wrong for the company. We were in a giveaway mode," Mr. Hamacher said.

"Companies wanted to be competitive with leaders in their industry, rather than designing benefit plans that were right for them," agreed Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

But exploding costs, especially for health care as well as massive demographic changes and meddling by Washington have given benefit managers a new importance and visibility in corporate America over the last 20 years, while completely changing the face of benefit plans.

"We moved from buying insurance policies to starting to ask where all the money was being spent," said Art Young, corporate benefits manager at Hewlett Packard Co. in Palo Alto, Calif.

"Benefit management is much more visible now. It had been out of sight and out of mind. It is visible because of legislation every year and because of the ever-increasing cost," Dayton-Hudson's Mr. Hamacher said.

For example, in 1967, health and life insurance benefits cost employers an average of $261 per employee. By 1979, the cost had climbed to $861 and by 1985 it had reached $1,561, according to surveys conducted by the U.S. Chamber of Commerce (see story, page 24).

"Corporate executives began to see that benefits were costing a lot more money. The cost of benefits, as a percentage of payroll, went from the 20s to 30s. Management said: 'We've got to do something,' " said Mercer's Mr. Stegner.

"There's no question there is more direct access to senior management because of the major costs we are now dealing with," said Mr. Duva of Allied-Signal.

"There emerged a new breed of benefit manager who was more financially oriented and who was as concerned about dollars and cents as he or she was about plan design," said Bernard Tresnowski, president of the Blue Cross & Blue Shield Assn. in Chicago.

"There was an upgrading of background. Benefit managers now increasingly have financial and legal backgrounds rather than emerging from the ranks of personnel departments," Mr. Rumack said.

Because of rising costs, benefit managers moved away from being administrators to assume a new role as corporate financial executives.

"The benefit manager now is more of a businessman, responsible for a line of business that has a direct impact on the bottom line. He is now concerned about how a company can get its money's worth out of the benefit plans it is offering," said Mr. Paine of Hewitt.

While the benefit manager's job now is more financially oriented, it also is more complex.

Today, benefit managers often must deal with and understand a widening variety of benefits, including flexible benefit plans, 401(k) salary reduction plans, health maintenance organizations, preferred provider organizations, utilization review programs and cash-balance pension plans. In addition, many benefit managers now must understand the intricacies of self-funding health care benefits.

Most of those arrangements did not even exist two decades ago.

At the same time, until the mid-1970s, Washington kept its hands out of the benefit arena. However, beginning with the passage of the Employee Retirement Income Security Act of 1974, and followed by a virtual blizzard of legislation, Congress and federal regulatory agencies began to exert their influence on benefit plans, forcing benefit managers to understand and comply with a set of ever-changing, ever-more complex laws and regulations.

The hand of Washington—sometimes encouraging, but more often interfering—also forced companies to seek benefit managers with new legal talents.

"The level of complexity and the compliance effort has increased enormously. There has been an upgrading of backgrounds, with more benefit managers having legal degrees," Mr. Rumack said.

"So much of the benefits practice has become legalistic. Today, people in benefits tend to know a lot about the law," said Howard Weizmann, manager of benefits planning and design at Sun Co. Inc. in Radnor, Pa., who is also a lawyer.

"Benefits has become one of the most heavily regulated areas of commerce and is becoming more so all the time," Mr. Weizmann explained.

Some benefit managers point out that Washington's ever-increasing role in benefits planning has helped shape the profession.

"ERISA helped give birth to the benefits professional. It added complexities that required real professionalism," said Mr. Hamacher of Dayton-Hudson.

However, others say that increased regulation, such as ERISA, has taken creativity away from benefit managers while adding mountains of often needless paperwork.

The time benefit managers spend complying with various federal regulations and law is "time we could spend in benefit design," said Paul Nordine, a benefits consultant with BankAmerica Corp. in San Francisco.

"Much of the legislation enacted by Congress has been a real nuisance in the administrative area but produced very little in the way of enhanced benefits for employees," said Tony Sawitoski, corporate director of compensation and benefits at Morton Thiokol Inc. of Chicago.

"ERISA was a compliance effort. It didn't change pension programs for major companies that much. But it created a lot of unnecessary

Continued on page 6



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WORKERS' COMPENSATION
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Managing benefits

Continued from page 4

documentation that is still a big burden," Mr. Duva said.

Just as benefit managers and the benefit management profession have changed, so have corporate benefit programs in response to rising benefit costs and an increasingly diverse workforce.

One way to meet those challenges was through the introduction of flexible benefit plans, an approach to benefits that did not really exist until the mid-1970s but then began to grow rapidly (see story, page 74).

"Employers were becoming increasingly aware of demographic changes in their workforces," said Carson Beadle, a managing director with Mercer in New York.

Benefit plans, often designed to meet the needs of a married male employee—with a non-working spouse and two children—who intended to stay on the job for many years, were less and less attractive for the large numbers of single wage-earners and two-income families that began to enter the workforce.

"We began to see a tremendous diversity in our employees. One may have wanted extra vacation, while another wanted extra life insurance. There was no way we could afford to provide that in a standard benefit program," said Mary Jane Klansky, formerly director of employee benefits at Educational Testing Service in Princeton, N.J., and now a consultant in Metuchen, N.J.

"Employees' needs change throughout their lifetime," observed Linda M. Spear, division staff manager for benefits planning with Bell Atlantic Network Services Inc. in the Arlington, Va.

"Everyone doesn't need a size 42 suit," said Lance Tane, manager of The Wyatt Co.'s flexible compensation team in Washington.

But, companies could not always add new benefits sought by their ever diverse workforce. Even if they could, it would not make good economic sense.

"Vision care may be used by just 20% or 25%, while for 75% of employees it would have very little value," said Bell Atlantic's Ms. Spear.

The introduction of Educational Testing Service's flexible benefit plan in 1974 provided the first clue that employers were interested in the concept.

"I received thousands of cards from people who wanted to know more about the plan. It told me that the time had come for flexible benefit programs," Ms. Klansky said.

But flexible benefit plans did not begin to take off until 1982, when word began to circulate in benefit consulting circles that the Internal Revenue Service would not oppose using salary reduction arrangements to fund benefits in flexible plans.

Through the use of salary reduction, employees could use pretax dollars to pay for uncovered benefit expenses, like medical care deductibles, or new benefits, like vision care.

"The tax incentive helped to speed" the adoption of flexible plans, although "flex would have grown anyway because it helps save money," said Robert Dankmyer, director of employee benefits at Marriott Corp., the Washington, D.C.-based hotel and restaurant chain.

No matter what the reason, flex plans multiplied. In 1983, there were 88 comprehensive flexible benefit plans operating. By 1985, that number had climbed to 356, while Hewitt estimates there will be more than 600 flexible compensation programs in operation by year-end 1987.

Some experts believe that if Congress decides to tax employees on the value of their benefits, flexible plans could become even more attractive.

"If you are taxed on something that you don't use, such as a rich medical plan, you will want a plan that lets you get by with paying less or no taxes. No one wants to be taxed on the value of something that is not used," said Hewitt's Mr. Paine.

Just as changing demographics and tax incentives have led to the growth of flexible benefits, they also are responsible for innovation in pension plans, a benefit area considered stuffy and stodgy two decades ago.

"If there was a stuffy field 20 years ago, it was pensions," said Kevin Meehan, an attorney in Wyatt's Washington office.

Two decades ago, employers typically offered a defined benefit pension plan, with relatively long

Continued on page 8

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Managing benefits

Continued from page 6

vesting periods, ranging from 10 years to sometimes as much as 15 to 20 years.

But these plans, designed for long-time employees, were of limited appeal to a new generation of workers entering the workforce, who did not expect to spend a lifetime with one company.

"Defined benefit plans didn't work very well for the baby-boom generation, the generation that would be changing jobs frequently. You had to offer something more," said Sylvester Schieber, director of Wyatt's Research and Information Center in Washington.

That something more was defined contribution plans, which offered faster vesting than defined benefit plans, as well as a more visible benefit.

"To attract workers, you had to offer a program that provided real benefits after a few years," Mr. Schieber said.

Defined contribution plans also appealed to employers because the cost often was low and predictable and because employees often were asked to share the cost.

"When we introduced a savings plan in 1982, we thought it was the way to go. Rather than just plowing more money into the company-paid pension plan, the cost and responsibility for saving for retirement would be shared by the company and the employee," said Hugh Marx, vp of human resources at Morton Thiokol.

Defined contribution plans boomed throughout the 1970s and 1980s, more than doubling from 272,000 plans in 1974 to 586,000 in June 1986, according to statistics compiled by the Employee Benefit Research Institute of Washington, D.C.

But it was one specific type of defined contribution plan—the 401(k) salary reduction plan—that emerged as the true benefit star of the 1980s.

While Congress added Section 401(k) to the Internal Revenue Code in 1978, it was not until the publication of proposed IRS regulations in late 1981 that the 401(k) plan bandwagon began rolling.

Those regulations made it clear that employees could make pretax contributions, or salary deferrals, to savings plans where the funds would earn tax-deferred interest.

Like conventional savings plans, 401(k) plans appealed to employers because the cost was low and predictable. Typically, employers matched each dollar of salary deferral with a 50-cent contribution, up to the first 6% of salary contributed.

And the mechanics of adding a 401(k) plan were relatively simple. Typically, a 401(k) feature could be tacked onto an already existing savings plan.

Employers liked 401(k) plans, but employees were ecstatic about them. Instead of making aftertax contributions, their retirement savings could now be used to lower their taxable income.

"Employees were convinced that the tax structure could be put to their use. There was a tax incentive, coupled with an employer incentive in the form of a matching contribution, to save. There was nothing like it before," Mr. Schieber said.

"A 401(k) plan was a much better deal for employees than an aftertax plan," said BankAmerica's Mr. Nordine.

The number of employers offering 401(k) plans exploded. For example, Wyatt found that by 1987, 47 of 50 major corporations it surveyed offered a 401(k) plan, compared with only 13 of the 50 companies it surveyed in 1983.

But defined benefit plans were not being neglected either. In response to employee complaints that defined benefit plans were valuable only to long-term employees, benefit consultants in 1985 came up with a pension hybrid: cash-balance pension plans, which combined elements of defined benefit and defined contribution plans.

"Employees couldn't see the benefits in a defined benefit plan. The plans had gotten so complex that employees didn't understand and appreciate the benefits," explained Lawrence T. Brennan, a partner at Kwasha Lipton in Fort Lee, N.J.

"We were spending $70 million a year on pensions, yet the benefits were not being appreciated. That told us something was wrong," said Mr. Nordine of BankAmerica.

But under a cash-balance pension plan, a concept developed by Mr. Brennan and first adopted in 1985 by BankAmerica, an account is established for each employee. Additional credits are added to the account each month based on pay and the employee's years of service, while the funds in the account earn interest at a predetermined rate.

This account balance, similar to a balance in a defined contribution plan, was easily understood by employees, Mr. Nordine said.

At the same time, employees vest at a rate of 10% per year, ensuring that even short-term employees receive a benefit when they leave.

But like a defined benefit plan, the employer promises to provide a specific retirement benefit and that benefit is insured by the Pension Benefit Guaranty Corp.

"A cash balance plan is the pension plan for today's employees," Mr. Brennan said. He estimates that between 50 to 75 employers—including such Fortune 500 companies as Sun and Borden Inc. in Columbus, Ohio—have established cash-balance plans.

"We added cash balance to help short-term employees. Our workforce became younger," Sun's Mr. Weizmann said, pointing out that defined benefit plans do not represent much of a benefit for young employees who only stay at a company for a few years.

Innovation also has been striking in the health care field, although change in the early 1970s got off on the wrong foot.

Twenty years ago, health care plans often paid benefits on a schedule. For example, a plan paid so many dollars per day in the hospital and so many dollars for surgical fees.

By the early 1970s, however, these scheduled plans began to fall by the wayside. Employees griped that the schedules did not keep pace with medical charges, forcing them to bear more of the costs.

By the early 1970s, employers increasingly were replacing scheduled plans with comprehensive programs that paid virtually all of an employee's medical costs.

"It was a time of first-dollar, super-rich, non-contributory plans," said David Walker, a principal at Mercer and head of its St. Louis office.

"The seeds were being sown for future problems," said Stanley Rosow, a partner in the Chicago office of Hewitt Associates.

By the mid- and late 1970s, employers, alarmed at escalating health care costs, began to take the first—albeit modest—steps toward controlling those costs.

"It was a time of passive cost containment, with employees being encouraged, but not required, to obtain second opinions for elective surgery," said Larry Leisure, national practice leader with Towers, Perrin, Forster & Crosby in New York.

But costs continued to shoot up, forcing employers to take more aggressive actions that today have

Continued on next page

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Continued from previous page
become commonplace.

"Since 1983, we've made more than 30 changes to our medical plans, compared to about a half-dozen in the entire decade of the '70s," said Hewlett Packard's Mr. Young.

"My department is half made up of people trying to control health care costs," said Mr. Hamacher of Dayton Hudson.

"Twenty years ago, no one looked at cost."

In battling health care costs, employers utilized a battery of weapons, including alternative delivery systems like HMOs and PPOs, utilization review, education programs and shifting some health costs on to employees to make them wiser health care consumers.

"Employers were beginning to realize that if you have free electricity, the lights around the house will burn constantly. But once it begins to cost, the lights will begin to be turned off. The same holds true with health care," said Mercer's Mr. Walker.

Morton Thiokol, for example, clamped down on Friday admissions to hospitals, which usually are unnecessary since few hospital procedures are performed on weekends, Mr. Marx said.

Bell Atlantic offered employees incentives to avoid high-cost hospitals.

"We gave 'incents' to encourage employees to use certain services," Ms. Spear said.

For example, medical care deductibles were waived for pre-admission testing.

But some health care cost-containment techniques, highly touted at first, have not always lived up to their promise.

"We've moved employees, through incentives, to non-hospital settings, where it may be more difficult to control charges," said Mr. Leisure of TPF&C.

"It appears that HMOs are attracting younger, healthy employees. That may not be saving us money; it may be costing us money," said Morton Thiokol's Mr. Sawitoski.

But the fact that employers suggest that employees join HMOs in the first place marked a change of attitude, some say.

"The company attitude toward HMOs used to be: keep them out," recalled Mr. Walker of consultant Mercer.

Now, it is the exception if an HMO is not part of a benefit package. For example, 95 different HMOs now offer coverage to employees of Marriott Corp.

In addition, benefit managers, striving to control health cost, quickly embraced another type of alternative health care delivery system, the PPO.

"PPOs have had a phenomenal effect in a short time," said Peter Boland, president of Boland Healthcare Consultants in Berkeley, Calif.

"They have educated purchasers that they have a great deal of bargaining clout because of the volume of business they can bring to providers."

"A PPO is a symbiotic relationship between the provider and the buyer. There are such powerful advantages to both parties that they cannot be ignored," said Wally McCall, vp-marketing and sales for the PPO Alliance, a Cypress, Calif.-based PPO.

PPOs taught employers that they could directly negotiate prices with doctors and hospitals, observers say.

"Today, we have people on staff who have the expertise to challenge medical bills and the expertise to negotiate prices directly with providers," Dayton-Hudson's Mr. Hamacher said.

In addition, employers have increasingly turned to self-funding of their health care plans to save money over the last two decades (see story, page 72).

"Self-funding was very small 20 years ago," recalled Samuel X. Kaplan, president of U.S. Administrators Inc., a Los Angeles-based third-party claims administrator.

"With self-funding, you could shave a couple of points off your costs. With employer costs 10 times what they were once were, those couple of points become more and more important," Mr. Kaplan said.

"By self-funding, we've saved between $10 million and $15 million on state premium taxes alone since the early 1970s," said James Clousing, director of employee benefits at Sara Lee Corp. in Chicago.

Today, self-funding has become the norm among large companies and increasingly common among small firms, too.

For example, among employers with between 10,000 and 19,999 employees, 70% self-fund their health care benefits, while 46% of all employers self-fund, according to a survey released earlier this year by Johnson & Higgins (*BI*, Jan. 26).

This growth of increasingly sophisticated benefit plans, coupled with new rules for benefit plans laid down by the federal government, has fueled a boom industry: employee benefit consulting.

"We were much, much smaller 20 years ago," said Hewitt's Mr. Rosow. Hewitt in 1967 had about 100 employees and annual revenues of about $1.5 million. Last year, Hewitt employed more than 1,500 people and generated revenues of $100 million.

Benefit lobbying also has picked up steam in the last 20 years. Groups representing benefits managers, like the ERISA Industry Committee, the Employers Council on Flexible Compensation and the Washington Business Group on Health, did not exist, while the Assn. of Private Pension & Welfare Plans was primarily an educational organization.

But with Washington, beginning with ERISA, exerting more influence on benefit plans, benefit lobbying groups began to be organized and strengthened.

"We had been an educational and research organization. But there was a need for political muscle. That is why we changed," said Stuart Brahs, former executive director of the APPWP and now vp-federal government relations in the Washington office of The Principal Financial Group.

The ERISA Industry Committee, which had relied exclusively on outside counsel for lobbying, established an in-house staff in 1984 to have more influence in the legislative arena.

"Without a full-time staff, we didn't have the resources to deal with benefit issues on a daily basis," said ERIC Executive Director Mark Ugoretz.

And now other organizations want to make their views known on benefit issues. Last year, the Risk & Insurance Management Society Inc. created the position of associate legislative director, who would primarily be involved in benefit issues.

"RIMS did not want to sit around while benefit legislation was becoming more important to its members," said Jon Harkavy, RIMS director of governmental relations.

RIMS already is making its views known on benefit issues. RIMS was among the first to endorse a variable rate premium structure for the PBGC, while 200 risk and employee benefit managers used a RIMS-drafted letter to complain to the IRS about tax penalties employers face if they violate the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act. ■

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Opinions

Thoughts from the past

During 20 years of commenting on employee benefit issues, Business Insurance editors have been prescient, sometimes pedantic and certainly persistent. Following are excerpts from editorials from the past 20 years addressing employee benefit issues.

WE ARE IMPRESSED with the remarks of Ben Goodenough of the Pacific Maritime Assn. who said that unions and employers should declare a moratorium on new benefits and instead bargain jointly to insure a workable cost control system. "No other powerful group is moving to curtail costs," Mr. Goodenough said, "and if labor and management do not move soon, the government will have to step in because mountains of discontent are building up."

We think Mr. Goodenough has hit the nail on the head. Cost control procedures seem about the best way to head off soaring health care costs, and we're encouraged to note that more and more attention is being paid in this area (*BI,* May 6, 1968).

THE EMPLOYEE Retirement Income Security Act of 1974, signed by President Ford during rose garden ceremonies on Labor Day, has been hailed as a mammoth piece of legislation that will, among other things, protect the pension rights of 30 million American workers.

That may be an understated description for employee benefit managers, for the new legislation is certain to bring new duties and responsibilities for corporate executives in benefits management. One area that is going to require swift response from benefits managers falls under the general heading of communications (*BI,* Sept. 16, 1974).

SOME SMALLER employers are being enticed into joining multiple employer trusts for pooling group benefit plans, either insuring or self-insuring the benefits with the aim of saving money.

There are suspicions that at least a few of the so-called self-insured METs are playing a classic Ponzi game, pyramiding premiums to pay claims generated by employees whose health coverages went earlier into the "pool."

What's as bad a disgrace is the complete lack of regulation in this area.

Thanks to ERISA, state regulation of pooled benefit plans under trust arrangements might be pre-empted, leaving the Labor Department as regulator to see to it that these pooled programs are financially sound, are sold without fraud and have the money to pay future claims as promised.

The Labor Department is amiss in not having done anything to date to supervise METs. Unless the Labor Department gets itself together, we suggest state insurance regulators be allowed to oversee the METs (*BI,* March 7, 1977).

CORPORATE BUYERS of health insurance plans and health plan underwriters should support hospices for two reasons: They offer alternative care for the terminally ill who don't want to prolong a life tied to countless life-support systems, and they offer more economical care. But health insurance policies routinely exclude reimbursement for hospice care (*BI,* Sept. 29, 1980).

WE ARE INTRIGUED by the suggestion that workers compensation and group life and health products could be integrated into one insurance product for employers.

There are strong arguments for integrating workers compensation and group life and health policies: Eliminating the duplication of policy purchasing and production expenses; eliminating the duplicate risk charges and eliminating the uncertainty over which policy should pay a claim (*BI,* Aug. 2, 1982).

LET'S GET THIS STRAIGHT once and for all. Neither General Motors Corp. nor Chrysler Corp. spends more on its group health care programs than on steel (*BI,* Aug. 13, 1984).

THE PENSION Benefit Guaranty Corp. is on the road to insolvency; its termination insurance program has a $1.3 billion deficit. Unless revenues are increased and reforms enacted, the PBGC will be unable to guarantee benefits to participants in terminated plans that the agency has taken over (*BI,* Feb. 10, 1986).

Letters

The following are a sampling of letters to the editor on employee benefit issues published by Business Insurance over the last 20 years.

Dec. 11, 1967

To the editor: I don't think that an increase in Social Security benefits calls for a reduction in a private plan when the benefits are based on final salary.

Employees who retired five or 10 or 15 years ago on final salary plans that provided reasonable pensions at that time are in financial trouble today due to inflation and our rising standard of living.

Social Security increases have been "catch-up" increases. In fact, they haven't caught up with inflation let alone helped previously retired employees share in the increases in technology and productivity that give us our present high standard of living.

The problem of the person who retired on final salary or fixed income in previous years is a real one and one that benefit managers have an obligation to bring to management's attention. Especially troublesome are the problems of widows of retired employees where there has been no automatic joint and survivor benefit.

David A. LaMoreaux
Administrator
Kaiser Motors UAW-CIO
Retirement Fund
Wayne, Mich.

Jan. 23, 1973

To the editor: Coming across the term "flexible compensation" twice in one issue of your fine publication (*BI,* Dec. 4, 1972), as I did in the reported comments of two highly qualified gentlemen—Messrs. Wood of Hewitt Associates and Attwood of Equitable—suggests that it has a cachet that makes it more palatable than the older, more hackneyed, "cafeteria approach to compensation."

To suggest that employees are competent judges of true, as opposed to more visible but less valid, needs is spurious—as is attested to by the average person's failure to provide adequately for his disability, retirement or death, if left solely to his own devices.

As Mr. Wood says, ". . .employees manage to make rather important choices off the job. . . ." This, however, is not synonymous with making the right choices!

On balance, cautionary remarks and suggested fail-safe mechanisms—in somewhat inhibiting the individual's choice by the use of sundry parameters—is closer to reality in my opinion.

The fundamental ingredient in any context, however, is to educate the individual. Without such insight and carried away by his own bias or favoring, the individual can gorge himself on the one hand and deprive himself on the other. Since everyone in that "cafeteria" is not an "economic dietician," there surely will be some acute distress unless some knowledge and moderation are brought to bear on the problems of the man, his family and estate.

George C. White
Consultant
Massapequa, N.Y.

April 8, 1985

To the editor: The cost of tax-free employee benefits ranging from 35% to 40% of wages is overstated. That figure includes Social Security, vacation, holidays (that are taxable) and coffee cups. When you really come down to it, tax-free benefits probably cost less than 10% of wages. I don't think it could stand taxing.

J.E. Louer
Corporate Risk Manager
Perkin-Elmer Corp.
Norwalk, Conn.

April 14, 1986

To the editor: You and your readers still demonstrate an inhibition to accept the notion that meaningful, long-term control of health care costs must be implemented at the provider level.

The vehicle(s) to achieve that objective can take several forms, but once achieved and coupled with an effective, comprehensive utilization review program, the magnitude of the savings in health care costs will be dramatic.

Ralph N. Galascione
Principal
The Benefits Consulting Group
San Diego

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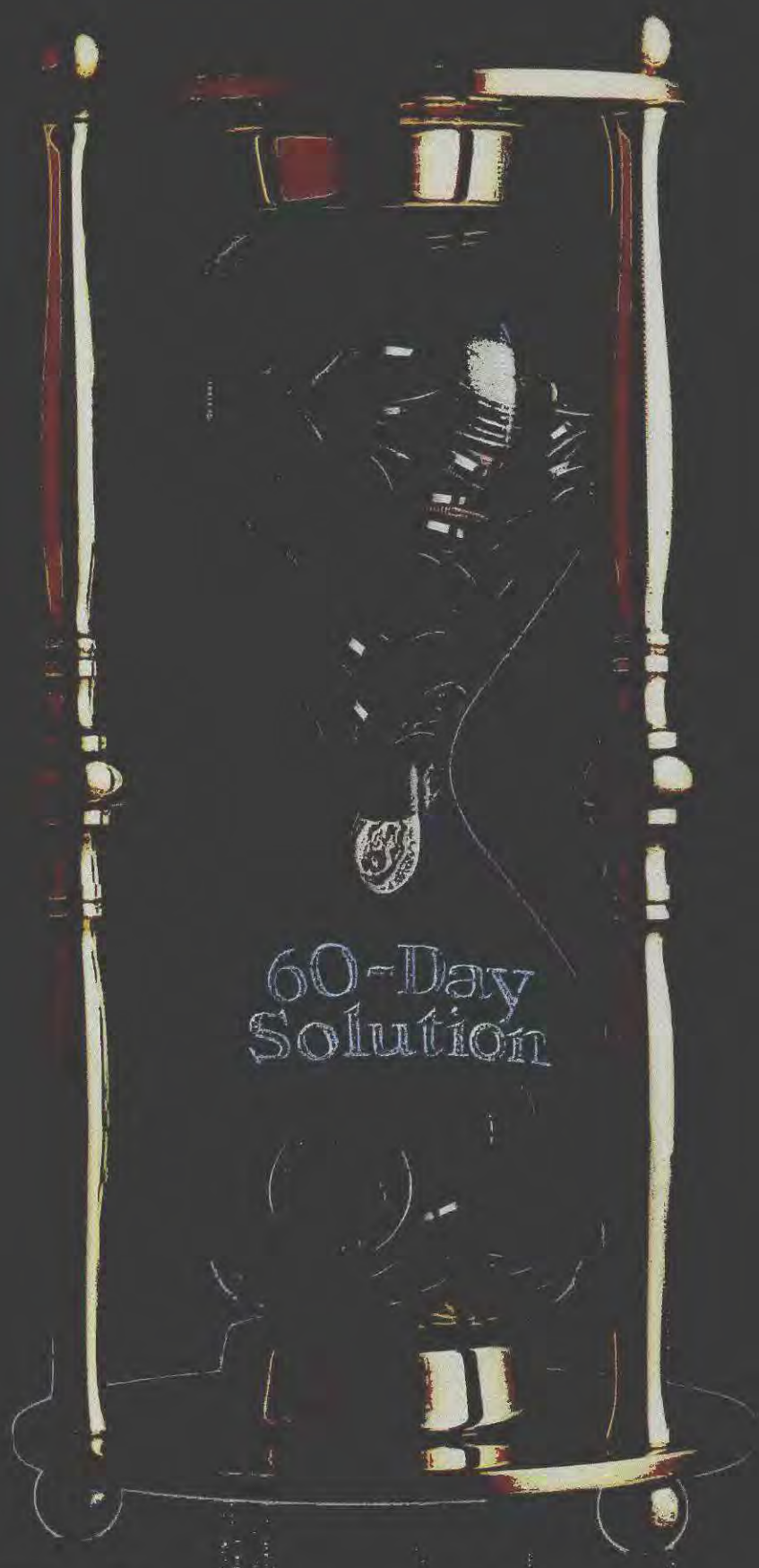
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Time capsule: 1967

The first national prescription drug plan is included in a three-year contract negotiated between the United Auto Workers union and Ford Motor Co. The plan, which does not take effect until October 1969, is a model for similar plans under negotiation by other autoworkers, as well as other unions nationwide.

Under the prescription plan, all active UAW members and their immediate families—but not retirees or survivors—may purchase prescription drugs from participating pharmacies for $2 per prescription. In most cases, the balance of the cost will be covered by Michigan Blue Cross/Blue Shield, although in some cases it is covered by Ford's life insurer, John Hancock Mutual Life Insurance Co.

Druggists participating in the plan sell the prescription drugs at a net cost, plus a professional fee. The Ford plan closely follows a model for prepaid prescription drug plans drawn up by the American Pharmaceutical Assn. (*BI,* Oct. 30, 1967).

* * *

The New York General Assembly plans to introduce a compulsory health insurance measure in its next session. The measure, the first to be introduced in any state, would require employers with three or more workers to offer hospital, surgical and medical expense coverage for their employees and dependents.

Employers of personal or domestic help in private homes would be exempted from the measure, legislators say.

Both state Sen. Seymour Thaler and Gov. Nelson Rockefeller are planning to introduce bills, and debate on those measures is expected to top the legislative agenda for the 1968 session. Senate officials said consideration of the issue was being delayed until the 1968 session because there was not enough time remaining in the 1967 session.

The differences between Sen. Thaler's proposal and Gov. Rockefeller's bill, which is considered more conservative, center on the availability of coverage, required benefits, eligibility, contributions and administration (*BI,* Oct. 30, 1967).

* * *

Unions, faced with the worst inflation since the end of World War II, are concentrating on wage increases in negotiations with employers, and downplaying the importance of benefits, according to Paul Hood, director of employee benefits service for EBS Management Consultants in New York City.

Speaking to the 10th annual conference of the Dallas-Fort Worth Chapter of the American Society of Insurance Management, Mr. Hood said he expects continued growth in survivor benefit packages and expansion of medical benefits "when we have a relatively stable dollar."

Mr. Hood cited the current negotiations between the United Auto

Continued on page 16

Looking back over 20 years

The more things change, the more they remain the same.

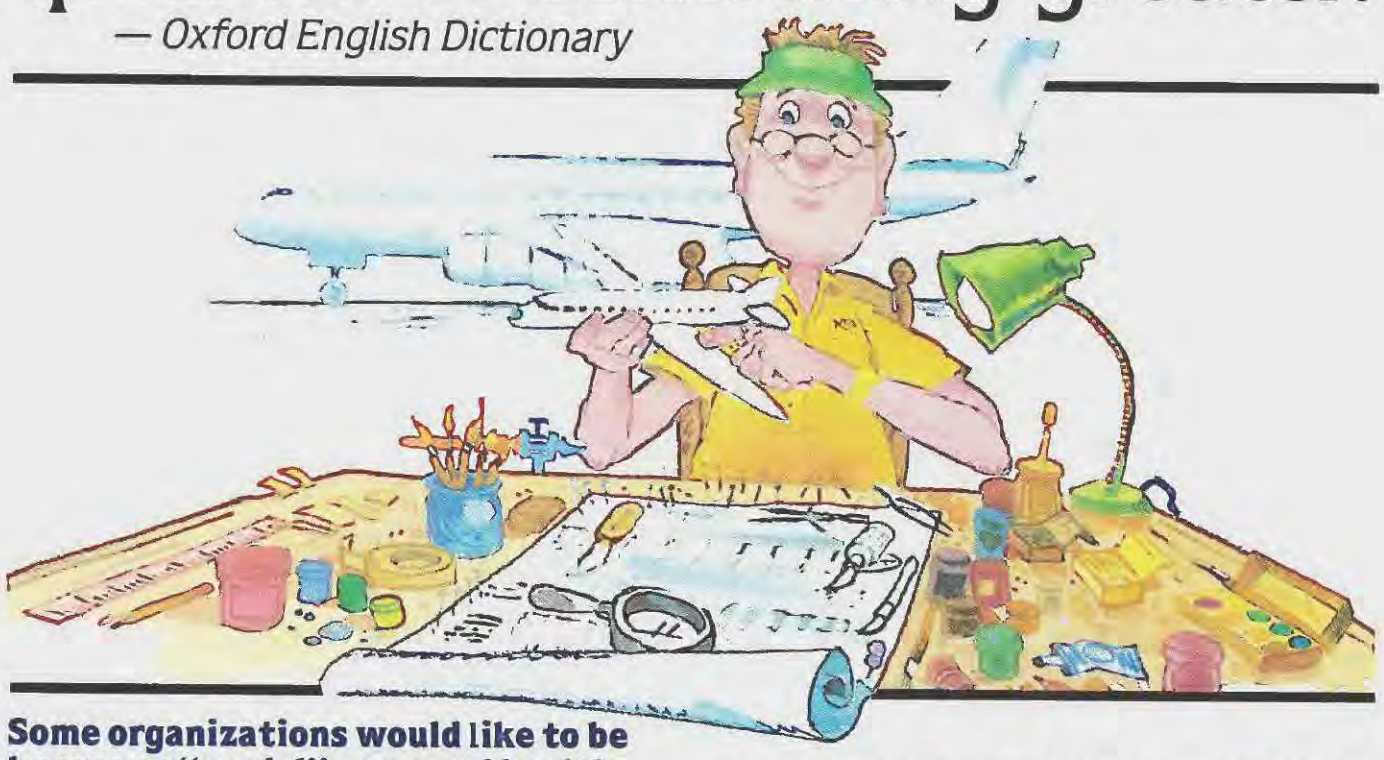
That's especially true in the employee benefit profession. Even though new benefit issues are constantly coming to the forefront, benefit managers still have some of the same concerns they harbored 20 years ago, like cost containment and new, perhaps unreasonable, government regulations.

To track the evolution of the employee benefits profession, the *Business Insurance* staff scoured its archives to present some of the most important, poignant and sometimes just plain funny stories of the last 20 years. We call these collections time capsules.

A review of the events of 1967 begin on this page. Time capsules for other years, up to and including 1986, appear throughout this edition.

The time capsules were written by freelancer Alison Kittrell, a former *Business Insurance* copy editor.

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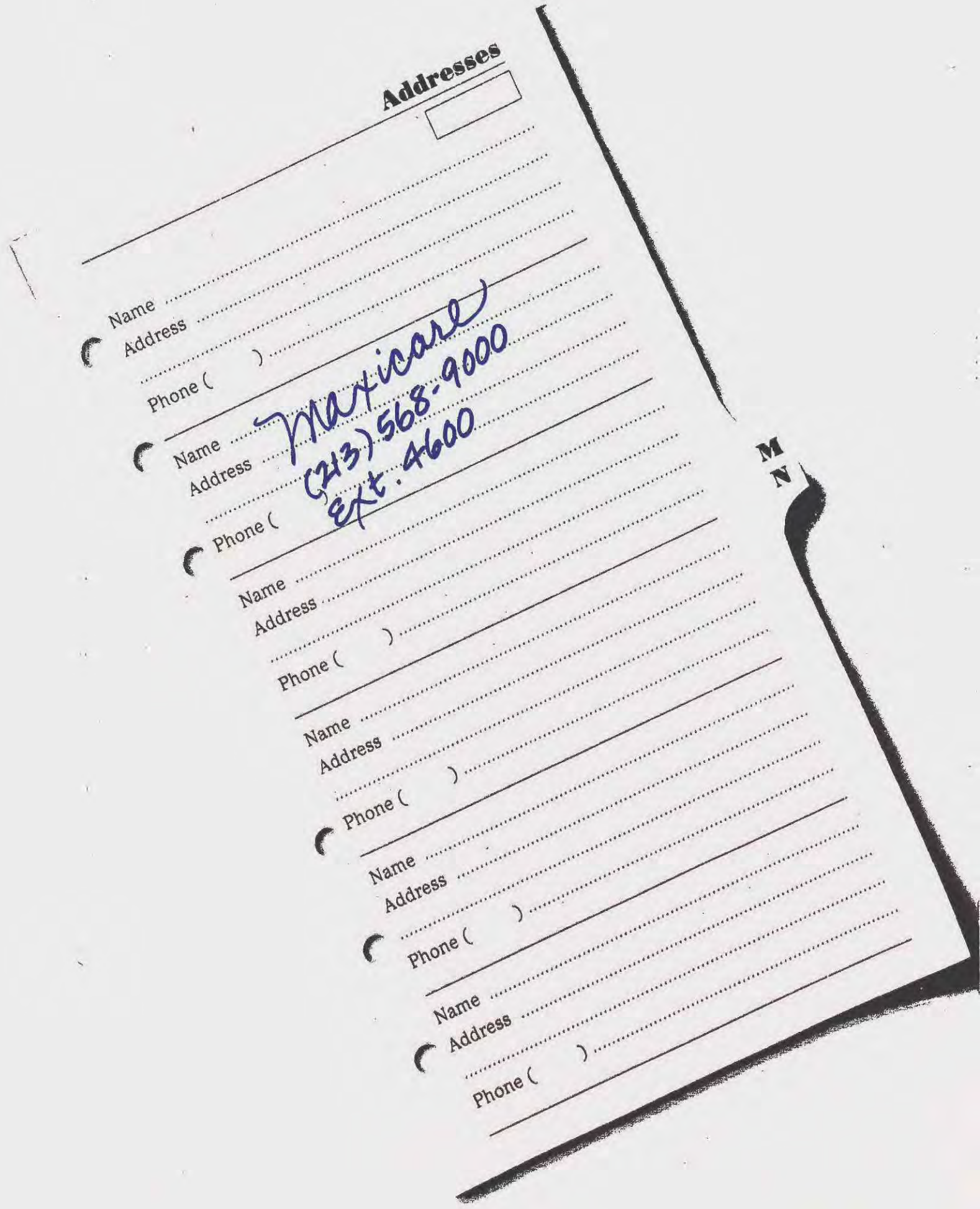
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Time capsule: 1967

Continued from page 12

Workers and the major U.S. automakers as an example of a trend away from employee benefits, noting that the union's demands are focusing on increased wages.

However, he predicted that when inflation eases and worker interest turns again to benefits, unions will push for liberalized early retirement plans, shorter vesting requirements, development of thrift and savings plans and the implementation of dental and prescription drug coverages (*BI*, Oct. 30, 1967).

* * *

Large increases in Social Security benefits currently being considered by Congress would reduce the level of benefits that need to be provided by private pension plans, according to an employee benefits expert.

Robert E. Royes, secretary of the employees' benefit committee at American Telephone & Telegraph Co., told *Business Insurance* that if Congress enacts large increases in Social Security, private employers would be "well-advised to take a look at the total benefits picture to see if too much money is in the retirement area."

Mr. Royes noted that about 85% of private pension plans in 1967 are integrated with Social Security so that if Social Security benefits increase more than wages do those private pension plans that supplement Social Security "can reasonably be lower, assuming the relationship of retirement income to pay is the right one."

However, he added that the problem of restructuring private pension plans has not yet come up on a general basis or in "acute form," and probably still would not be critical for most companies, even with the Social Security increases that have been passed by the House (*BI*, Oct. 30, 1967).

* * *

Hospital daily service charges have increased far more rapidly in recent years than that Consumer Price Index, causing increases in the costs of group health and accident insurance, according to the Bureau of Labor Statistics and the American Hospital Assn.

And, hospitalization costs are expected to rise an additional 25% in 1967 and 1968 (*BI*, Oct. 30, 1967).

* * *

The effective date for a precedent-setting Blue Cross/Blue Shield "national account" with Ford Motor Co. is less than a year away.

The national account is to go into effect Nov. 1, 1968, to equalize employee health care benefits at Ford plants across the country. It was a key part of the recently negotiated three-year contract between Ford and the United Auto Workers union.

Under the plan, the health care benefits of all Ford employees nationwide will be under the control of Michigan Blue Cross/Blue Shield.

For out-of-state workers not currently covered by Michigan Blue Cross/Blue Shield, the company will try to negotiate coverage with the local Blue Cross/Blue Shield plan. But, if necessary, the Michigan plan will administer and underwrite the coverage itself (*BI*, Nov. 13, 1967).

* * *

An analysis of accrued but unfunded pension liabilities saved a unit of Kaiser Industries Corp. $2.5 million on the purchase of another company, a Kaiser official revealed recently.

Walter B. Farrell, vp of industrial and union relations at Kaiser, said that before its purchase about 10 years ago of a large New England operation, Kaiser performed an analysis of the New England company's pension plan.

Mr. Farrell said the plant in question was an old one with many long-service employees and, in keeping with general practice, the owner had not made any arrangements for prefunding pension liabilities.

After allowing for the unfunded liabilities, he said, the purchase price of the operation was revised downward to $6.5 million from $9 million. And, he added that Kaiser began funding for the plan shortly after the acquisition, "and now there are substantial assets available to ensure payments of pensions to covered persons" (*BI*, Nov. 13, 1967).

* * *

Reforms are needed in pension survivor's benefits so that a widow would be automatically entitled to a pension if her husband dies "in active service," a professor and actuary told delegates to the National Foundation of Health, Welfare & Pension Plans.

Hilary L. Seal, a professor at Yale University in New Haven, Conn., and an actuary with Meidinger & Seal in New Haven, proposed an "easy formula" under which a widow would receive half the pension to which her husband would have been entitled at his death.

He also suggested giving additional credits up to age 65 for widows with children, "whose needs may be greater."

And, Mr. Seal claimed that the cost of such plans would be moderate, "in spite of rumors to the contrary" (*BI*, Nov. 13, 1967).

* * *

An official of the U.S. Department of Health, Education and Welfare says that the growth of prepaid dental plans has been "agonizingly slow.

Ferris M. Hoggard Jr., chief of the dental care economics section of HEW, noted that although 75% of the population has at least some protection under private medical insurance programs, only 2% has prepaid dental protection. And, he placed part of the blame on dentists, whom he characterized as "less than enthusiastic" in support of such programs.

However, Mr. Hoggard noted that a recent move on the part of unions to press for prepaid dental coverage is evident (*BI*, Nov. 27, 1967).

* * *

A "new breed" of buyers is pushing up interest in qualified minimum premium plans as a way to reduce state premium taxes on health and welfare benefits.

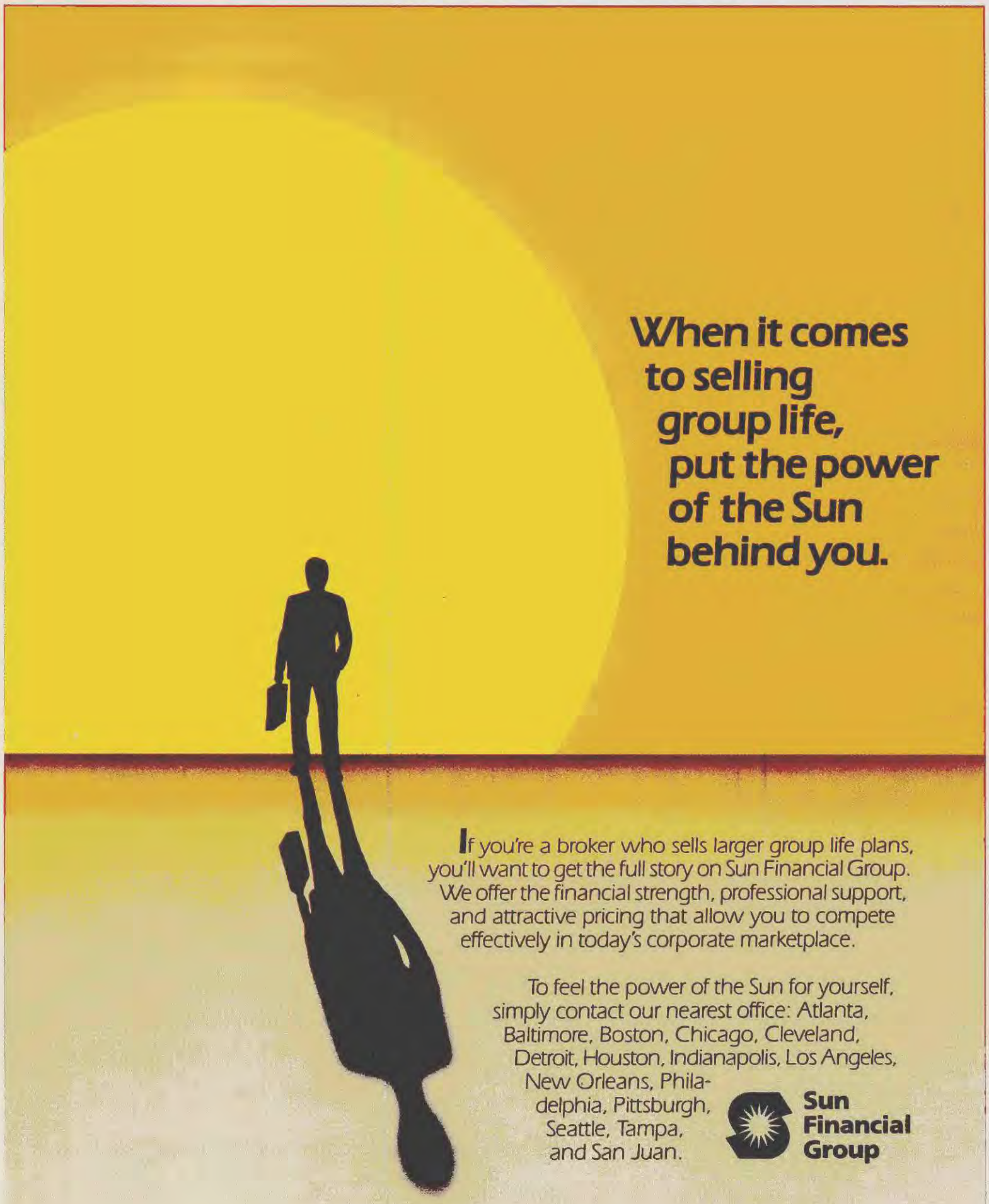
The cost of state premium taxes is a reason for companies to self-insure, experts agree.

State premium taxes are based on "retained" premium, or premium minus dividend. In minimum premium accounts, however, the amount of retained premium is much less than in traditional accounts, giving the minimum premium plans some of the major economic attraction of self-insurance, the experts say (*BI*, Nov. 27, 1967).

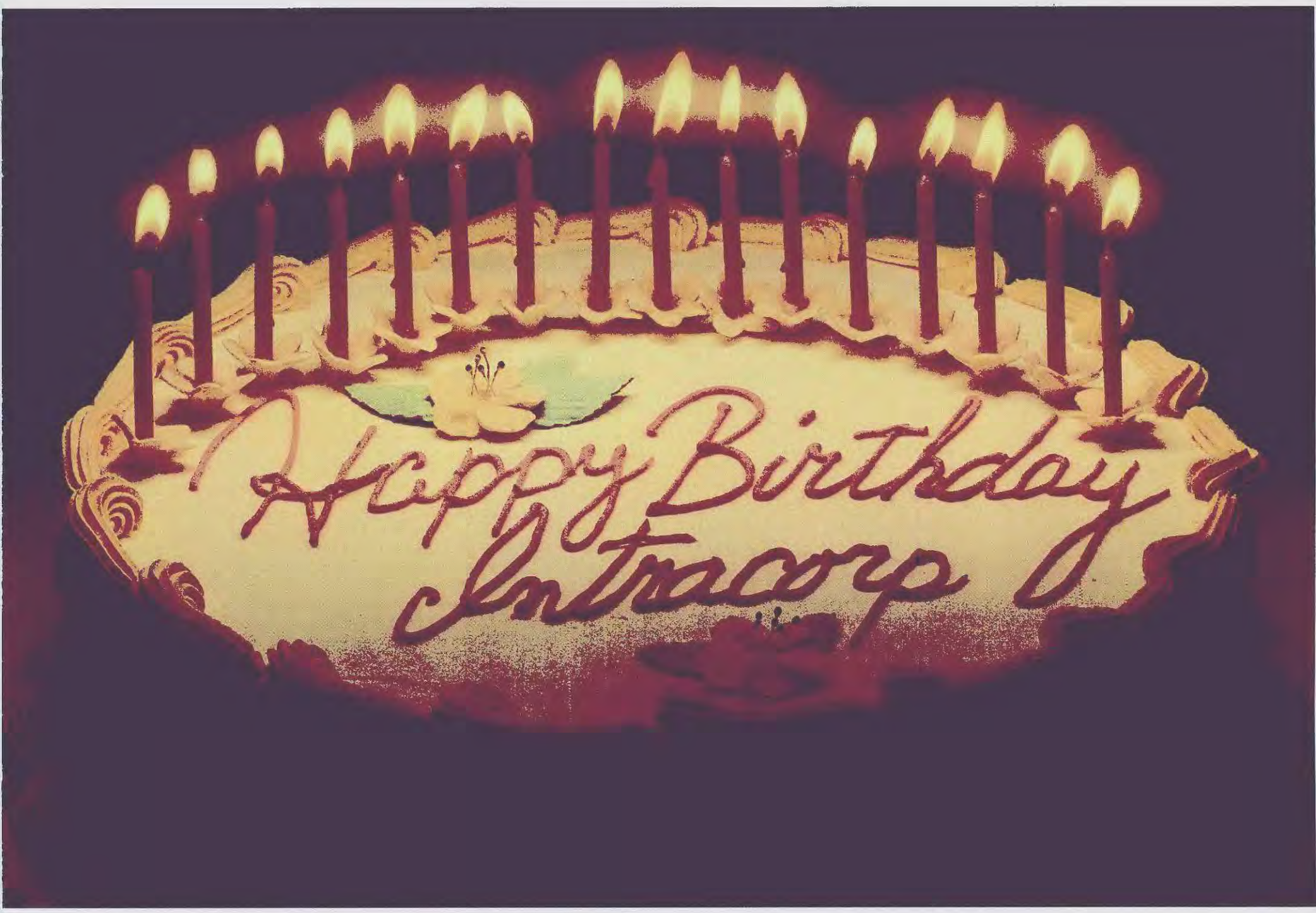
* * *

A major government study calls for a private-sector effort to "reshape. . .the health care system."

The report, by the National Advisory Commission on Health Manpower, notes that the government is not big enough alone to improve the nation's health care while holding down costs. Instead, the private sector—as a major buyer of health care services—must work together to exert pressure on buyers and users to make a more cost-efficient system (*BI*, Dec. 11, 1967).



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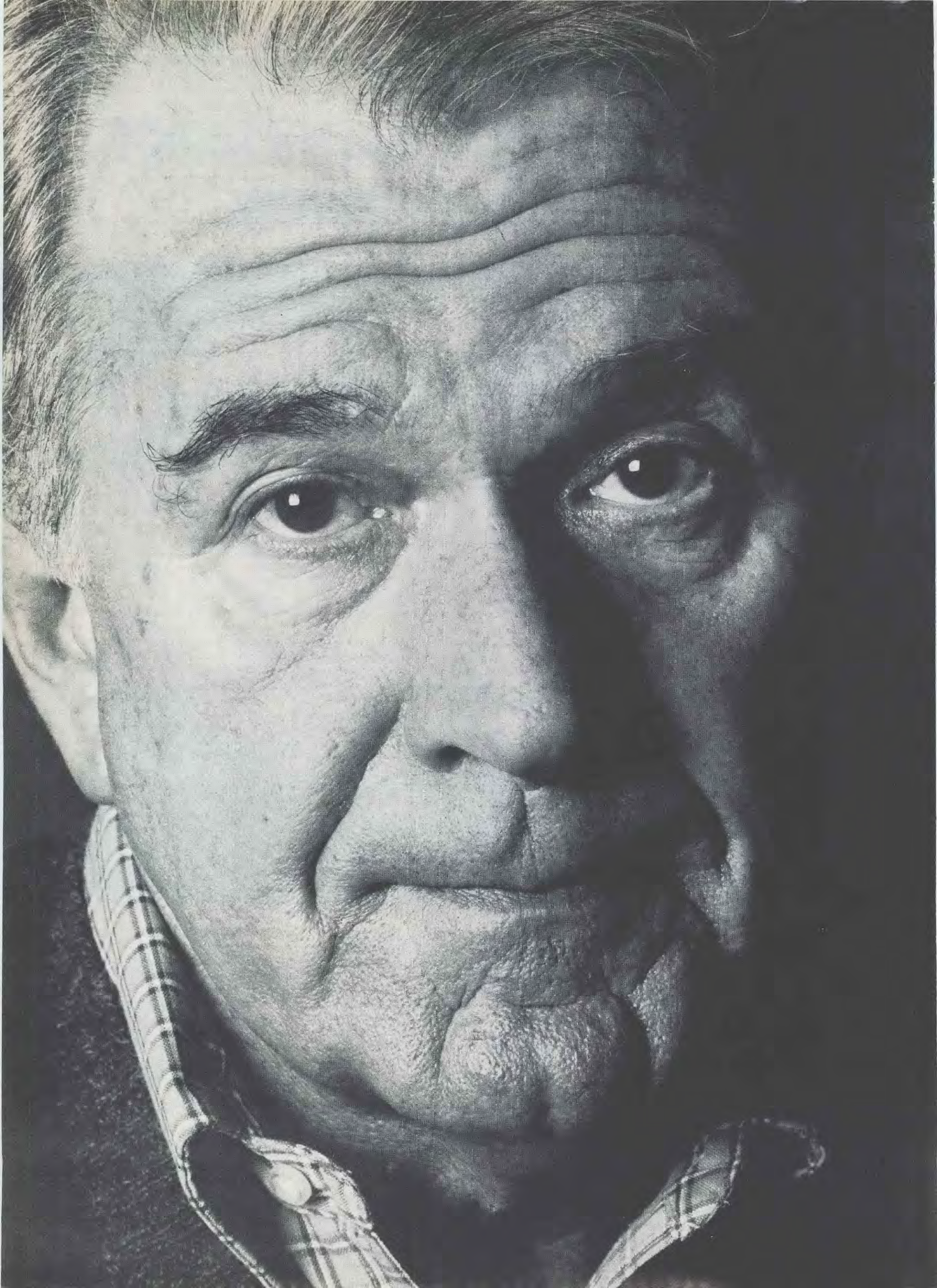
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CATASTROPHIC CASE MANAGEMENT

Dental benefits rank high with employees

By KARI BERMAN

Dental care coverage is one benefit that really makes employees smile, benefit experts say.

Group dental coverage, born during union contract negotiations in the late 1960s, has emerged over the past 20 years as a standard benefit offered by the majority of employers.

"Twenty years ago, dental coverage didn't even exist as an employee benefit," said Pat Wiley, an assistant vp at Johnson & Higgins of New York.

Ms. Wiley partly attributes the growth of dental plans to the economic stability of the early 1970s, before inflation soared into double digits. "Employers could afford to offer the extras without a lot of financial strain," she explained.

But what started as a way for employers to keep unions happy at a relatively low cost, compared with increasing wages, quickly became a benefit that virtually all employees demand, explained Mark Schwehr, partner and actuary at Hewitt Associates in Lincolnshire, Ill.

In fact, 85% of the 818 employers that responded to the William M. Mercer-Meidinger-Hansen Inc. 1987 survey of "Miscellaneous Group Benefits and Benefit Costs" provide some type of dental coverage for employees.

The typical dental plan offered by survey respondents covers 100% of preventive services, with no deductible; 80% of basic, or non-surgical, services; and up to 50% of major services, or those involving oral surgery. Basic services and major services are often subject to a $25 to $50 deductible.

In addition, 69% of the companies surveyed by Mercer offered orthodontia benefits.

Benefits experts agree that employees prefer dental benefits over just about any other type of benefit.

"Dental care is the most popular benefit offered," said Bernard Tresnowski, chief executive officer of the Blue Cross & Blue Shield Assn. in Chicago.

"Dental benefits have a high prestige level for employees. It's something they appreciate," agreed Duse Moretti, director of national marketing services for Delta Dental Plans Assn. in Chicago.

Delta Dental Plans, which began in 1955 as a benefit for shipyard workers, offer fee-for-service arrangements in 50 states with an estimated 17 million enrollees, Ms. Moretti said.

Dental plans' popularity is reflected in the increase of the number of individuals taking advantage of the employer-provided coverage.

"In 1967, 4.5 million people were covered under an employee benefit dental plan," Mr. Tresnowski said. "In 1984, we calculated over 110 million participants."

While employees gain a lot by taking advantage of dental benefits, employers do not have to a lot to lose by providing the benefit, experts concur.

By paying 100% of preventive costs and encouraging employees to take care of their teeth before serious problems occur, employers can increase goodwill with employees and avoid costly claims resulting from neglected teeth.

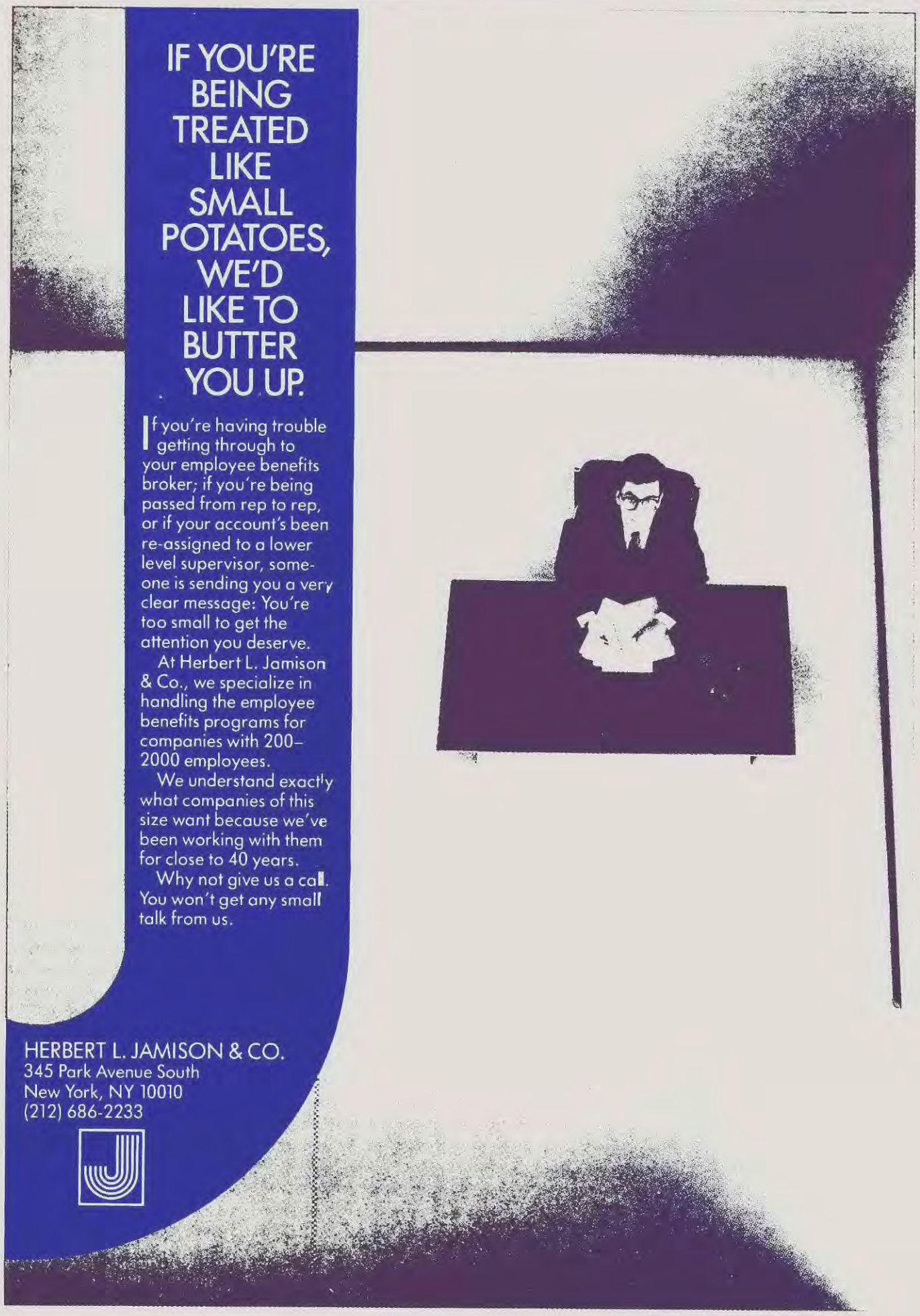
Employers can control the costs of their dental coverage by evaluating all procedures that exceed a certain amount before agreeing to cover the procedure.

Multinational employer Smith & Nephew Inc. in Elk Grove Village, Ill., has had a pre-approval system since March, when the company revised its dental plan. Now, when an employee or a dependent family member needs serious dental treatment, such as oral surgery, the procedure must be approved by the company before the 50% copayment benefit under the company's plan is authorized.

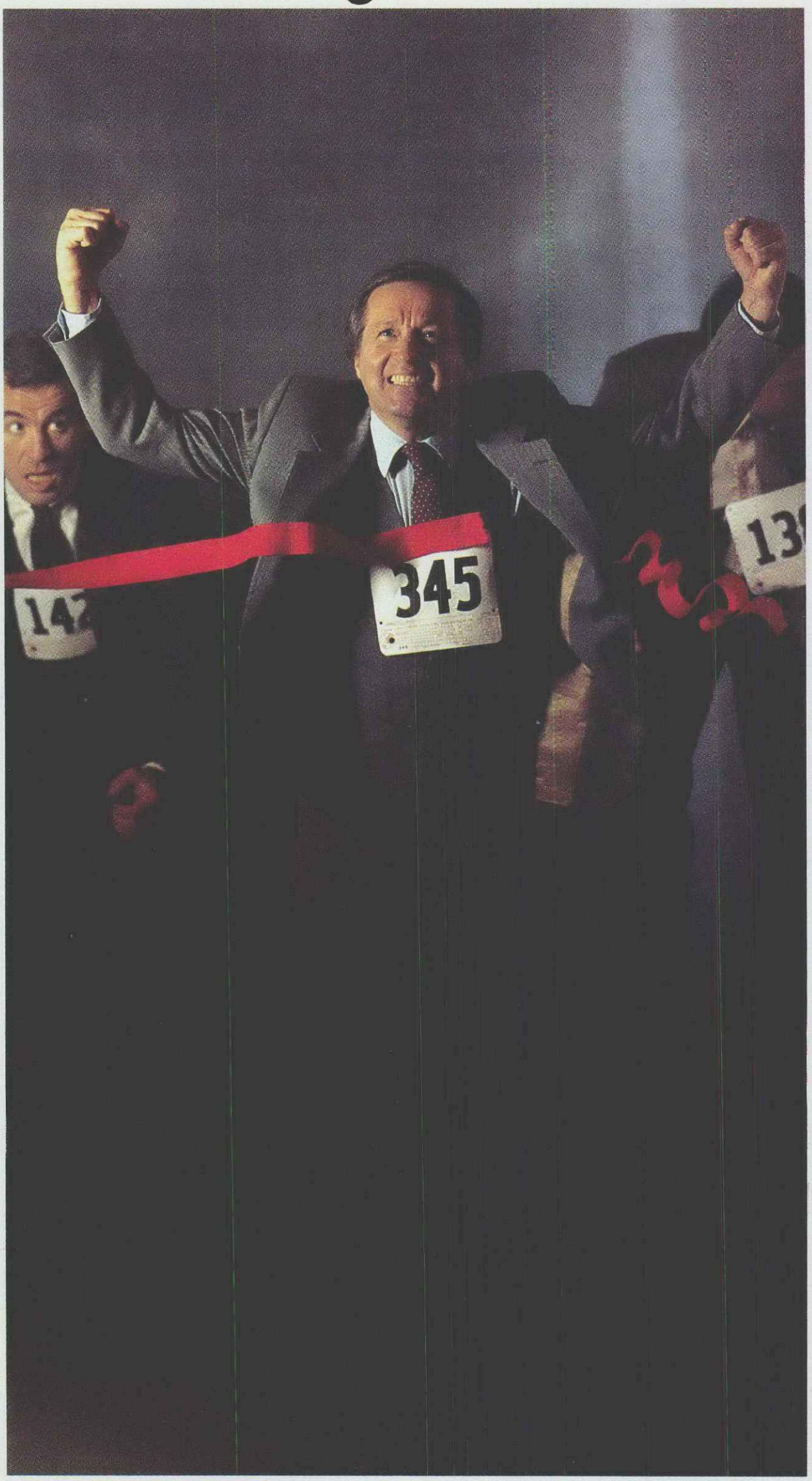
Employees are not troubled by this prerequisite, according to Charles Ingram, corporate insurance manager, noting there is 100% employee participation in the plan. "It is the most appreciated benefit I've ever dealt with," he said.

Barnett Banks Inc. in Jacksonville, Fla., also offers employees

Continued on page 22



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Time capsule: 1968

Employees of R.J. Reynolds Co. are celebrating 1968 with increased benefits and decreased employee contributions.

The new comprehensive medical package for salaried employees now pays the first $400 of covered expenses above the deductible, up from the previous $300, and 80% of the expenses above that up to a maximum of $15,000.

In addition, changes in the amount of required employee contributions will save salaried employees up to $4 per month.

The Blue Cross/Blue Shield plan covering hourly employees also increased coverage to $23 a day from $17 a day for hospital room and board rates. And hourly employees will pay only $3 per month for dependent coverage, down from $6.25 (*BI,* Jan. 1, 1968).

* * *

The 13% increase in Social Security benefits will cost employers $52.80 more in Social Security payroll taxes in 1968 for each employee earning $7,800 or more a year. The tax increase will be due to a boost in the taxable wage base, to $7,800 from $6,600 a year.

The joint employer-employee tax rate will remain the same —8.8%—until 1969, when it will be raised to 9.6%. This increase will cost U.S. employers an additional $31.20 per year for each employee making $7,800 or more. The bill calls for additional increases in the tax rate to 11.8% by 1987 (*BI,* Jan.1, 1968).

* * *

Kaiser Aerospace & Electronics has increased the limits of its major medical coverage to $50,000 from $25,000 as part of its improved hospital benefits package.

The new coverage is underwritten by either the Kaiser Foundation health plan or New York Life Insurance Co., and also extends coverage to mentally or physically handicapped children, regardless of age, if they are dependent on a Kaiser employee for support (*BI,* Jan. 15, 1968).

* * *

The Michigan attorney general has approved group auto insurance in an opinion declaring that group rating of auto insurance is not in conflict with state statutes.

This opinion would clear the way for a "true" group auto plan, in which all members of the group pay the same amount for the same level of coverage, regardless of factors such as age, driving record, place of residence or type of automobile. Some so-called group auto plans are operating in other states, but although the premiums are deducted from employee paychecks, the policies are rated individually (*BI,* Feb. 26, 1968).

* * *

The Equal Employment Opportunity Commission has ruled that, effective July 1, 1968, any pension or retirement plan that provides for a sex-based difference in optional or compulsory retirement ages is in violation of the 1964 Civil Rights Act.

Other differences in retirement plan provisions based on sex, such as differences in survivor benefits, will be decided on a case-by-case basis. Witnesses before the commission had charged there was widespread discrimination against female workers (*BI,* March 25, 1968).

* * *

U.S. businessmen making business trips to South Vietnam are being charged much higher premiums for accidental death and dismemberment insurance.

In the wake of the Tet offensive and the general intensification of the war, AD&D premiums have increased to $50 per $1,000 of coverage, and can be as high as $75 if extensive air travel is involved. Rates were about $6 per $1,000 of coverage as recently as six months ago (*BI,* April 8, 1968).

* * *

About 85% of the civilian population not covered by Medicare—or about 149 million people—have some form of health insurance. The percentage of Americans covered has grown from 8% in 1938 and from 42% in 1948, according to an official of the Health Insurance Assn. of America.

Of the 149 million Americans with health insurance in 1968, 57% have coverage from commercial insurers, 38% from Blue Cross/Blue Shield plans and 5% from miscellaneous

Continued on next page

Dental benefits

Continued from page 20

extensive dental care coverage through the bank's medical care flex plan account. It controls costs by providing a yearly maximum benefit of $1,200 for each covered employee and dependent.

The plan provides 100% coverage for preventive services and 80% coverage for basic and major restorative services, says Catherine Corse, assistant vp/manager of employee benefits.

The company also provides orthodontia coverage of $1,000 per dependent child, Ms. Corse said.

"Our dental plan is one of our most popular, and employees ranked it very high in our employee survey," she said.

Miller Brewing Co. in Milwaukee introduced dental benefits in the late 1970s, according to John Van Vliet, corporate benefits manager at Miller.

All of Miller's 10,000 salaried employees nationwide and their families can take advantage of 100% coverage for preventive care coverage, 80% coverage for basic care and 50% coverage for oral surgery.

In addition to standard dental insurance plans, employers can now contract with dental health maintenance organizations and dental preferred provider organizations.

"Dental HMOs and PPOs will be the dental care of the 1990s and well into the future," Ms. Wiley predicted.

Pacific Gas & Electric Co. in San Francisco began offering a dental HMO option to its employees last year. The plan provides 100% coverage for preventive care and requires minimal copayments for all other procedures, according to Sally Gottlieb, supervisor of benefit administration.

However, while "employees were initially very interested, there was not a high enrollment because of a lack of participating dentists," Ms. Gottlieb reported. "We are offering it again with more dentists."

Prudential Life Insurance Co. of America of Newark, N.J., offers an HMO-style Dental Maintenance Organization. Dentists nationwide who belong to the network are paid by Prudential a capitated fee for each member of a covered employee's family.

"With our plan, we pay 100% of all care, including surgery," explained John Wickens, vp-underwriting at Prudential's Roseland, N.Y., branch.

After marketing the product nationwide for only about 18 months, already more than 1 million employees and dependents are covered under the plan, Mr. Wickens reported. "It has been popular with all areas in the marketplace, and I think that managed dental care will continue to gain in popularity." ■



Continued from previous page
plans (*BI*, May 6, 1968).

* * *

The Colorado Dental Assn. is sponsoring a prepaid dental insurance plan. Currently, membership in the plan is open to groups, and rates for coverage range from $8.50 to $13.50 per family per month, depending on the group.

The plan pays 70% of dental costs during a patient's first year in the plan. Then, if the patient follows the advice of the dentist, the plan pays 80% of costs in the second year and 90% in the third year. The dental association says proper dental care will help prevent major expenses in later years (*BI*, June 3, 1968).

* * *

The nation's automakers are studying the impact of early retirement plans as a means of avoiding or reducing layoffs.

The move toward early retirement began in 1964, when the United Auto Workers urged the implementation of early retirement plans to persuade senior employees to retire, allowing younger, laid-off employees to return to work (*BI*, June 3, 1968).

* * *

The American Medical Assn. is reviewing a proposal for a system of "credit card" payments for medical care and negative tax credits for those who cannot afford care.

Under the proposal, anyone could pay for medical bills with a credit card. Those who could afford it would pay premiums for their coverage to a community insurance agency, and the poor would have their payments made by a local welfare agency.

In addition, the poor would receive medical care payments from the government as an income tax credit, making a kind of negative tax (*BI*, July 1, 1968).

* * *

Capital Blue Cross of Harrisburg, Pa., and the Visiting Nurse Assn. of Reading, Pa., are testing a program under which Blue Cross subscribers in Berks County can receive home health agency services.

Blue Cross will provide coverage up to 30 home care visits during any 90-day period for nursing service, oxygen therapy, speech therapy and dietetic service.

Prior hospitalization is not required for benefits (*BI*, July 15, 1968).

* * *

Delta Airlines has begun a payroll deduction plan to provide personal lines insurance coverages for its employees. The coverages will be voluntary and fully paid by the employees.

The coverages available to Delta's 16,500 employees will include automobile, homeowners, jewelry, furs, boats and fine arts. The coverages will be underwritten by Chubb & Son Corp. (*BI*, July 29, 1968).

* * *

In its recent settlement with 11 major companies, the United Steelworkers union received substantial boosts in pensions, group life insurance and medical coverages.

Effective Aug. 1, 1969, monthly pension credits will be increased to $6.50 from $5 per year of service. Group life insurance coverage will be increased $1,000 for each union member, effective Aug. 1, 1970. And, a new major medical package that pays 80% of covered expenses will be added to the basic hospital policy, effective Aug. 1, 1970. That coverage will be written by Blue Cross/Blue Shield (*BI*, Aug. 12, 1968).

* * *

Key-man life insurance policies valued at $1.2 million each have been taken out on John Lennon and Paul McCartney, two of the Beatles.

The beneficiary of the policies is Northern Songs Ltd., the music publishing company established by Mr. Lennon and Mr. McCartney. The policies were purchased to protect public shareholders in Northern Songs.

The other Beatles, Ringo Starr and George Harrison, are not involved in music publishing and therefore carry private life insurance (*BI*, Aug. 26, 1968).

* * *

Two Blue Cross units are moving to cut the length of hospital stays.

Capital Blue Cross of Harrisburg, Pa., and Geisinger Medical Center in Danville, Pa., have set up a system of pre-admission testing, so that subscribers can receive diagnostic tests before admission.

And, Blue Cross of Syracuse, N.Y., has received approval from the state Insurance Department to increase benefits for emergency outpatient care and outpatient surgery (*BI*, Sept. 9, 1968).

* * *

Blue Cross of Oregon is conducting a study to determine whether home health services can help cut the high cost of hospitalization.

Blue Cross explains that home health care may be a more cost-effective way to deal with convalescing patients or those with long-term illnesses (*BI*, Sept. 23, 1968).

* * *

The United Auto Workers union has won dental and psychiatric benefits for its 42,000 members at Douglas Aircraft Corp., and is about to win similar benefits throughout the aerospace industry.

If the dental plan is accepted industrywide, it will be the largest dental plan in the country, according to the UAW. Implementation of the plan will be delayed for 18 months, while the union and the industry discuss how to set up the plan (*BI*, Oct. 7, 1968).

* * *

In 1968, U.S. employers' contributions to benefits will be $66 billion. The payments will go to private and government-administered pension, life, health and other benefit plans.

Employer contributions have increased 180% since 1958, when they totaled less than $16 billion. Reasons cited for the increase include a growth in the workforce, economic expansion, a growth in productivity and rising prices (*BI*, Oct. 21, 1968).

* * *

A cafeteria benefit plan has been proposed as a way of giving employees more choices in their benefits.

Ernest F. Boyce, president of Colonial Stores, suggested that employees be allowed to choose from among a variety of benefit options, rather than having to accept a set benefit plan. He also said that employees should be able to change their individualized benefit plan every five years, as a way of making sure benefits meet their specific needs (*BI*, Nov. 4, 1968).

* * *

Experts predict that in 1980 benefits will include plans under which insurers will pay 100% of medical expenses, three times salary in life insurance coverage and cover the donor of a transplanted organ.

In addition, experts say the 1980s will bring higher benefits for disability coverage, compulsory severance pay, college tuition benefits, death benefits paid as part of retirement benefits and cost-of-living adjustments for pensions.

"We may also see a tendency toward medical coverage for surviving spouses," Edwin M. Bush Jr. of Towers, Perrin, Forster & Crosby told the American Management Assn. conference.

The changes will come about, experts say, because of an expanding economy, inflation and changes in the workforce (*BI*, Nov. 18, 1968). ■

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Benefit inflation

Expenditures increase 800% over 20 years

By PAUL D. WINSTON

Employee benefit costs have exploded over the past 20 years, increasing nearly eightfold, according to U.S. Chamber of Commerce surveys.

And, the cost of providing benefits for each employee has more than quadrupled during the two-decade period.

The Chamber estimates that employers spent $691.3 billion on employee benefits in 1985, a 797.8% increase from an estimated $77 billion spent on benefits in 1965, the result of steady double-digit cost increases during the intervening 20 years.

The cost of benefits per employee in 1965 was $1,502, or 24.7% of payroll, according to the Chamber's "Fringe Benefits 1965" survey, which was released in 1967.

Twenty years later, the Chamber reported in "Employee Benefits 1985" (*BI*, Nov. 26, 1986) that benefit costs were $8,166 per employee—a whopping 443.7% increase over 1965 figures.

In addition, by 1985, benefit costs had grown to represent 37.7% of payroll.

The rise in benefit costs has outstripped both the general inflation rate and the increase in medical care costs, according to figures gleaned from the Consumer Price Index. From 1965 to 1985, the overall CPI has increased 322.2%, while the CPI's medical care component climbed 350.4% during the same period.

The Chamber estimates that employers spent $691.3 billion on employee benefits in 1985, a 797.8% increase from an estimated $77 billion in 1965.

The U.S. Chamber has conducted its employee benefits surveys since 1947, providing benefit managers with a detailed look at benefit spending within 21 industry groups.

Until 1977, the Chamber released its surveys on a biennial basis; it released surveys annually thereafter.

During those earlier years, the greatest two-year increase in benefits costs occurred between 1971 and 1973, when costs jumped 27% to $3,230 from $2,544 (see chart below right). This increase exceeds any two-year increases extrapolated from the Chamber's subsequent annual surveys.

According to a 1979 Chamber review of benefit costs over the previous 28 years, the reasons for cost increases include:

- The introduction of new employee benefits including dental and short- and long-term disability coverage.
- An increase in the cost of benefits.
- An increase in the duration of paid vacation, sick leave and holiday benefits.
- An increase in the number of employees eligible for benefits.

The Chamber notes that originally, many "fringe benefits" were offered to only office or professional workers, but increasingly have been extended to many blue-collar workers.

The cost of several specific benefits increased far more than the overall average during the past 20 years, according to figures gleaned from the Chamber surveys.

For example, group life insurance and group health insurance expenditures in 1965 cost employers $184 per employee. But by 1985, those costs had soared to $1,561 per employee, a gain of 748.4%.

Social Security payroll taxes, which cost an average of $163 per employee in 1965, zoomed 776.1% to an average $1,428 per employee in 1985.

FICA taxes in 1965 totaled 3.625% of the first $3,000 of salary and wages. By 1935, that FICA tax rate had increased to 7.05% of the first $39,600 of a worker's salary.

Currently, the FICA tax is 7.15% of the first $45,800 of an employee's salary.

Pension costs posted a 300.4% increase to $905 per employee in 1985 from $226 per employee in 1965.

However, the surveys show that employers have managed to slow benefit cost increases—and in some cases reduce benefit costs—in recent years.

For example, pension costs declined over the past three years because of a bullish stock market. As the prices of stocks, bonds or commodities rose, the value of pension plan assets also increased, reducing the need for and size of employer contributions to the plans.

In 1965, the five costliest benefits, measured in dollars per year per employee, were:

- Paid vacations, which cost $252 per employee.
- Pensions, which cost $226 per employee.
- Life and health insurance premiums, which cost $184 per employee.
- Social Security taxes, which cost $163 per employee.
- Payments for holidays not worked, which cost $161 per employee.

By 1985, the costs of these benefits shifted dramatically, with the five costliest becoming:

- Life and health insurance premiums, which cost $1,561 per employee.
- Social Security taxes, which cost $1,428 per employee.
- Paid vacations, which cost $1,049 per employee.
- Pensions, which cost $905 per employee.
- Paid rest periods, which cost $752 per employee.

Paid rest periods include lunch periods, washing time and travel time.

In 1965, paid rest periods were the sixth-costliest benefit at $150 per employee.

Among 21 specific industry groups, employee benefit costs have increased a high of 585% in the primary metal products industry to a low of 282% for financial institutions during the last 20 years (see above right).

The cost of benefits per employee in the primary metal products industry surged to $11,344 in 1985 from $1,656 in 1965.

The cost of benefits per employee for banks, finance companies and trust companies increased from $1,715 in 1965 per employee—the third-highest figure among all industry groups at that time—to $6,552 in 1985—the fourth-lowest benefit cost. In addition, the financial institutions group was the only industry group in which benefit increases lagged behind inflation figures.

Other industries where employee benefit costs increased by more than 500% over the past two decades, were:

- Electrical machinery, equipment and supplies, in which benefit costs grew 536% to $8,573 per employee in 1985 from $1,348 per employee in 1965.
- Transportation equipment, up 533.6% to $9,649 per employee in 1985 from $1,523 per employee in 1965.
- Fabricated metal products, up 516.7% to $8,659 per employee in 1985 from $1,404 per employee in 1965.
- Machinery, up 505.8% to $9,408 per employee in 1985 from $1,553 per employee in 1965.

The industry with the highest benefit costs in 1965 still had the highest benefit costs in 1985: The petroleum industry spent $12,303 per employee on benefits in 1985, which exceeded the cost of benefits in primary metals industry by nearly $1,000 per employee. The petroleum industry's 1985 benefit costs represent a 474.1% increase from $2,143 per employee in 1965, which was $300 more than the next highest industry—public utilities, with $1,825 per employee.

The industry that spent the least on employee benefits in 1965 was the textile products and apparel industry, which spent $839 per employee. This group had the second-lowest benefit costs in 1985—$4,599 per employee—despite a cost increase of 448.2%.

The industry that spent the least on employee benefits in 1985 was department stores, which spent $4,292 per employee, up 346.6% from $961 per employee in 1965, the second-lowest in the Chamber of Commerce survey.

The U.S. Chamber of Commerce currently is preparing its 1986 benefits analysis, which is due out at the end of November, according to a Chamber spokeswoman.

•

Copies of the U.S. Chamber of Commerce's annual "Employee Benefits" surveys are available for the years 1979 ($7), 1980 ($8), 1982 ($12), 1983 ($17.50), 1984 ($20) and 1985 ($20). Prepayment is requested and discounts are available for bulk orders. Contact the U.S. Chamber of Commerce, Publications Fulfillment (RKVL), 1615 H St. N.W., Washington, D.C. 20062.

Increases in employers' benefit costs per employee

Industry	1965	1985	% change
Primary metal industries	$1,656	$11,344	585.0%
Electrical machinery, equipment and supplies	1,348	8,573	536.0
Transportation equipment	1,523	9,649	533.6
Pulp, paper, lumber and furniture	1,245	7,786	525.4
Fabricated metal products	1,404	8,659	516.7
Machinery (excluding electrical)	1,553	9,408	505.8
Chemicals and allied products	1,692	10,086	496.1
Rubber, leather and plastic products	1,358	8,095	496.1
Public utilities	1,825	10,622	482.0
Petroleum industry	2,143	12,303	474.1
Textile products and apparel	839	4,599	448.2
Stone, clay and glass products	1,377	7,511	445.5
Printing and publishing	1,358	7,292	437.0
Insurance companies	1,427	7,608	433.1
Food, beverages and tobacco	1,620	8,425	420.1
Instruments and miscellaneous manufacturing	1,364	6,948	409.4
Miscellaneous non-manufacturing	1,552	7,731	398.1
Trade (wholesale and retail)	1,188	5,697	379.5
Department stores	961	4,292	346.6
Banks, finance companies and trust companies	1,715	6,552	282.0
Hospitals	***	6,745	***
Total, all industries	1,502	8,166	443.7

*** data not shown separately for this group until 1975.
Source: U.S. Chamber of Commerce Survey Research Center

Cost of leading benefits per employee

	Life/ health	% increase	Pensions	% increase	FICA taxes	% increase	Total employee benefits	% increase
1965	$184	13.6%	$226	3.7%	$163	-3.0%	$1,502	5.0%
1967	209	13.6	261	15.5	254	55.8	1,719	14.5
1969	260	24.4	306	17.3	335	31.9	2,052	19.4
1971	369	41.9	402	31.4	372	11.1	2,544	24.0
1973	457	23.9	503	25.1	527	41.7	3,230	27.0
1975	582	27.4	620	23.3	636	20.7	3,984	23.4
1977	760	30.6	759	22.4	693	9.0	4,692	17.8
1978	774	1.9	779	2.6	783	13.0	5,138	9.6
1979	861	11.3	825	5.9	877	12.0	5,560	8.3
1980	950	10.3	888	7.6	954	8.8	6,084	9.5
1981	1,073	13.0	950	7.0	1,123	17.7	6,627	9.0
1982	1,274	18.7	1,040	9.5	1,274	13.5	7,187	8.5
1983	1,460	14.6	1,032	-0.1	1,305	2.4	7,582	5.5
1984	1,581	8.3	1,011	-2.0	1,408	7.9	7,842	3.5
1985	1,561	-1.3	905	-10.5	1,428	1.4	8,166	4.2

Source: U.S. Chamber of Commerce Survey Research Center

Automated Job Analysis Aids in Record Placements

From Minneapolis to Phoenix to Portland, Maine, Crawford & Company Health and Rehabilitation Services placed more than 4,000 disabled employees in jobs during 1986. Increased automation was a major contributing factor to Crawford's successful placements, which increased professional productivity and resulted in substantial return-to-work cost savings for several employers.

Operational in all Crawford & Company major Health and Rehabilitation locations, the Crawford Occupational System (COS) is an indispensable resource to the company's 700 medical services and vocational staff. Through COS, rehabilitation counselors can access a bank of over 12,300 job titles and skills descriptions from the U.S. Department of Labor's Dictionary of Occupational Titles (DOT). Its electronic skills transfer determination is a valuable tool for accurately placing disabled workers.

Since April 1985, the information provided by COS has also helped employers to modify an increasing number of jobs to accommodate disabled workers, according to Crawford Vice President G. Berk Lynch, Ph.D.

Crawford's rehabilitation counselors utilize COS through the company's entire Return-to-Work process. Through a series of screens and menus, COS aids the counselor to enter and store the worker's job history, including training, experience, education and nature of the disability.

COS then stores the job history files by DOT code, or by job title, establishing the basis for a match between the worker history and DOT files later on.

After creation of the cl[illegible] file, the rehabilitat[illegible]selor then searches the D[illegible] file for [illegible] descriptions matching [illegible] ant's abilities, [illegible] and physical limitations. Through [illegible] counselors may impose restric[illegible] on the search for appropriate occupations, such as isolating the highest *level* of an appropriate job (in terms of physical limitations or requirements) to which the worker can aspire.

"For instance, t[illegible] description [illegible] that sho[illegible] a r[illegible] ne[illegible]y lifti[illegible] ...uirements jo[illegible] ...eone with a back i[illegible] ...ekly allow[illegible] co[illegible] ...rule out a[illegible] ti[illegible] that re[illegible] ...lifting more than a specific [illegible]. Counselors may also choose to refine the search at the highest level of academic [illegible] ience requiremer[illegible] ...ding to Dr. Lynch.

The system then produces a printout of [illegible] priate occupations [illegible] ...ed time for the process is ar[illegible] ...imately 45 minutes. S[illegible] ...job openings are identified.

"It condenses the time spent to determine the claimant's transferable skills and appropriate occupations. "Now counselors can devote more time to the ultimate goal of the rehabilitation counseling program—finding actual work for people that takes advantage of their skills and experience. Job placement [illegible] ...ed dramatically," Lynch. □

Crawford Health & Rehab Opens In Canada, 155th Office In System

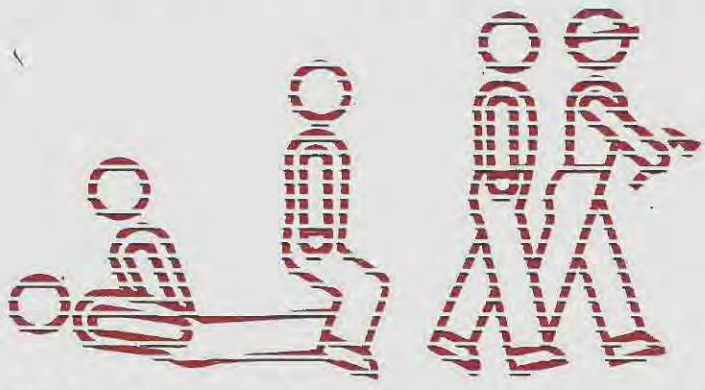
Crawford & Company offers disability/rehabilitation management and medical cost containment services through some 155 locations across the United States and, as of June 1987, in Canada.

Located in Toronto, services through Crawford's first Canadian Health and Rehabilitation office will focus on Long Term Disability and Automobile Liability cases. The company will provide disability case management services to facilitate the rehabilitation and Return-to-Work process.

Crawford expects to open at least two additional offices in Canada during 1987 to accommodate substantial growth in the LTD and auto liability markets. □

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Vice President
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John Trumbull: *The Declaration of Independence* (detail) ©Yale University Art Gallery

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HIGH RISK PREGNANCY
IDENTIFICATION AND MANAGEMENT

Time capsule: 1969

Most of the country's 2.5 million federal civil service employees now have coverage for treatment of drug and alcohol addiction. The changes took effect Jan. 1, after the Civil Service Commission approved higher premiums (*BI,* Jan. 6, 1969).

* * *

Major league baseball players say they will strike unless team owners agree to add to the players' pension fund when their contract expires in March.

The minimum benefit under the current plan is $250 a month at age 50 after five years as a player or coach. The maximum is $1,487 a month at age 65 after 20 years in the league. The current pension is funded through television revenues, and the players want owners to fatten the benefits with the additional television revenue they will receive during the upcoming season, when the major leagues institute a playoff system for the World Series (*BI,* Jan. 20, 1969).

* * *

Although the Age Discrimination Employment Act prevents employers from refusing to hire older workers, those employers are not required to offer older workers the same benefits that are offered to newly hired younger workers or to older workers who have been with the company a long time.

The Wage Hour Administration says identical pension and insurance benefits are not required for both older and younger workers under the law (*BI,* Feb. 17, 1969).

* * *

Attendees at the American Society of Insurance Management convention were urged to resist the move to group auto insurance.

Experts told the benefit managers that companies should concentrate on traditional benefits, such as life and health insurance and pensions, and avoid potentially troublesome casualty insurance such as auto coverage (*BI,* March 3, 1969).

* * *

Under a new three-year contract signed with club owners, major league baseball players will receive dental coverage. The coverage will pay 80% of most dental costs and 60% of orthodontic costs, above a $25 deductible.

The new contract also increases ballplayers' pensions by $10 per month for each year of service up to 20 years and makes players eligible for retirement after four years of playing time rather than the current five years (*BI,* March 17, 1969).

* * *

Unions will push for better medical benefits during the next decade, according to an official of the Teamsters union.

Abraham Weiss, director of research for the International Brotherhood of Teamsters, predicted that union emphasis during the 1970s will be on coverage for all medical costs, including dental care, early diagnosis and preventive health care (*BI,* March 31, 1969).

* * *

Eleven unions have sued Automatic Electric Co. and Illinois Blue Cross/Blue Shield, concerning plan dividends allegedly due to the 10,000 Automatic employees represented by the unions.

The suit charges that premiums paid to the plan exceeded claims paid and that the money should have been placed in a fund to earn interest for the employees (*BI,* April 14, 1969).

* * *

The International Brotherhood of Teamsters has negotiated employer-paid personal auto insurance for more than 1,000 West Coast union members.

The contract covers seven separate employers, which finance the auto coverage by contributing to two trust funds from which premiums are paid. Coverages are individually rated (*BI,* May 12, 1969).

* * *

The U.S. Supreme Court has refused to review a lower court ruling that blocks a union from recovering the surplus pension assets of a bankrupt employer.

The suit, which involves Hamilton Steel Products Inc. of Chicago and the United Steelworkers union, concerns whether excess pension assets of Hamilton should go to the bankrupt company's employees or to its estate (*BI,* May 12, 1969).

* * *

Hartford Life Insurance Co. will

Continued on page 30

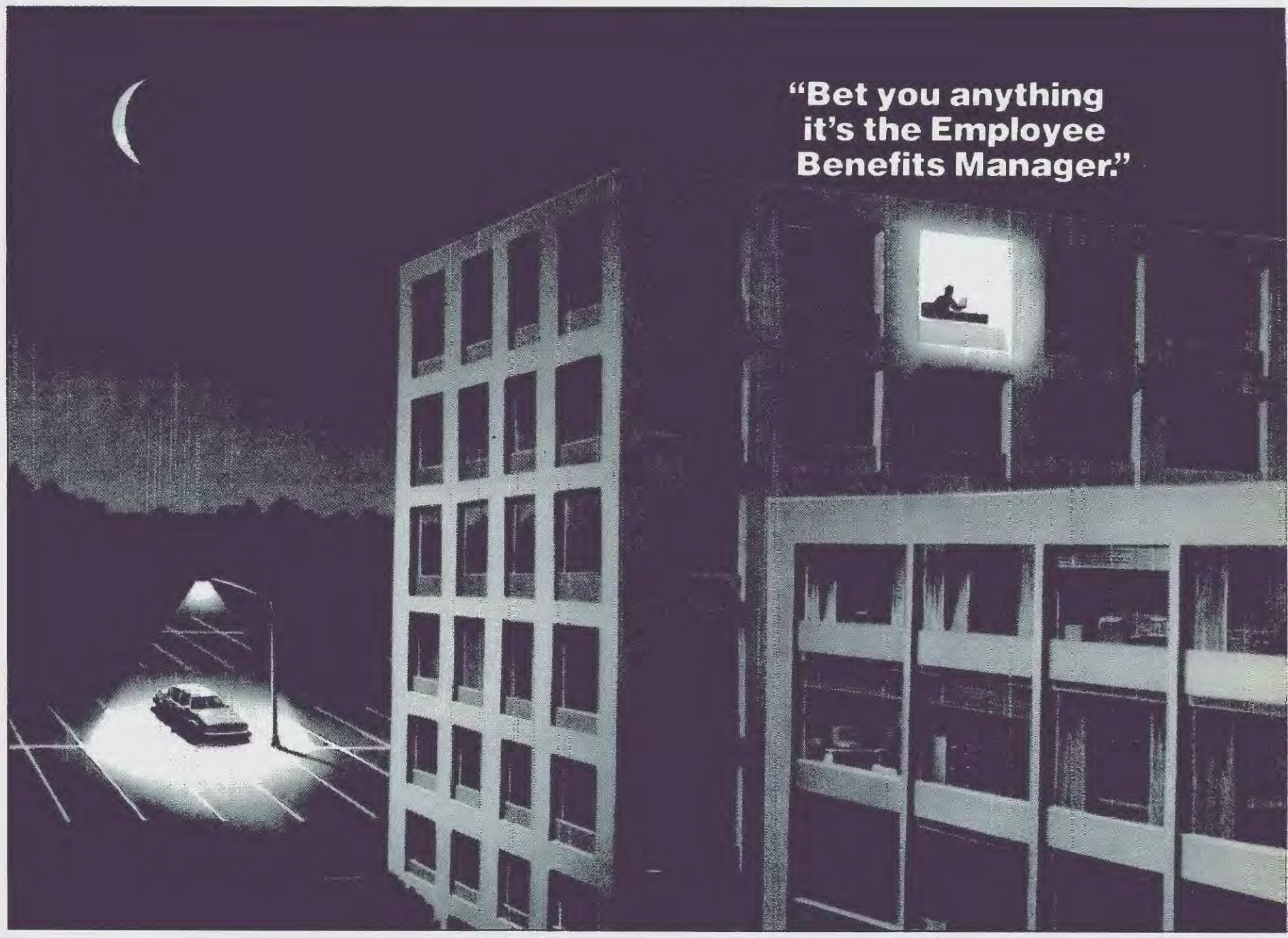
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Time capsule: 1969

Continued from page 28

cover the cost of organ transplants. The coverage—up to $50,000—is available for an extra premium to Hartford's existing group health insurance clients.

California Western States Life Insurance Co. began offering transplant coverage last year (*BI,* May 26, 1969).

* * *

Hartford Insurance Group has implemented a new benefit for its employees that guarantees 70% of salary for life for workers who suffer a total disability.

The program is designed to protect Hartford's employees against rising medical costs by guaranteeing the disability benefit for life (*BI,* July 21, 1969).

* * *

Autoworkers soon will be able to pay for their prescription drugs using special credit cards.

The cards are part of some prepaid drug plans negotiated in contracts between the United Auto Workers union and several automakers. Under the contracts, employers pay the cost of most prescription drugs above a $2 deductible (*BI,* July 21, 1969).

* * *

The National Governors Conference is urging the federal government to establish a compulsory national health insurance program.

The governors have adopted a resolution urging the federal government to require that health insurance be purchased from private insurers and paid for by employers and employees. Among the strong opponents of the plan was Gov. Ronald Reagan of California (*BI,* Sept. 15, 1969).

* * *

In New York, unions and state officials are looking for alternatives to traditional health insurance as a way of coping with skyrocketing medical costs.

Among the suggestions being made are treating hospitals as public utilities, whose rates are subject to approval by a state board, and urging insurance companies to set up their own hospitals. (*BI,* Oct. 13, 1969).

* * *

About 1,200 retired employees of the New York, New Haven & Hartford Railroad were threatened with the loss of their group life insurance, after the bankrupt New Haven line merged with the Penn Central Railroad. Insurance payments had been made by the estate of the New Haven line, but were discontinued (*BI,* Oct. 13, 1969).

However, after a hearing, the Interstate Commerce Commission was asked to order the Penn Central to resume insurance payments for the retirees (*BI,* Dec. 8, 1969).

* * *

Almost half the men who retired under Social Security in 1968 were younger than 65, according to the Social Security Administration, which called the number of young retirees surprising.

After the administration in 1961 gave workers the option to retire at age 62 with reduced benefits, it was expected that the number of early retirees would taper off once those who were age 62 to 64 and already retired applied for early benefits. However, that decline has not occurred (*BI,* Oct. 27, 1969).

* * *

Baltimore clothing workers are helping to pay for a day-care center for workers' children.

Under a joint bargaining agreement between the Clothing Workers union and clothing manufacturers, workers pay 2% of their gross pay to finance the center, which can accommodate 325 children aged 2 to 6. A similar center already is operating in Virginia, and several others are planned (*BI.* Nov. 10, 1969).

* * *

More and more benefit managers are using computer-generated personal benefit statements to communicate with employees. Using a computer, benefit managers can produce a statement that explains each worker's personal benefits, giving each employee a clear dollars and cents idea of the value of benefits (*BI,* Nov. 24, 1969).

* * *

Inadequate control over hospital stays is a major cause of spiraling health care costs, according to health care experts.

An unbridled increase in physicians' fees also is cited as a reason for the staggering increases (*BI,* Nov. 24, 1969).

* * *

Tax-supported employers lag behind their private counterparts in providing maximum benefits at minimum cost, says an expert.

And, the situation is not likely to improve, because tax-supported groups do not have the same kind of fiscal accountability found in corporations, says George A. Corkum, executive director of Fringe Benefit Consultants (*BI,* Nov. 24, 1969).

* * *

A 16,000-member local of the United Steelworkers of America has negotiated what it is calling the richest benefit and wage package of 1969 in the United States and Canada.

The major components of the new contract between Local 6500 and International Nickel Co. of Canada include an end to pension offsets, fully company-paid welfare benefits, a new prescription drug plan and a wage increase and a cost-of-living bonus (*BI,* Dec. 8, 1969). ■

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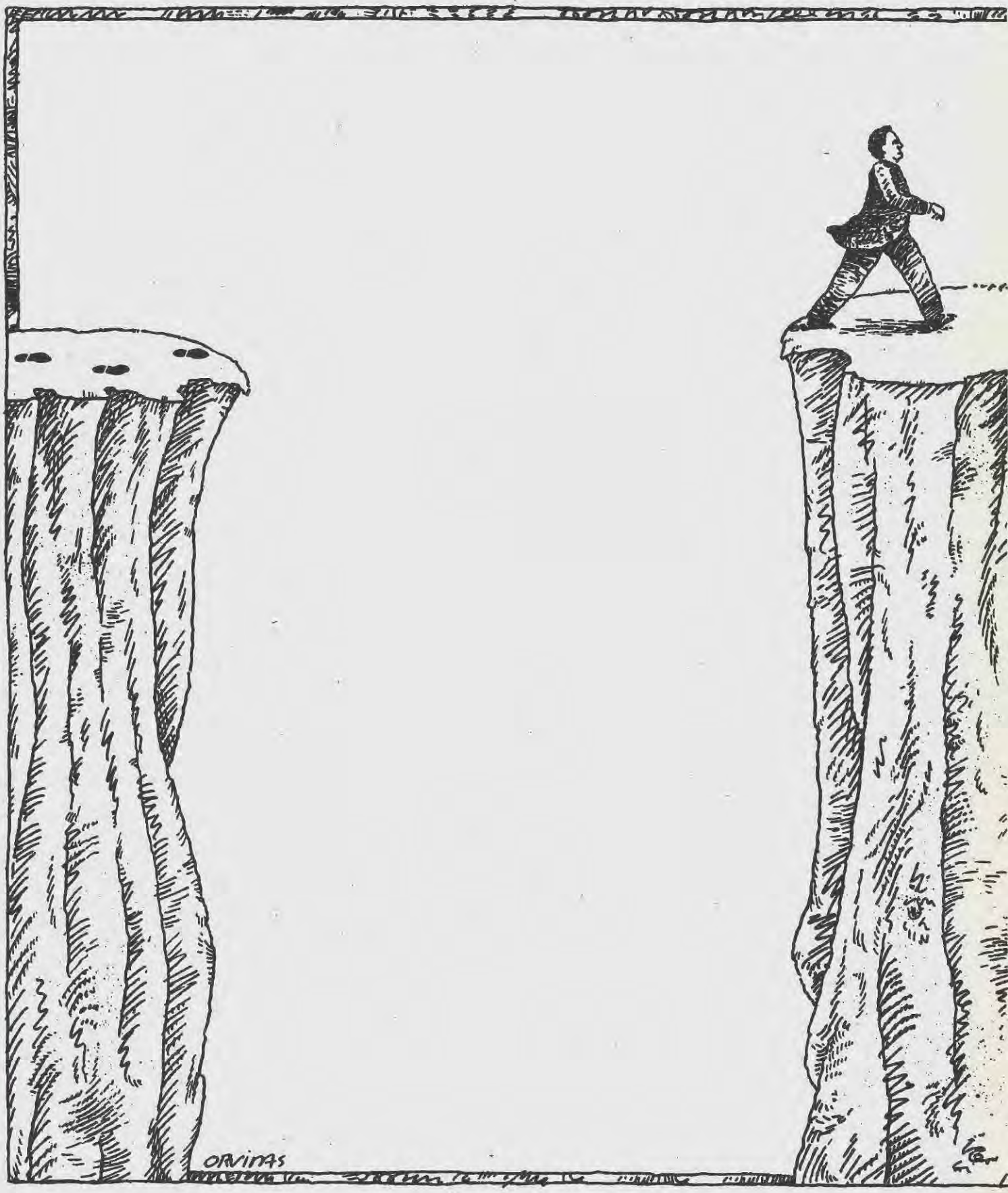
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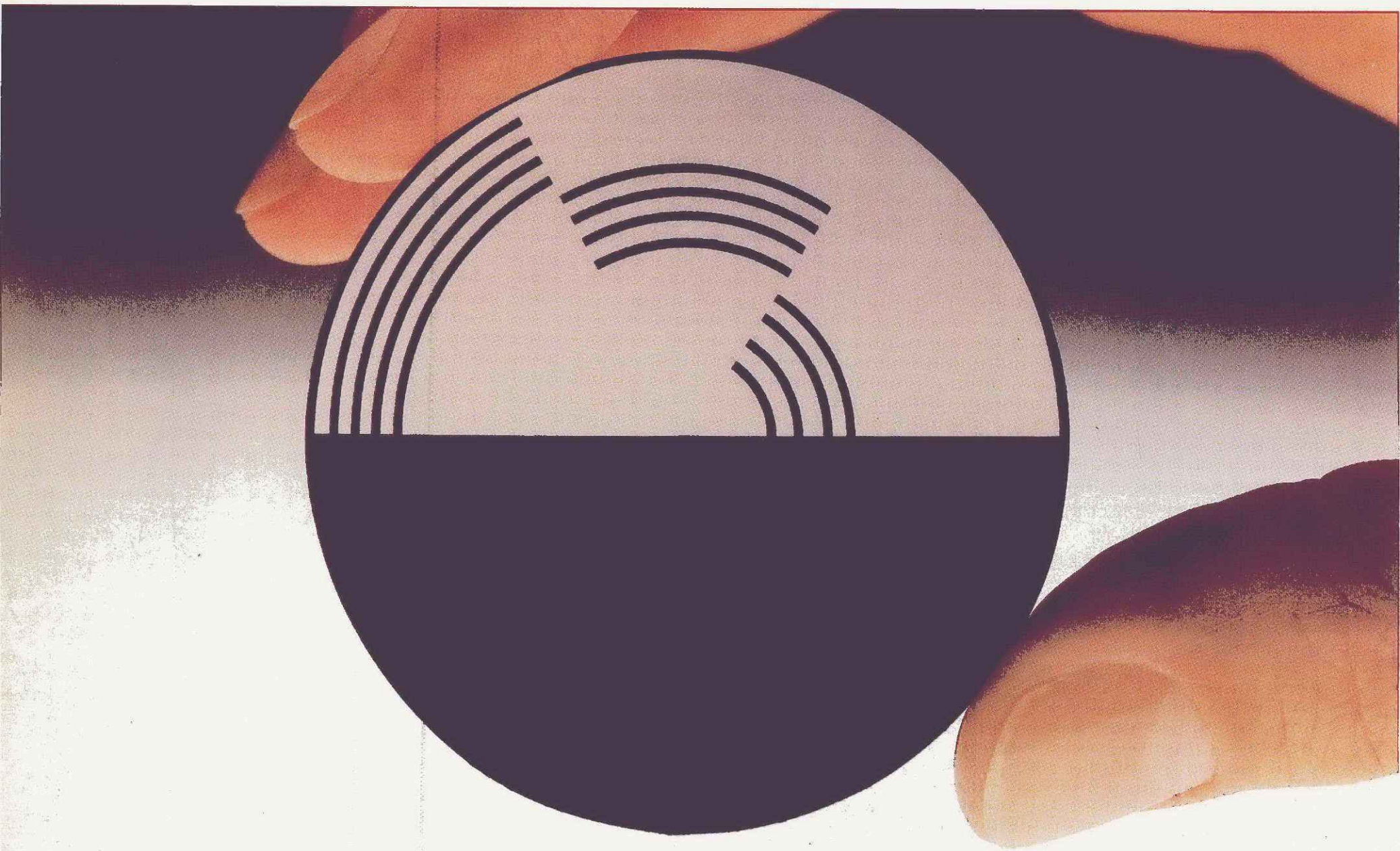
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20 years in my view

Managing health care costs

Employers will purchase, not just pay for, health care

By Art Young

HEALTH CARE AT Hewlett-Packard in the future will be more expensive than today. In 1972, that company spent $4 million on health care. Today, with triple the number of U.S. employees, the company will spend $100 million.

Cost is going to be influenced by a number of factors.

First of all, our company is more concerned than ever with international competitiveness, and we are going to be much more driven by costs and a desire to manage costs than was true in the past.

Second, Medicare's reimbursement is being held relatively flat, which means that all of the inflation in health care basically must be borne by the private sector, our employees and retirees, through higher costs or increased demand.

Third, we have a tremendous excess capacity in terms of physicians and hospital beds. That is going to generate more special interest legislative proposals for mandated benefits, mandated providers, risk pools and the like. It would appear that proposed legislation is going to increase our costs as more costs are shifted to the private sector.

Another consideration in dealing with our health care will be elder care. As our employees and their dependents get older, there will be pressures on corporate America to pay for more of these services.

Because of all these negative trends, Hewlett-Packard and a number of other companies have made a decision to buy health care rather than simply pay for it. In other words, we want our employees to be informed purchasers of health-care services as opposed to simply submitting charges for reimbursement without an understanding of the necessity of the procedure or the typical charges.

The purchase of health care will involve a partnership with employees. We need to provide employees with data on cost, as well as financial incentives to use certain providers, complication rates—which utilization review vendors calculate based on the number of complications arising from a particular procedure in a particular hospital—and so forth, so that they have an ownership interest in helping Hewlett-Packard and our third-party administrator.

In terms of plan design, we have made about 30 changes to our medical plan in the last four years, adding second opinion programs, outpatient programs, hospital copayments, home health care coverage, hospice coverage and so on. We need to continue to make changes to our health plan, evaluate the results of these changes, drop the changes that are not cost-effective and broaden the implementation of pilot programs that appear successful.

In terms of incentives, we have changed the incentives to encourage outpatient surgery and conservative treatment plans. We are starting to put in incentives in our health plan for providers that contract with Hewlett-Packard or with other organizations we are employing.

We want to emphasize low-cost, low-complication-rate providers without sacrificing quality of care; we want to do selective contracting in certain areas, for certain types of services; and we want to develop some partnerships in managing health care, particularly for expensive procedures.

We offer more than 80 health maintenance organizations, several preferred provider organizations and some capitated dental plans. We mean to do a lot more contracting in some of these areas. We need to contract for price and, at the same time, move toward conservative, effective case management.

That means we will need to develop relationships with organizations that can negotiate and work with the medical communities around the country and will be more interested in people who can help us manage medical cases and less interested in things like brokers' fees, experience, retention and so forth. Some of the things we have tried like voluntary second opinion programs will be changed.

We need to analyze, for example, why we have 1,000 hospital days for every 1,000 people covered in some parts of the country, and only several hundred days per 1,000 in other areas.

We need to understand why the chiropractic mix is significantly different in certain areas than in others.

We need to understand why the rate of generic drug utilization is almost 40% in some areas and less than 20% in other parts of the country.

So, we will be doing a lot more analysis and selective contracting based on data.

We need to address the different case costs between hospitals. There are very few reasons why we should be willing to pay for care that might cost $4,000 at one hospital when the same care with low complication rates can be achieved at $2,500 at other hospitals.

We will start to do more precertification and concurrent reviews and we will make available the costs and the coverages. Employees can then make their own decisions, but they will have data before the procedure or treatment plan happens.

Based on analysis, we need to address the whole issue of wide disparities, not only between institutions, but between types of providers to make sure that they are reasonable.

The whole area of chemical dependency, stress management and mental health care also needs to be addressed. It is a very large portion of our total costs and is growing rapidly. That will have to be integrated with how we work with HMOs, because there are coverage problems with mental health and HMOs.

Since we will have an older population, the whole focus of elder care and taking care of our retired people will become increasingly more important in the future.

I think you are going to see companies get a lot more active and interested in managing their health-care costs. At Hewlett-Packard, we are running a $100 million program, and it needs to be run more like a business. I think you are going to see more changes rather than fewer. ■

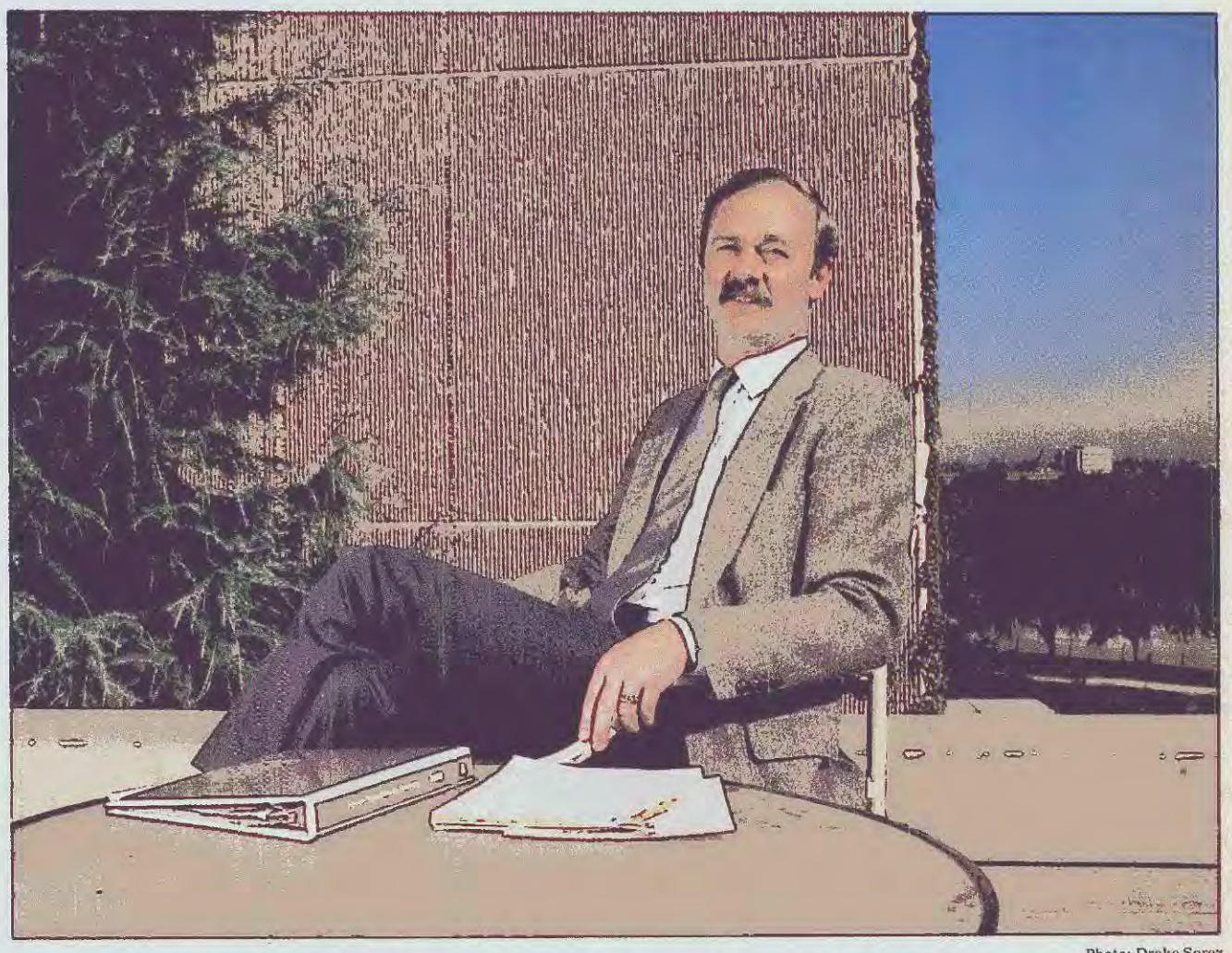


Photo: Drake Sorey

Art Young, corporate benefits manager at Hewlett Packard Co., outside his office in Palo Alto, Calif.

Art Young is corporate benefits manager at Hewlett Packard Co. in Palo Alto, Calif. Hewlett Packard was the first employer to negotiate its own preferred provider contract with an area hospital in 1984.

20 leaders look at the future of benefits

Employee benefit plans have evolved over the past 20 years from simple health insurance and pension programs to complex financial instruments. But, as benefit management has grown, so have challenges by demographic, regulatory and other forces.

The *Business Insurance* staff selected 20 leaders in the employee benefit field to comment on the growth of employee benefit plans over the next 20 years and the challenges that face benefit managers.

Besides the essay on this page by Art Young, corporate benefits manager at Hewlett Packard Co., on how employers will manage their health care costs, the other leaders who give their views on the future of employee benefits include:

Willis B. Goldbeck:
How coalitions can shape the health care system Page 34

Douglas L. Elden:
The role of preferred provider organizations..... Page 36

Laird Miller:
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Kathleen P. Utgoff:
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The future of post-retirement health benefits..... Page 63

20 years in my view

Coalitions treat health care concerns

By Willis B. Goldbeck

Cost management strategies, health planning, retiree health benefits, state-mandated benefits, elder care, child care and AIDS offer just an indication of the range of issues with which coalitions are attempting to work.

REGIONAL, STATE and local business coalitions are the institutional manifestation of employers' concerns for and involvement with the management of escalating health care costs.

The growth of these groups from their origins in the late 1970s to a loose network of nearly 200 today makes a strong statement about the magnitude of employer concerns.

Perhaps most important is the fact that these groups have come into existence at the very time that so many major employers have been down-sizing, reducing their participation in membership associations and generally seeking to avoid new financial commitments.

Also significant has been the impressive breadth of the coalitions' agendas. Cost management strategies, health planning, health promotion, retiree health benefits, state-mandated benefits, utilization review, elder care, child care and AIDS offer just an indication of the range of issues with which these fledgling organizations are attempting to work.

Equally diverse is the composition of the coalitions themselves. From all employers to multiple purchasers to all parties, the models vary but all are dependent upon one constant: the degree of employer concern and commitment to become a force for change.

Evaluating the impact of coalitions is further complicated due to their diverse goals.

In general, the movement has been successful at creating focused local forums in which employers could meet with each other and with providers; at developing educational programs which could translate the national attention to cost management into local implementation; and at building a system through which business could have an aggregated impact upon state, county and municipal health care legislation.

In many communities, the coalition has begun to give the buyers organizational, economic and political parity with the sellers of health care.

Selected coalitions have been very helpful in providing federal policy-makers with local employer constituent perspectives that can never be as meaningfully represented by national organizations.

Another positive example is the evolution of state health care data organizations, a development that would not have existed without business groups in states as diverse as Iowa and Pennsylvania.

More disappointing has been the recent closure of several coalitions due to lack of sustained employer leadership; the reluctance to invest in staff of quality comparable to the provider and legislative organizations with which the coalitions must interact; the failures of many to educate senior corporate leaders; often naive media relations; and finally the ease with which some coalitions adopt rather than fight the traditional short-term business perspective on obtaining economic results.

Nonetheless, the balance sheet of the coalition movement is positive and new groups continue to form regularly.

However, the coalitions face four major challenges:

- **Investment.**

The prudent management of funds (health benefits), the reorganization of systems (medical and health), the intersection of public and private institutions, (government and business) and the education of employees, retirees and dependents (about lifestyle and careful use of the medical system) will not be cheap. The coalition movement will succeed in relation to the employer's commitment of resources and the coalitions' own growing sophistication. Good coalitions require good staff and a commitment of resources sufficient to let the staff do their work without being consumed by fund-raising.

- **Cost and quality.**

Coalitions are at the center of a health care cost conflict that will become much more intense in 1988. Many will be pressed to consider trade-offs between cost and quality. The challenge will be to resist this false dichotomy.

For business, the most economically prudent purchase will always be that which produces the most favorable result as measured by the quality continuum which runs from patient satisfaction to scientifically studied medical outcomes. Coalitions will have every reason to demand increasing accountability from providers and to establish purchasing systems that reward high-quality providers by directing patients their way. Coalitions will be increasingly involved in the direct purchase of medical care. Comparative information is the key to prudent purchasing and coalitions are in the best position to force access to and conduct analysis of that data.

- **A health agenda.**

One of the most difficult challenges facing coalitions, yet one of the great opportunities, lies in their ability and willingness to become part of the re-examination of our health care priorities. Knowledge about technology assessment will be essential. An understanding of the long-term value of prevention and commitment to invest in building a long-term care infrastructure of programs and facilities to meet the needs of the chronically ill are two more underpinnings of the future U.S. health care system.

A true health care system, and an economically efficient one, will pay much more attention to values, to the importance of self-esteem, to the changing social patterns of education, employment, family structure and retirement. Mental health, or more accurately the mind-body relationship, is gaining

Continued on next page

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Photo: Ken Heinen

Willis Goldbeck, president, Washington Business Group on Health.

Continued from previous page

new appreciation. From the latest peptide research to the emerging fields of psychoneuroimmunology and psychoneuroendocrinology, to behavioral medicine, to the ancient healing professions of the shaman and acupuncturist, scientists are telling us that it is our own hidden reserves that hold the key to achieving our true health potential. Medical systems alone, no matter how well managed, will never be sufficient.

- **Social role of employers.**

Coalitions will be increasingly challenged to assist their members and government in an examination of the role that employers should play as the social service provider for populations no longer limited to active workers. Coalitions are the perfect local structure to assume many of the functions lost with the demise of local health planning and to provide a forum for reasoned debate about the degree to which employers should be the distributional vehicle for child care, basic and remedial education, insurance for former workers, social as well as medical care protection for retirees and the dependents. . . .The list of proposed responsibilities is nearly endless and will not go away.

Coalitions are forming state networks; more regional systems are soon to follow.

Looking ahead, 1988 can open a new era for coalitions. The Washington Business Group on Health will initiate the National Coalition Policy Forum, which will bring together the professional staff of those coalitions that want to have more direct involvement with federal health policy. This effort will be guided by the participating coalitions, which will help set, not only respond to, the federal agenda.

A second WBGH-initiated program, the Quality Resource Center, will provide coalitions with the references and analysis of the quality of care measurement literature so that the process of purchasing medical care can be as influenced by quality data as it recently has been by price information.

Third, the WBGH and its publishing partner, Health Learning Systems, will be developing communications systems to economically and efficiently expand the production and dissemination of many valuable coalition publications.

Increasingly, coalitions are forming state networks, and it seems safe to predict that more regional systems are soon to follow. The essential factor is that coalitions be dynamic, flexible, evolving and accepting of new challenges.

As coalitions expand their role and, at least potentially, their impact, it is only appropriate that they become subject to the same scrutiny and accountability that they have been demanding of others.

Coalitions are, above all else, a process for fermenting, identifying and then giving exposure to new leaders.

Some will emerge from staff positions, others from participating employers or the other organizations that belong to many of the coalitions.

Health care will remain a social policy issue with very large economic and political ramifications. No matter the speed with which the United States moves toward or rejects a national health insurance plan, the fact remains that care will always be delivered locally. Employers, other purchasers and providers will have no choice other than to deal with the ever expanding set of delivery issues and the increasingly complex matrix of subjects such as education, retirement, transportation and housing that represent barriers and opportunities for achieving our common need for high quality, economic efficiency and guaranteed access.

Coalitions can be both the institutional arena in which business considers these issues and the spawning ground for the new leaders so clearly needed for balanced programs. ■

Willis Goldbeck is president of the Washington Business Group on Health in Washington, D.C. Mr. Goldbeck founded the organization, which now has 180 members, in 1984 to give major employers a voice in the shaping of U.S. health care policy.



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Douglas L. Elden, partner, Altheimer & Gray in Chicago.
(Photo: Mary Herlehy)

Employer-sponsored PPOs to improve quality of system

By Douglas L. Elden

DURING THE PAST several years, the financing and delivery of health care in the United States have been dramatically altered due to substantial changes in the economic realities of the marketplace.

Under the prior delivery system, euphemistically referred to as the "free lunch system," medical care was delivered without regard to cost containment and on many occasions without regard to medical necessity.

The result was continued high costs during a period when the general economy was experiencing deflation.

Since that time, economic conditions and attitudes driving the health care system have been altered drastically. Where formerly the supply of physicians had been controlled, there developed a physician surplus.

The attitudes of group health insurers and the government have resulted in a demand for "managed care"—quality, cost-efficient health care. As a consequence, new cost reduction methods have been instituted in an attempt to prevent continued health care inflation.

As new systems emerge from the initial restructuring toward the era of managed care, it appears that the direction of the marketplace is shifting toward preferred provider organizations or preferred provider arrangements.

PPOs were initially formed by providers—physicians and hospitals—to maintain or increase their market share of patients. Once employers demonstrated a minimal acceptance of the provider PPOs, insurers became interested and formed their own PPOs or contracted with existing PPOs. Both provider and insurance PPOs are basically "health care selling organizations," selling the health care product on behalf of the providers and insurance companies.

However, in many areas providers and insurance companies are failing to deliver cost-efficient health care, employers and business coalitions, the "sleeping giants" that are the ultimate purchasers of health care, are forming their own PPOs, known as "health care purchasing organizations" (HCPOs), to protect their interests. By establishing HCPOs employers could ultimately control the financing and delivery of health care.

(One other note, there is a new unknown entering the PPO marketplace as the Department of Health and Human Services commences the development of its Medicare PPO Proposal.)

To understand the future of the marketplace and the role of PPOs, it is necessary to review the chronology of the establishment of PPOs. Initially, providers formed PPOs to market their services. "Physicians recognized that their traditional control of health care delivery was being usurped and sought to re-establish their position," says Lynn O. Dowling, director of practice management for the American Medical Assn.

These providers, who had long appreciated the role of third-party payers, sought to establish an organization to market, not to patients, but to these third-party payers who had the power to control the flow of patients. The PPO represented the providers as marketing agent, as negotiator and as administrator of these PPO contracts.

The marketing of these provider PPOs is based upon the concept that the PPO will manage health care:

- The PPO will obtain the services of quality physicians and quality physicians save money—no unnecessary surgeries, fewer readmissions, etc. According to Brant Kelch, president of Health Alternatives, a Washington, D.C.-based consulting firm, "Selection criteria for physicians is an essential PPO requirement for the establishment of a quality, cost-efficient PPO organization."
- The PPO will perform utilization review to prevent over-utilization by physicians and hospitals.
- The PPO will gather data to assure that only quality, cost-efficient physicians will remain on the PPO panel and to demonstrate savings to the payer.
- The PPOs will have the administrative sophistication to deliver health care.
- PPOs also offer discounts

Continued on page 38

Douglas L. Elden is a partner with the Chicago law firm of Altheimer & Gray, where he specializes in managed health care systems law. Mr. Elden also is president of the American Assn. of Preferred Provider Organizations.



In Switzerland many traditions have their roots in the day-to-day life of the farming community. The Swiss farmer's life has never been easy, and it is impossible to stand alone. There is no way around cooperation, mutual trust, and a strong feeling of responsibility.
Pruning the vines is an example for this. Whether a good grape harvest can be gathered in autumn depends to a large extent on early spring, the time of vine pruning. Without this measure, the yield would be three to five times lower. No wonder, then, that there are age-old fertility rituals associated with this operation: on the slopes of the vineyards along the Rohne valley some of the locals play along on drums and flutes while others tend the vines.

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Elden

Continued from page 36

from usual and customary fees and charges.

However, in many geographic areas the PPOs established by providers have failed to fulfill these marketing claims.

For example, in many instances, due to internal politics, the PPO panel may be open to all members of the medical staff of a sponsoring hospital. Therefore, many PPOs permit the same, inefficient physicians who contributed to the inflation of the past to participate in the PPO.

Many utilization review systems established by PPOs are ineffective or non-existent. Some PPOs do not collect the data necessary to remove poor quality or inefficient physicians or even to demonstrate their cost-effectiveness. Many PPOs have generated an insufficient flow of patients to even permit the collection of meaningful data. "Without sufficient, accurate data collection, it is impossible for PPOs to demonstrate their quality and cost effectiveness," says Charles M. Jacobs, president of InterQual Inc.

In many instances the PPO panel may be open to all members of the medical staff of a sponsoring hospital. Therefore, many PPOs permit the same, inefficient physicians who contributed to the inflation of the past to participate in the PPO.

Many PPOs are underfunded and cannot afford the systems and personnel necessary to manage health care and cannot purchase the business expertise to operate in a competitive environment. Finally, many of the "discounts" offered by PPOs have been illusory and often in excess of physicians' regular charges.

Insurance companies entered the PPO business after their analysis of the marketplace indicated that provider PPOs were becoming increasingly accepted. Some insurance companies have engaged existing PPOs to serve as their "private label PPO."

However, insurers, as well as employers, have had difficulty assessing the quality and viability of PPOs. As a response to this problem, the American Assn. of Preferred Provider Organizations, the PPO trade association in Washington, D.C., is establishing an accreditation program for PPOs. "The accreditation program should serve as a guide for payers in the PPO selection process," according to Peter Boland, president of Boland Health Care Consultants in Berkeley, Calif., and chairman of the AAPPO's accreditation committee.

The successful insurance companies have engaged consultants, conducted a thorough investigation of the marketplace, analyzed the components necessary to produce quality, cost-efficient health care and have sought to implement PPOs reflecting these factors. However, many insurers have created PPOs that resemble the poorer-quality provider PPOs or have contracted with the poorer-quality provider PPOs.

The insurance companies are marketing their PPOs based upon the premise of managed health care by expounding the same claims as the provider PPOs. However, insurance companies have been less successful in developing physician criteria and therefore fail to exclude physicians who cannot demonstrate quality and cost-effective care. Their utilization review systems are often claims-based and not adequate to assess quality, to change physician practice patterns or to prevent hospital overcharges. Many of the discounts offered by insurance companies are illusory and reflect the broker charge of insurance companies.

In geographic areas where performance of the provider and insurance company based PPOs has been inadequate, the purchaser of health care continues to receive costly, inefficient health care. As a result, the ultimate purchasers of health care are forming their own PPOs or health care purchasing organizations. Inland Steel Corp. in northern Indiana has formed an HCPO. Chrysler has used its leverage to obtain preferred provider arrangements.

HCPOs can succeed because:

- The impetus to establish an HCPO has usually occurred in geographic areas where provider and insurance company PPO delivery systems have failed.
- HCPOs control the key components to the health care system, i.e., the patients and the dollars. As a result HCPOs have the leverage to require and enforce selection criteria for physicians and hospitals. HCPOs have the leverage to demand strict utilization review because proper utilization of health care resources will save company dollars.

Initially, employers were believed to be incapable of organizing HCPOs and managing their own health care programs due to their lack of health care experience. However, the expertise of health care personnel, consultants, hospital administrators, physicians, PPO directors and utilization review companies are available and ready to assist the employer in the formation of HCPOs. Employers recognize that provider and insurance company PPOs are "health care selling organizations" and may not offer protection for the interests of the employer.

An HCPO formed by an employer or business coalition is established for the protection of the interests of the employer. Employers are recognizing that they can buy the talent they need. The purchase of health care expertise is just a small percentage of the quality and savings that will result from the application of this expertise on their behalf.

The direction of health care delivery is moving increasingly toward PPOs and the direction of PPOs is toward HCPOs. The only way for the providers and insurance companies to prevent HCPOs from controlling the marketplace is to provide quality, cost-efficient health care services and effectively demonstrate this fact to payers.

Most employers admit they do not want to enter the health care business. However, with predictions that health care may achieve 12% of the gross national product by the year 2000, sophisticated employers that develop health care expertise out of necessity may find opportunities to remarket it as well.

If the proposed Medicare PPO utilizes the entrepreneurial system established by providers, insurers and employers, the Medicare PPO will probably be accepted in the marketplace. However, if Medicare merely seeks to extend its existing over-regulated system of health care payment calling it a "PPO," this program is doomed to failure similar to that of the competitive medical plan program for Medicare health maintenance organizations. ■

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20 years in my view

High-tech medicine challenges payers

By Laird Miller

Plans must evaluate the intricate technical and therapeutic merits of new technologies while often simultaneously dealing with desperate patients or their families who are willing to try any treatment—proven or not—that might save a life.

GROUP HEALTH care plans, insurers and governmental health care programs have traditionally approached experimental and high-tech medical procedures with caution.

Most plans specifically exclude investigational and experimental drugs, and procedures, limiting coverage to technologies that:

- Are considered generally safe, "effective" and medically necessary.
- Use accepted standards of medical practice in an appropriate setting.

Although insurers and government programs have been accused of rejecting new technology because of its cost, payers assert they have a responsibility to protect beneficiaries from the risks of treatments that may have limited therapeutic value. Experience supports this argument in that payment guarantees from insurers and government programs improve a treatments's popularity and proliferate its use.

Typically, employers and insurers follow government's lead in approving payment for new treatments. Heart transplants have been an exception, however. Although it was widely publicized that the government was still studying the procedure's therapeutic merits, the public put intense pressure on individual plans to cover heart transplants. It worked. More than 80% of insurers currently cover heart transplants for patients who meet defined criteria. Thus, heart transplants are a case where social and political considerations played an important role in diffusing a new technology.

Clearly, the issues, facts and pressures affecting plans as they decide whether to pay for new technologies are very complex. Plans must evaluate the intricate technical and therapeutic merits of new technologies while often simultaneously dealing with desperate patients, their families or others who are willing to try any treatment—proven or not—that might save or prolong life.

But, saving and prolonging life can be very expensive. In this society where most employers and consumers are shouting in unison "they can't and won't pay higher health care bills," the emergence of new (and usually costly) technologies is presenting dilemmas that are not easy to resolve.

Will it get easier? No, it will probably get harder. Take heart transplants, for instance. More than 3,000 transplants have been performed at 94 U.S. "transplant centers" with an overall one-year survival rate of 80%.

With heart transplants, we've, in a sense, postponed addressing the cost issue; the shortage of donor hearts has limited the number of transplants, which in turn has controlled the total cost. What will happen as artificial heart technology advances? Will we as employers, taxpayers and consumers be willing to pay the bill as transplant recipient criteria become less stringent and the procedure is accessible to more and more people?

Right now, wearing our consumer hats, we're saying "we can't pay more money," but we must expect "someone" to pay. After all, we don't reject new technologies nor have systems in place to evaluate their suitability.

What will health plans do? There are observable trends surfacing:

- **A trend to performance standards.** In the case of heart transplants, for example, some plans and private insurers have from the beginning directed beneficiaries to specific facilities and physicians who have demonstrated proficiency (low mortality, low incidence of complications, good patient outcomes, etc.).

What happens if a patient goes to a facility that doesn't meet the plan's criteria? Normally, the plan or insurer will not pay for it.

For high-cost technology like heart transplants, where 78% of surgeons surveyed said ability to pay was an important factor in choosing organ transplant recipients, a plan's refusal to guarantee payment will negatively impact the patient's access to treatment.

Is denying payment to patient's chosen provider unfair? Some would, of course, argue that it is. But by directing beneficiaries to centers that are experienced in the new technology, plans are:

- Improving the probability that the new technology will have the desired therapeutic effect for the patient. For example, research on renal transplants clearly shows that the number of transplants performed is associated with better patient outcomes: fewer deaths, complications, infections and longer survival rates. With experience comes knowledge and better protocols for managing the patient from pre-treatment workup through post-treatment followup.
- Reducing the costs of implementing high technology. Fewer complications and infections usually translate to lower medical costs. And there are also, of course, in any industry, certain economies associated with high volume. High-tech medical care is no exception. More patients should mean experienced physicians and trained support staff. With protocols and equipment in place, these high-volume facilities should be able to treat patients for lower rates and with better results (patient outcomes).
- Establishing performance expectations. By selecting providers based on performance and giving them incentives to maintain and improve performance, plans will have a very positive effect on the quality of health care.

- **A trend toward uniform guidelines across plans.** With organ transplants we have seen another trend: written guidelines from national and private

Continued on next page



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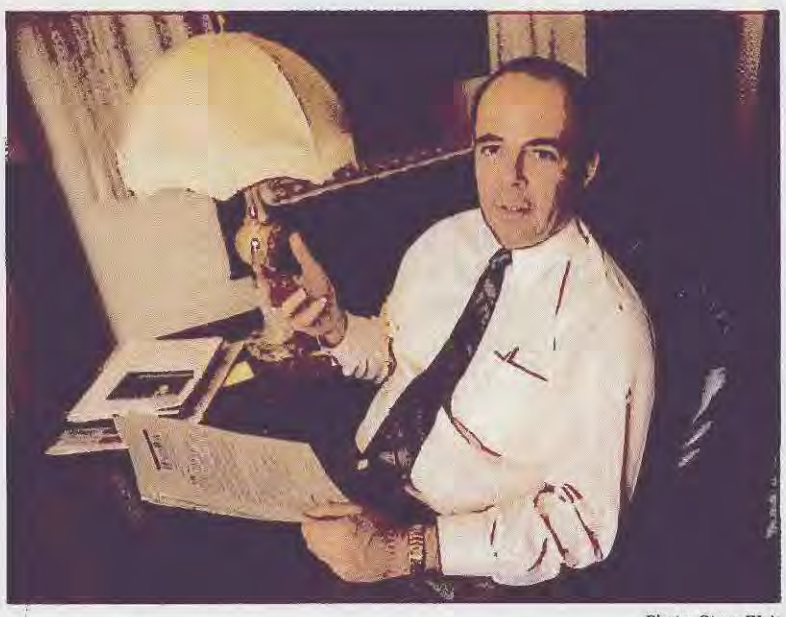


Photo: Steve Wolt

Laird Miller, president, Health Systems Management Inc.

Continued from previous page

task forces, describing criteria for choosing transplant recipients and organ donors, as well as for selecting transplant medical centers.

The U.S. Public Health Service, the Blue Cross & Blue Shield Assn. and the Health Insurance Assn. of America are examples of organizations that have (or are developing) guidelines for selecting transplant centers.

A trend to develop guidelines across plan and insurance organizations is important because health plans and other payers will need to implement consistent systematic approaches to evaluating new technology. And they won't have the resources to do it alone. Payers will find it works well to work together.

Plans and government payers will realize how important it is to be pro-active and have a system or mechanisms in place to begin evaluating the therapeutic merits of a technology before it becomes entrenched through public sentiment. To limit access to inappropriate therapies and providers who do not meet performance standards, plans and other payers will also need strong and skillful public communications.

Early technology evaluation will also allow plans to write and negotiate reasonable reimbursement strategies. Unless we see a rapid and complete 180-degree turnaround in consumer attitudes toward rising health care costs, plans will continue to be pressured to reduce medical costs while improving the quality of and access to health care.

• **A trend to tie performance to payment.** How can plans do this? Group health care purchasers, including employers, plans and government programs, are showing increasing interest in performance-based payment systems. These systems tie provider reimbursement to provider performance. Did the provider's patients get the expected therapeutic results given their individual conditions when presenting for the high-tech treatment? And was the treatment justified in that it improved the patient's quality of life? Then, the provider should be paid the negotiated rate for expected satisfactory performance.

Note that we said rate. The plan will negotiate a set package rate with the provider and the provider will know the criteria for satisfactory performance and its associated payment. The provider will also be aware of disincentives for poor patient outcomes or for selecting patients to treat for whom there is no prospect of improvement in quality of life.

Does an analysis of all the provider's patients who received the new high-tech treatment show that the majority of patients have fewer complications and longer survival rates than would be expected given how sick they were when treatment began? Was the treatment justified in that it sustained or improved quality of life? If yes, this performance merits a bonus for the provider.

But suppose a provider's patients don't do as well as expected? The plan then pays the provider less money.

• **A trend toward bundling services.** We've talked about providers. Who is the provider in our prospective performance-based payment system? The physician? The hospital? The nurse? The anesthesiologist? The pharmacist? The answer is all of the above—and more: the entire medical team involved in providing treatment for the patient.

In the last decade, we've seen a trend toward "unbundling" services. By this we mean each person or specialty separately bills the patient (or plan) for his or her services. So, for example, the patient (or plan) receives separate claims from the attending physician, the anesthesiologist, the surgeon, the surgeon's assistant, the heart pump specialist, the hematologist, the immunologist, the physical therapist, the hospital, the surgical facility, the pharmacy—each person or entity involved in the treatment bills as a separate business.

Obviously, this creates more work for the plan's claims processing unit. It also tends to drive the cost of health care up. But these people are a team: a team brought together to make the patient better.

Plans will see that these groups should be given incentives as a team so that all have a financial interest in making the patient as well and preferably better than expected. Plans will negotiate fixed prices with one provider entity. The fixed price will be performance-based and will include severity adjusted, bundled services previously billed for separately.

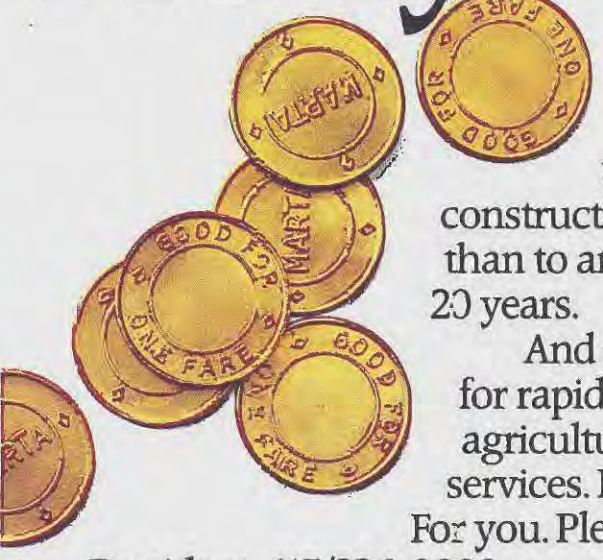
Although we have recognized for awhile that health care is a business, it's only recently that we've realized health care has enjoyed a rather unique status in the marketplace when compared to other businesses.

Our neglect has created a fiscal monster, and plans are being asked to fix it; employers are putting them at financial risk to do so. And it will be fixed eventually, but it will take determination, fairness, knowledge, the strength to be unpopular, and a commitment among plans to work together toward a shared vision of an effective and efficient health care system. ■

Laird Miller is president of Health Systems Management Inc., a Minneapolis-based consulting firm. He is former corporate manager of provider relations at Honeywell Inc. in Minneapolis.



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20 years in my view



Ms. Utgoff

PBGC a pawn in political game

By Kathleen P. Utgoff

WILL THERE, should there, be a Pension Benefit Guaranty Corp. 20 years from now? It isn't hard to understand why this question is being asked. Over its short history, despite an eightfold increase in revenues, the PBGC has managed to accumulate a huge deficit. But what is even more disturbing is that the PBGC has become a pawn in a dangerous game that threatens rather than enhances retirement security.

Unless the rules of this game are changed, there will not be a PBGC in 20 years. Well-funded companies will terminate their defined benefit pension plans rather than continue to pay premiums to support a system that transfers billions of dollars to their underfunded competitors. Under these conditions, the PBGC should not exist because it would serve as a vehicle for taxing the defined benefit system out of the business.

I believe that this dreary scenario will not become a reality because Congress will act to make sure that the PBGC does not destroy the defined benefit pension system.

I make that prediction because I am confident that Congress will preserve the pension system that provides the best, most secure type of retirement.

With the right reforms, the PBGC can become a safety net for workers rather than a back door to misguided industrial welfare. It *can* provide the considerable benefits of true insurance by pooling and diversifying risks.

The PBGC can become a safety net for workers rather than a back door to industrial welfare.

Workers with a defined benefit pension plan should be confident that their pension promises will be kept no matter what happens to their company. No worker should be threatened by an insurance system that encourages underfunding and the plan terminations that are now the only alternative for some underfunded plans.

To make this transition, the pension system must be reformed so that employers are more responsible for their own pension promises. Funding and bankruptcy rules must be changed so that all companies back their promises either with contributions to a pension trust or with their own assets. Companies that do not fund their promises should bear more of the cost of the pension insurance system through higher premiums. Employers should be given reasonable access to funds that are truly in excess of pension promises; otherwise, they will fail to adequately fund those promises.

Reforms that strengthen funding standards and restructure premiums are now being actively considered by the Congress. I hope that they will be enacted in the near future because they represent a giant step toward a rational, sustainable and productive pension insurance system.

These reforms also represent a step away from the dangerous route of pension insurance as back-door industrial welfare. The premiums that employers are willing to pay as a cost of having a defined benefit pension plan will never support the industrial welfare program that has been forced on the PBGC. Nor should they.

Whether or not you believe that the government should use an industrial policy program to direct resources in ways that the private economy would not, there is no reason to believe that one group of companies—those that sponsor defined benefit pension plans—should pay for the cost of a program that is supposed to benefit the general welfare. As long as this group is forced to pay that cost, the defined benefit pension system is in danger of being overwhelmed by the extra and unjustified weight that is being forced upon it.

The PBGC's current industrial welfare program also allocates its subsidy in pernicious ways. Companies can now qualify for some of the biggest handouts ever provided by the federal government by intentionally underfunding their pension plans. There is no relationship between pension underfunding and any rationale that has been given for industrial policy. Some of the steel companies that have been hit hardest by imports and have had the biggest capacity reductions do not qualify for a handout from the PBGC because they have reasonably well-funded pension plans. I do not blame them for being annoyed with our current pension system.

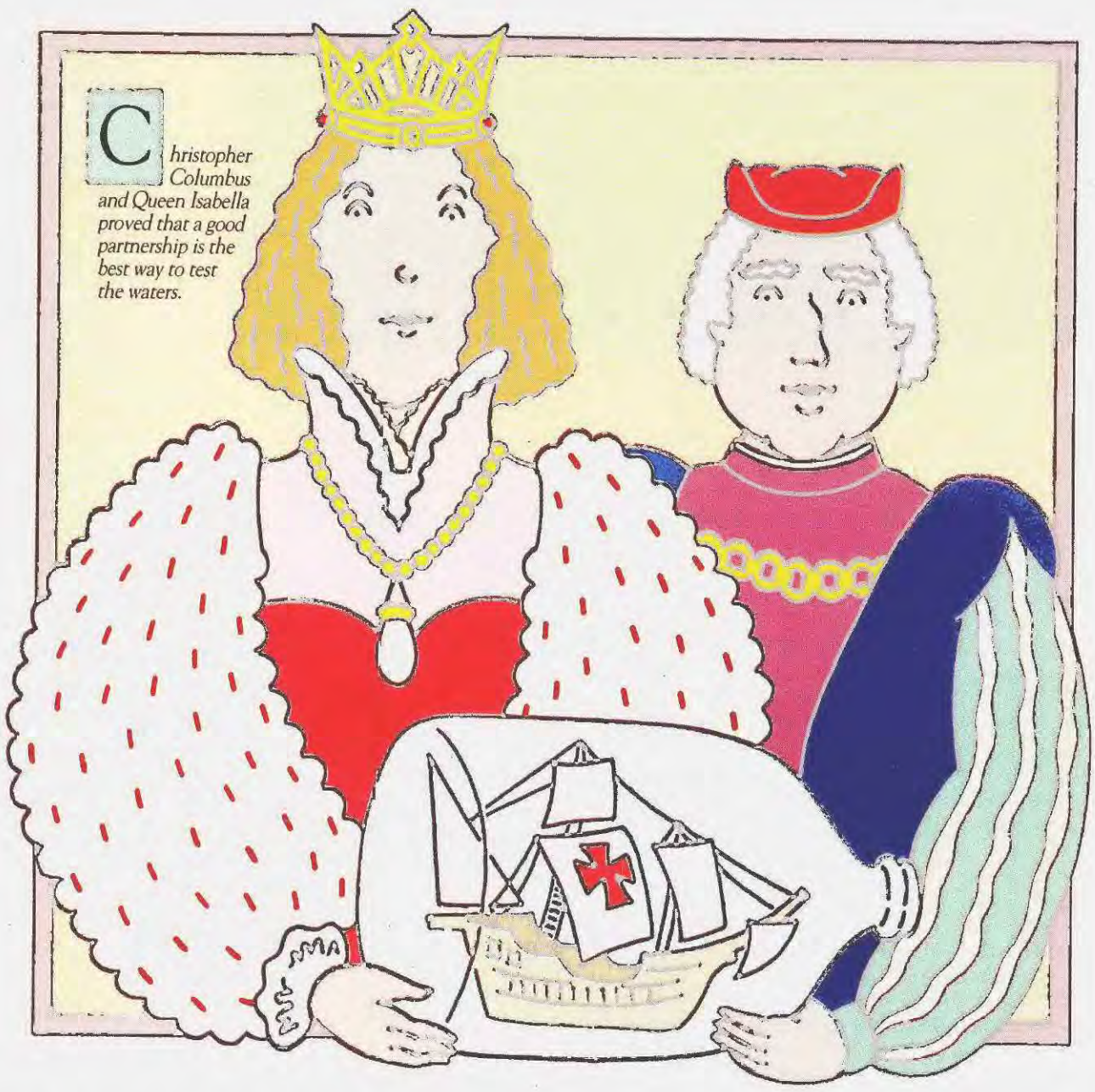
When Wheeling-Pittsburgh terminated its underfunded pension plans after it filed for bankruptcy in the fall of 1985, many people questioned this move that enabled the company to lower its labor costs by $3 an hour and increased the PBGC's deficit by nearly a half-billion dollars.

Officials at Wheeling-Pittsburgh responded to negative comments about their actions by asking, "Isn't that the purpose of pension insurance?"

If pension insurance is to survive for the next 20 years, the answer to that question must be a resounding "NO!" ■

Kathleen P. Utgoff is executive director of the Pension Benefit Guaranty Corp., the federal agency in Washington that guarantees workers' and retirees' basic pension benefits. Ms. Utgoff has led the drive to try to convince Congress to enact legislation to improve pension funding and put the PBGC on solid financial ground.

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U.S. needs mandated health care benefits

By Fortney H. Stark

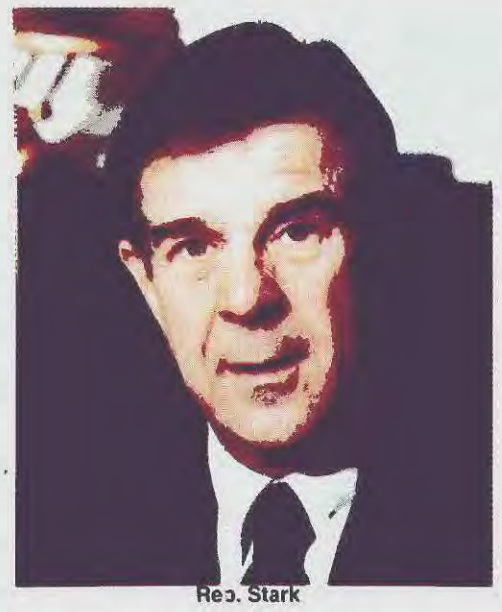
WHAT WE SHOULD DO, as soon as possible, is make sure that *all* Americans have health care coverage, so no American is constrained by financial worries from seeking needed health care.

I think we will do this, and very soon.

The United States is almost the only industrialized nation in the world that does not have a way of rationally taking care of all of its citizens' health needs. We do, of course, provide health care to most of our people—it is just done in a wasteful, Rube Goldberg fashion. One out of every six citizens does not have health insurance. When they face a serious illness, we all pay for their health care through Medicaid taxes and various state and local property taxes and/or through increased donations to local hospitals.

It is wasteful, because those who are uninsured often forgo treatment until the problem is really serious and then the bills become catastrophic. The patchwork system of government welfare is inefficient. The "charity" cases tend to concentrate in certain hospitals, putting enormous strains on the ability to provide quality care to the rest of the community. Finally, by not having health insurance, the uninsured often do little to contribute to meeting their health care costs.

As partial solutions to the problem. I have authored two bills. The first encourages the states to establish risk pools for the uninsurable or hard-to-insure. This measure—which is strictly voluntary—passed the House last



Rep. Stark

year, but died in a conference committee.

We are trying again this year: the House Ways and Means Committee has approved the idea and included it in this year's budget package. Basically, the proposal is modeled on the risk pool programs that exist in 11 states. It allows people to buy a major medical policy and requires all employers with more than 20 employees to contribute to any shortfalls in the pool.

In effect, it will mean that these uninsurable or hard-to-insure individuals will be able to buy policies at about 150% of the going rate in the state for an individual health insurance policy, and it means that the employers in the state will have to contribute $1 or $2 per worker per year to keep the fund in the black. While the plan will enable thousands of individuals to contribute to their health insurance costs, it also means that the lower income individuals will not be able to afford to "buy-in." One hundred fifty percent of the cost of already expensive individual policies would be about half the income of a minimum wage worker!

A second bill I've introduced would impose a 1% tax on all health insurance premiums to create a pool of money which will be used to reimburse those hospitals which provide the most charity and uncompensated care. This bill will help about 1,000 out of the nation's 6,000 hospitals that go the extra mile to provide for the indigent and uninsured.

Obviously, neither of the above proposals are total solutions to the problem. A more comprehensive approach is needed.

I expect to introduce in the near future a mandated benefits bill. Of the nearly 40 million Americans without health insurance, about 25 million are in the workforce and could be protected through the requirement that employers offer health insurance protection. The bill would be less elaborate, and less costly, than the pending Kennedy-Waxman bill.

Everyone agrees that it is time to raise the minimum wage, which today is merely a poverty wage. I would urge that we consider combining a smaller minimum wage increase with a mandated health insurance benefit.

I would hope business would support this proposal. As I indicated earlier, businesses are already paying for uninsured care through higher Medicaid and welfare taxes and subsidizing their competitors that do not provide health coverage.

Those that do not provide coverage should support the effort to develop a larger group insurance market, because they would gain tax-advantaged benefits for owners and lower group rates that would be available for workers.

No one should argue that mandated health insurance will make us less competitive. The Germans have had mandated health insurance for a century now, and the last I looked, they were awfully competitive!

The combination of risk pools, help for the hospitals who provide the most charity care and mandated health benefits for those in the workforce will go a long way to providing a rational cost-sharing for health protection for all Americans.

The fact that so many Americans are without coverage and are constrained in their use of health services raises another issue which we must address: health inflation. ■

Rep. Fortney (Pete) Stark, D-Calif., is chairman of the House Ways and Means Health Subcommittee. Rep. Stark was the original sponsor of legislation—incorporated into the Consolidated Omnibus Budget Reconciliation Act of 1985—that requires employers to extend their group health care programs to former employees and to employees' dependents.

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20 years in my view



Dr. Milstein

Three changes expected for UR

By Arnold Milstein

UTILIZATION REVIEW is the process of independently judging the necessity of health care, usually with the aim of discouraging unnecessary services. It is the linchpin of most successful programs to contain medical costs.

Well in advance of our ability to evaluate its current forms, UR is metamorphosing rapidly in its sponsorship, scope and methods. Based on current trends and opportunities, future UR is likely to reflect multiple changes:

- **Changes in sponsorship.**

In what has been termed "the migration of risk," health plan sponsors are altering the basis of reimbursement in order to transfer the financial burden of unnecessary services onto hospitals and doctors. Medicare reimbursement of hospitals on a fixed, per-admission rate and HMO reimbursement of hospitals on a fixed, per-enrollee rate, exemplify this trend.

Over time, these reimbursement changes will shift the primary sponsorship of UR from purchasers to providers.

- **Changes in scope.**

Three changes in the scope of UR are likely. First, UR will be applied more fully to categories of service use beyond its traditional domain of need for overnight hospitalization. Physician services, both inside and outside of the hospital, home health agency care, emergency room care and nursing home care will more often be subject to utilization review.

More money will be spent to research the outcomes of competing utilization practices.

Second, UR, which either precedes or is concurrent with health care service, will increasingly be used to serve other objectives which are better accomplished before the service has been rendered. Verification of eligibility and coverage, including, for example, application of pre-existing illness exclusions, will be piggybacked onto the UR function. Screening for common and/or relatively dangerous quality of care defects in physician treatment plans is another likely expansion.

Finally, UR-related activities like assurance, or actual provision, of discharge planning, case management and second opinion will lose their distinct identity and become routine components of UR.

- **Changes in methods.**

Many changes in UR methods are likely to grow out of the current environment, in which lack of dogma and intensifying competition for good results have encouraged creativity and experimentation:

- UR standards will be rooted in a more scientific base. More money will be spent to research the outcomes of competing utilization practices. Research and expert consensus will supplant the boldness of UR system medical directors in deciding, for example, whether a UR system should advocate a two- or three-day length of stay following uncomplicated gallbladder removal.
- UR systems will increasingly rely on pre-established networks of home health care agencies, half-way houses and other intermediate providers, so that they can be rapidly substituted for more expensive hospital care.
- Greater psychological sophistication will be incorporated in UR system interaction with attending physicians. UR impact depends heavily on a process of persuasion. Much more can be done to enhance the success of this interpersonal transaction.
- There will be a greater degree of matching between the medical specialty of UR physicians and the case under review. This is an offshoot of the prior point in that greater knowledge and therefore credibility in a particular clinical area will enhance the persuasiveness of a UR physician.
- As hospitals and physicians move toward computerized medical records, UR nurses will be substantially replaced by automated interactions between electronically stored data on patient status and computerized algorithms that determine when the patient is sick enough to warrant hospitalization. Some electronic interactions may motivate a physician to hospitalize a patient who otherwise may not have been hospitalized.
- Patient, physician and hospital-specific data from prior UR interactions and claims submissions will be used in making UR judgments and to identify providers who can be safely exempted from routine UR. For example, doctors whose treatment plans have been consistently approved by UR staff and/or who, on average, achieve better and more economical outcomes, will more likely be subject to unobtrusive, low-cost monitoring, rather than be required to obtain UR clearance on every case.

In some well-established selective provider programs (HMOs or PPOs) almost all utilization control may be converted to this leaner mode.

In overview, utilization review in the future will vary in at least three significant dimensions as a new and powerful tool is honed to increasing levels of net yield. ■

Dr. Arnold Milstein is president of National Medical Audit, a San Francisco-based cost management consultant. The company, a division of William M. Mercer-Meidinger-Hansen Inc., uses a panel of physicians to audit medical records and utilization review programs.

Does your employee belong in a psychiatric hospital?

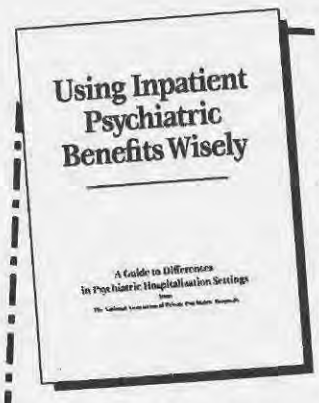
Maybe so. Fortunately, serious mental illness is highly treatable. But what sort of treatment setting is most appropriate? If your group insurance plan offers mental health care benefits, you can't afford to be confused about what types of therapeutic services, hospitals and facilities are available. In fact, understanding who needs a private psychiatric hospital and who doesn't can help you manage your inpatient psychiatric benefits more efficiently.

Not all hospitals treating mental illness are alike—and you need to know the difference.

The diverse and individual needs of the mentally ill require an equally diverse range of health care facilities, from state institutions to general hospital settings to specialty psychiatric hospitals. The services and therapies offered by different types of hospitals also vary in scope and intensity.

The National Association of Private Psychiatric Hospitals (NAPPH) has assembled a comprehensive booklet which clearly defines the differences among mental health inpatient providers. We've also included useful information about the types of patients we treat and the costs involved, plus the latest facts on hospital trends and the utilization of inpatient services, all broken out in easy-to-understand, reproduceable language and charts.

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Employee benefits in 2007 will be more limited, costly

By Dallas L. Salisbury

THE COMPOSITION of employee benefits in 2007 will be a function of the environment as it develops over the coming 20 years. Demographics. Economics. Workforce attitudes. Employer attitudes. Human needs and preferences. Public policy. Global politics.

An accurate prediction of where these environmental factors will be in the year 2007 is nearly impossible.

One can, however, based upon a scan of books, articles, surveys and data, assess directions. Such an assessment paints a "limits to growth" picture of what the composition of employee benefits may be in 2007.

The next 20 years will require difficult and wrenching decisions and actions.

Should present trends continue, 2007 will see medical care services absorbing 28% of the gross national product; Social Security tax rates nearly doubled; the average age of the population up 20%; an even greater percentage increase in the over age 65 *and* over age 85 populations; fertility at the historically low rate of 1.7 or lower; a higher Social Security retirement age; and much greater rates of job turnover with shorter business and product life cycles.

The next 20 years will require difficult and wrenching decisions and actions, says Dallas L. Salisbury.

That world might include expanded long-term care; private retiree benefit promises being funded; the beginning of rationing of health care; full taxation of cash and in-kind benefits received during retirement; and a lower standard of living for non-retired Americans should economic growth not exceed levels of the last 20 years.

The tax laws of 2007 would also be different, with trends shown in legislation of the 1980s having carried forward to additional laws. The rationale stated by Congress will be the need for a coherent approach to national retirement income policy.

Employee benefits provided to active workers will be more limited than they are today, but more expensive.

All retiree benefits paid for by the employer will be advance-funded within one umbrella financial limit.

That is, a Section 415 of the Internal Revenue Code—which sets maximum annual benefits that can be provided through a defined benefit plan and the maximum annual contribution that can be made to a defined contribution plan—that is no more generous than today in real terms, and probably less so, which must accommodate funding for pensions, health care, life and long-term care protections. Segregated individual accounts for each purpose will be a common approach among employers.

Pensions will all have a cash basis because cash value portability will be the law. Rollovers will be required, except for cases of extreme hardship.

Post-retirement distributions will be restricted to a remaining life stream of payments, except for hardship, major medical expense, home care or nursing home confinement.

Both defined benefit and defined contribution plans will exist, but the principle decision factor

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Dallas Salisbury, president, Employee Benefit Research Institute.
(Photo: Ken Heinen)

Dallas L. Salisbury is president of the Employee Benefit Research Institute, a 250-member Washington, D.C.-based independent benefits think-tank. Mr. Salisbury, a former official at the Labor Department and the Pension Benefit Guaranty Corp., helped organize EBRI in 1978 to provide objective information on benefit plans and issues to legislators, regulators and the public.



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Continued from previous page

on plan type will be investment-related since few employees will stay with one employer long enough for an affordable defined benefit plan to provide an adequate benefit.

Mandatory base (3% to 5%) defined contribution plans are likely to be required to provide resources for income, health copayments and long-term care. Defined contribution plans will be more heavily incentive-based than today, with more of the employer contribution dependent on employee contributions.

Defined benefit plans will more frequently be cash balance individual account designs, floor designs or based upon career average benefit formula.

Cost will motivate change, and far fewer employers will be willing to support final average benefit formulas. Post-retirement benefit increases will not be provided in defined benefit plans, with defined contribution plans expected to provide any needed additional income.

Health plans will be required by law as a catastrophic protection, with richer benefits producing taxable income. Medicaid buy-in and risk pools will be available as well to provide access to more comprehensive protection for the otherwise uninsurable and the unemployed.

Employee choice will be used on a widespread basis above the base (flexibility), and aftertax employee payments will be much higher in absolute and percentage terms than today.

Managed health care will have moved many generations beyond the present. Patient choices will be severely restricted as design focuses on utilization, payment, quality and rationing. Employers will promise and pay for far leaner benefits than they do today for both active workers and retirees. And defined contribution approaches with a catastrophic cap will be common.

Employee benefit assets will primarily be invested by individuals through directed account alternatives, with large defined benefit plan sponsors continuing to make investment decisions.

Patient choices will be severely restricted as design focuses on utilization, payment, quality and rationing.

The portability requirement will combine with much higher annual benefit payouts, however, to change investment time horizons.

A much higher proportion of employee benefit assets will be managed within the corporation. For individuals, the accumulated funds will have to pay for a wider range of needs.

As retirees, for higher taxes, higher Medicare premiums and copayments and co-premium payments for employer "provided" (access to buy on a premium-sharing basis) retiree medical and long-term care protection.

Retiree medical plans will have been transformed. Few private-sector retirees will have a primarily employer-paid defined benefit retiree health promise. Balance-sheet recognition of retiree health liabilities will have begun in the early 1990s. Program redesign will have taken place, and a growing number of retirees will be paying for most of their medical premium costs out of their accumulated retirement portability accounts. Transition retirees with defined benefit retiree medical will be paying more, with fewer choices.

The new composition of employee benefits will also bring more intense efforts at communication with employees, as employee choice, risk sharing and payment sharing combine to require more employee attention and face more careful financial planning.

The composition of employee benefits has changed in the last 20 years due to the same factors noted at the beginning of this short article.

Factor changes in the next 20 years will be far greater. Obligations have expanded while the capacity to pay has declined.

As a growing number of industries are finding, the piper must ultimately be paid. The laws, and their interpretation, will assure that promises made are promises kept. ■

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Future of 401(k)s is promising



Mr. Duva

By Joseph W. Duva

From the late 1970s, 401(k) plans were the fastest growing employee benefit, since they were too good for employees not to take advantage of and they offered employers a relatively low-cost benefit that was highly visible.

IN ORDER TO PREDICT the future of 401(k) programs, it would be helpful to review the history of defined contribution plans, the change to pretax plans that began in earnest in the late 1970s when Congress clarified that 401(k) arrangements were entitled to favorable tax treatment, and the effects of the Tax Reform Act of 1986.

In the 1960s and 1970s many major employers provided a savings plan (defined contribution plan) for a segment of their employees. The plans were qualified as profit-sharing plans under Internal Revenue Service regulations and permitted employees to make contributions to a qualified trust on an aftertax basis. The fund earnings and employer contributions (normally matching on the first 3% or 6% of pay) were tax-deferred until withdrawal.

There was a steady growth of these plans as they were acknowledged as the most exciting employee benefit program because employees understood the cash balance buildup and were involved in making investment decisions for their contributions, and, in some plans, for the companies' matching contribution. Many plans required the employer's matching contribution to be used only to purchase company stock on the participant's behalf, subject to vesting requirements. The purpose of this was to bring both the employee and the employer interest together in working toward the success and growth of the company.

It is important to recognize that savings plans were growing prior to 401(k). What actually happened in the late 1970s was that the government made defined contributions even more attractive with favorable tax treatment permitting employee contributions to be on a pretax basis—401(k).

From the late 1970s, 401(k) plans were the fastest growing employee benefit, since they were too good for employees not to take advantage of and they offered employers a relatively low-cost benefit that was highly visible and greatly appreciated by employees.

The significant growth of 401(k) plans and the current revenue loss to the government drove the Treasury Department in 1985 to recommend complete elimination of 401(k) programs. The Treasury Department's recommendation was based on its assumption that these programs only benefit the high-paid and its intention to create a level playing field for all Americans.

Fortunately, however, Treasury I—the most serious effort to date to eliminate 401(k) plans—was not successful. A study by the Employee Benefit Research Institute in 1986 indicated that 54% of employees participating in 401(k) plans earned less than $25,000. Another EBRI study found that the lower-earning two-thirds of participants contributed an average of 4.9% of compensation, while the upper-earning one-third contributed an average of 6.5%.

What was once viewed as a retirement savings plan that favored the highly paid was more appropriately identified as a plan that belonged to the rank-and-file employees.

Instead of the complete elimination of 401(k) plans as was recommended by the Treasury Department, the Tax Reform Act of 1986 preserved 401(k), but made significant amendments to the provision.

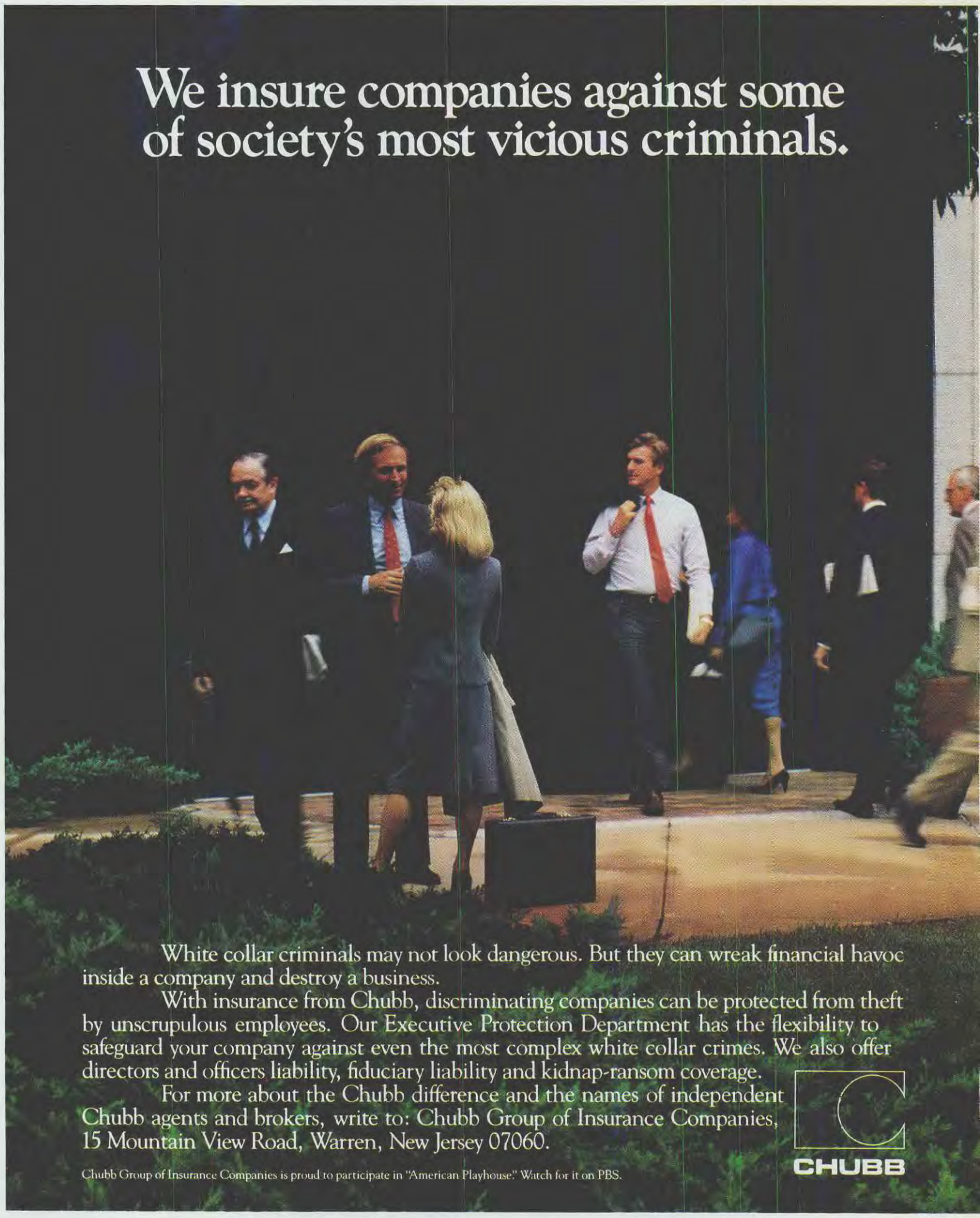
Generally, the new 401(k) rules, most of which became effective in 1987, are more restrictive than the prior rules. A recent survey of employer practices completed by Hewitt Associates on 401(k) plans after tax reform indicate the following:

- Plan design has changed little from 1986 to 1987. The most significant change is the addition of a loan provision to many plans.
- Employee participation has remained constant from 1986 to 1987. Companies expect some employees to be affected by the $7,000 annual limit. Companies have estimated fewer than 5% of participants will be affected.
- In 1987 some of the highly paid employees will have to cut back their level of contributions (below $7,000 limit) to pass the new actual deferral percentage test.
- There will be fewer withdrawals in 1987.
- There will be more loan activity in 1987.
- Most companies are not planning to make up any reductions because of tax reform.
- The companies that plan to make up for reductions will use non-qualified deferred compensation arrangements.

The battle to preserve 401(k)

Continued on page 64

Joseph W. Duva is director of employee benefits at Allied Signal Inc. in Morristown, N.J. He was formerly director of benefits and compensation at SCM Corp. in New York.



20 years in my view

U.S. health care system is ailing

By Walter B. Maher

ALL IS NOT well with health care in America. Despite the wonders medical science has produced, the resulting costs have proved to be excessive. While there appears to be universal acceptance of the fact that a large amount of unnecessary care is being rendered, there is no similar consensus regarding how to solve the problem.

The fact we have a health care cost problem in America should not be surprising. We decided long ago to entrust health care delivery to the private sector. However, we gave the health care entrepreneurs a big break. While turning health care *delivery* over to the private sector, we essentially turned health care *financing* over to government and employers. We then turned the health care *consumers* loose.

The resulting sharp increase in the demand for health services and the similarly sharp increase in the supply of doctors, hospitals and ancillary health professionals should not have astonished us. We further should not be surprised that the significant financial investment in health care has markedly enhanced the prospects of experimentation and innovation. It is truly a mixed bag; however, an unfortunate byproduct is that we find today significant overcapacity throughout the health care delivery system.

Given this oversupply of sellers, health care consumers have become rather picky; people have gotten used to seeking care from whatever doctor or hospital they may hear about. Even the thought that someone might question their ability to see Dr. Jones as opposed to Dr. Smith disturbs some people. The fact that the person seeking to create those distinctions is the one paying their bills does not appear to merit much consideration on their part.

In short, Americans are pretty spoiled when it comes to the health care system that has been handed to them.

Anyone wishing to address the excesses of the current system has ample targets from which to choose. Today, almost four out of every 10 beds in an American hospital are empty. The wonders of high-tech medicine have proved to be both spectacular and frightening. Spectacular, obviously, to the patient who is helped. They are frightening, however, to those who have to pay for the provision of multiple unnecessary tests. Practically any physician in America can buy a piece of high-tech equipment and start doing things to people. You also find this problem in hospitals. Despite the existence of data showing that a patient having coronary artery bypass surgery is better served in a hospital specializing in the procedure, there remain hospitals in American cities that have equipped themselves to conduct this procedure, notwithstanding the fact that they seldom perform the operation. It is equally frightening to observe the significant variations in physician practice patterns across America.

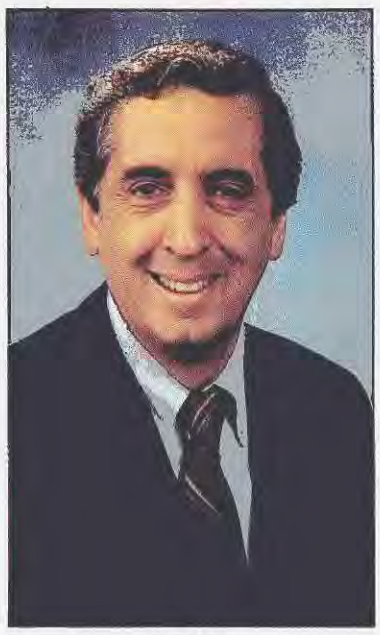
We at Chrysler and the country at large have been looking for a fix to this problem for years. Early in the game, it was thought the fix was to have patients pay part of the bill. That would make them think twice before asking for medical services. Clearly, cost shifting will deter some use of unnecessary services and, to that extent, will also reduce the cost of health care. However, it is not *the* big answer to this problem.

The more recent, and I submit more appropriate, strategies to manage health care costs have centered on how we structure what we agree to pay for under public and private health plans and how we pay for such services. Medicare has started to do this and so have we at Chrysler. Once Medicare stopped paying on a cost-plus basis and started paying hospitals a fixed fee based on a patient's diagnosis, lengths of stay dropped dramatically. When Chrysler started requiring proof that a hospitalization was necessary and that a certain length of stay was appropriate, similar results followed. From 1981 through 1985, we at Chrysler have seen our hospital admissions decrease by 37% and the days of care rendered our employees decrease 46%. Sad to say, however, during this same period, our average cost per admission has risen almost 50%. The net effect, therefore, has been that our inpatient hospital costs have just marginally decreased despite the sharp reduction in use. A major reason for this is that we are continuing to pay for hospitals that are only 60% occupied.

Chrysler also started looking at issues on a more micro basis. When faced with excessive incidences of foot surgeries, for example, we decided to work with a preferred provider organization limited to the provision of services to the feet. If our employees wanted their services paid for in full, they would use this PPO. If they went elsewhere, without the plan's consent, they would have to pay a major part of the bill. This program has been an unqualified success.

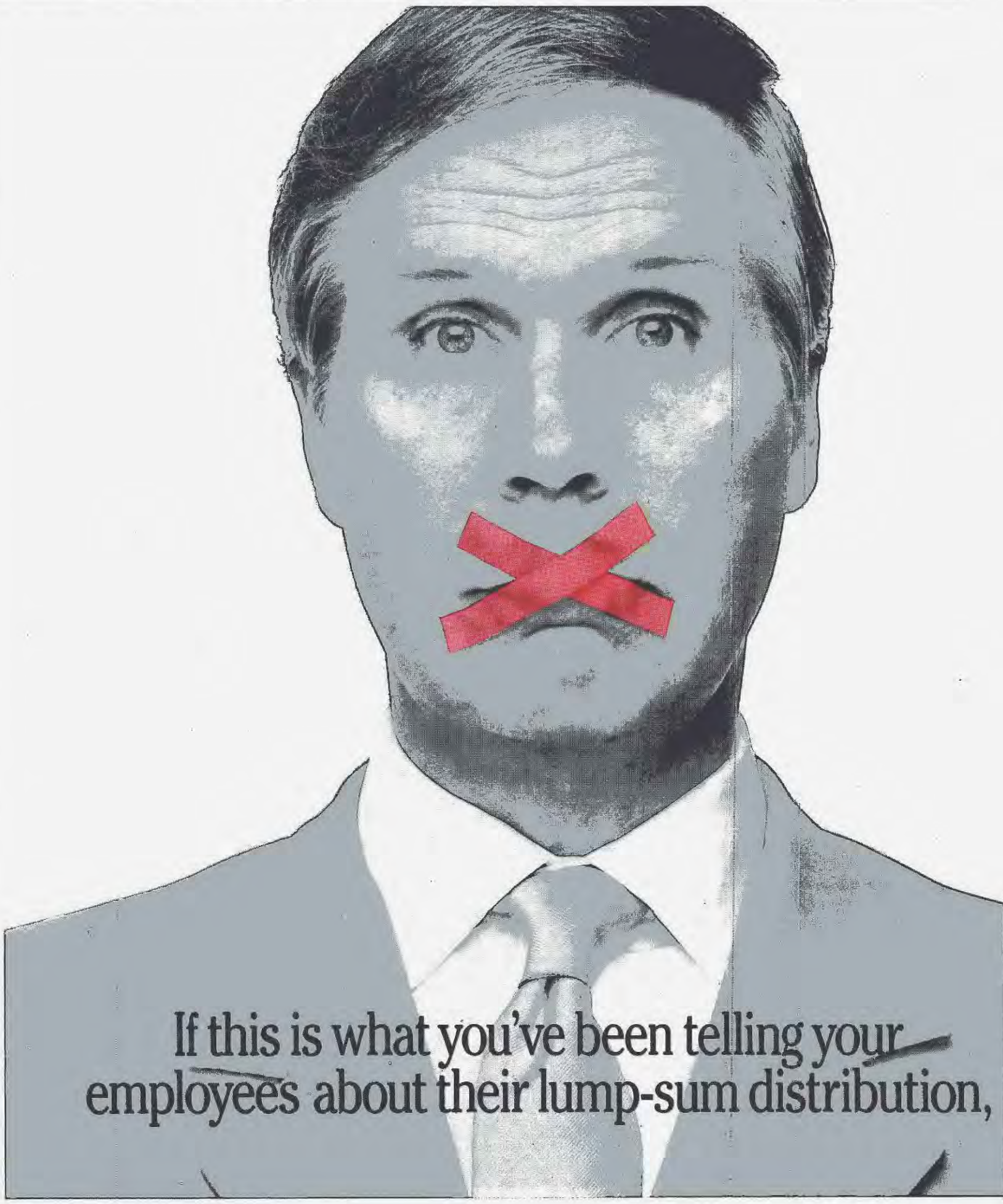
Large-scale PPOs are now proliferating, covering all medical services, and effectively competing with Blue Cross/Blue Shield and commercial insurance plans. This is a significant development. At Chrysler, we now have almost half our employees enrolled in PPOs and health maintenance organizations. They have directories listing

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Mr. Maher

Walter B. Maher is director of employee benefits at Chrysler Corp. in Highland Park, Mich. Mr. Maher, who joined Chrysler in 1963, has helped design and implement programs to bring the automaker's health care costs under control.





Mr. Erlenborn, partner, Seyfarth, Shaw, Fairweather & Geraldson

More changes in the offing for employee benefit plans

By John N. Erlenborn

IN THE PAST 20 years we have witnessed the greatest changes and growth in employee benefits ever recorded. The principal reasons for change have been twofold: demographic and government policy.

The demographic forces include baby boomers moving into the job market and the increasing participation of women in the business world. Government policy was reflected in legislative initiatives that provided for more types of benefits and greater regulation of benefit programs to better secure the benefit promises made. ESOPs, IRAs, 401(k)s, cafeteria plans, salary reduction funding, ERISA and the employee benefit provisions of the Tax Reform Act of 1986 are all examples of the changes wrought during the past 20 years.

What will the next 20 years bring? How will government policy influence change and the shape that it may assume? No crystal ball is available to answer these questions, but some of the forces are discernible and recent actions by Congress portend the future.

The continuing inability of Congress and the administration to obtain control over the budget and the resulting deficits appear to be likely to continue for a considerable period of time. Already the pressures attendant to the budget problems have caused employee benefit provisions to be questioned. What public policy is being served? Is this method of delivering benefits the most efficient? Is the cost to the public in terms of revenue foregone offset by the achievement of social objectives?

These questions and the answers agreed to by the majority of policy makers have curtailed incentives and led to new restrictions. The action that returned IRAs to the function of benefiting only those who did not enjoy other substantial retirement tax benefits, the new non-discrimination rules and penalties on early distributions from retirement plans exemplify the trend. A reversal of these policies is not in the cards for the near future and even greater restrictions may be adopted.

The imposition of greater controls on defined benefit plans is a trend that will not change. Together with demographic changes in the workplace, greater job mobility and the desire for portability, the trend toward defined contribution plans will accelerate.

To provide the variety of benefits employees desire, flexible benefits will be more widespread.

To secure the promise of retiree health insurance, the federal government is likely to adopt minimum standards for welfare benefits similar to those now in effect for pensions. To lessen the impact of these standards and to help control costs in the light of medical cost inflation, employers are likely to move toward a type of defined contribution plan providing help for funding retiree health insurance premiums rather than the promise of health benefits.

To provide the variety of benefits employees desire and at the same time control employers' costs, flexible benefits and cafeteria plans will become more widespread. Congress is likely to establish minimum mandated benefits for such things as health insurance. The realities of multi-worker families and differing needs of workers should result in mandates allowing actuarial equivalents rather than the duplication of benefits.

Government policy will, in the future, be one of the most important elements in determining what benefits are provided and the method chosen to provide them just as it has been in the past. Employee benefits will continue to be evolving and growing as an important part of compensation and the means to achieve broad public policy objectives. ■

John Erlenborn is a partner with the law firm of Seyfarth, Shaw, Fairweather & Geraldson in Washington, D.C. As an Illinois Republican congressman from 1964 through 1984, Mr. Erlenborn played a major role in the passage of the Employee Retirement Income Security Act and the Multiemployer Pension Plan Amendments Act. He also wrote legislation, later enacted, that gave state insurance departments more power to regulate multiple employer health care trusts.

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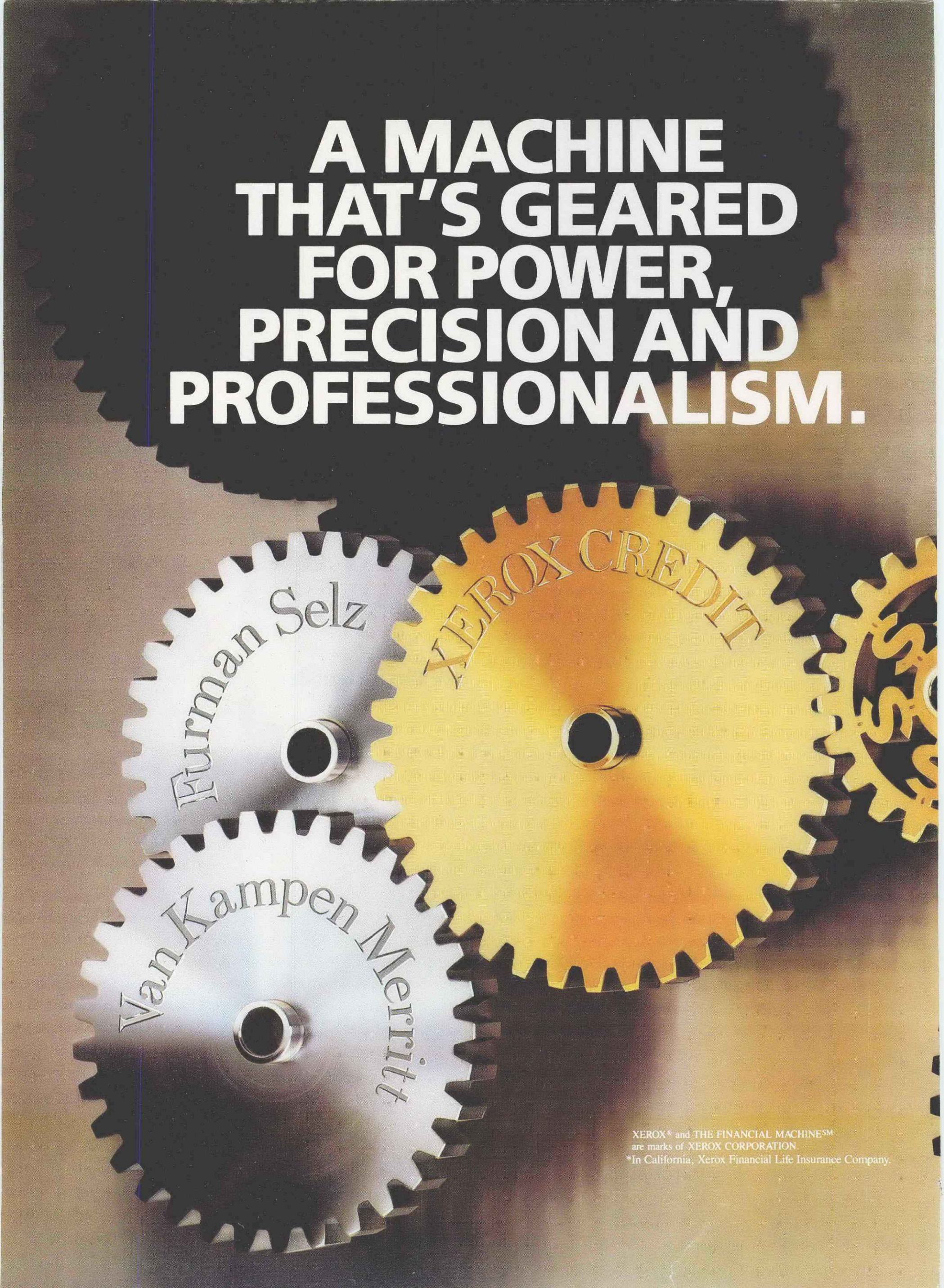
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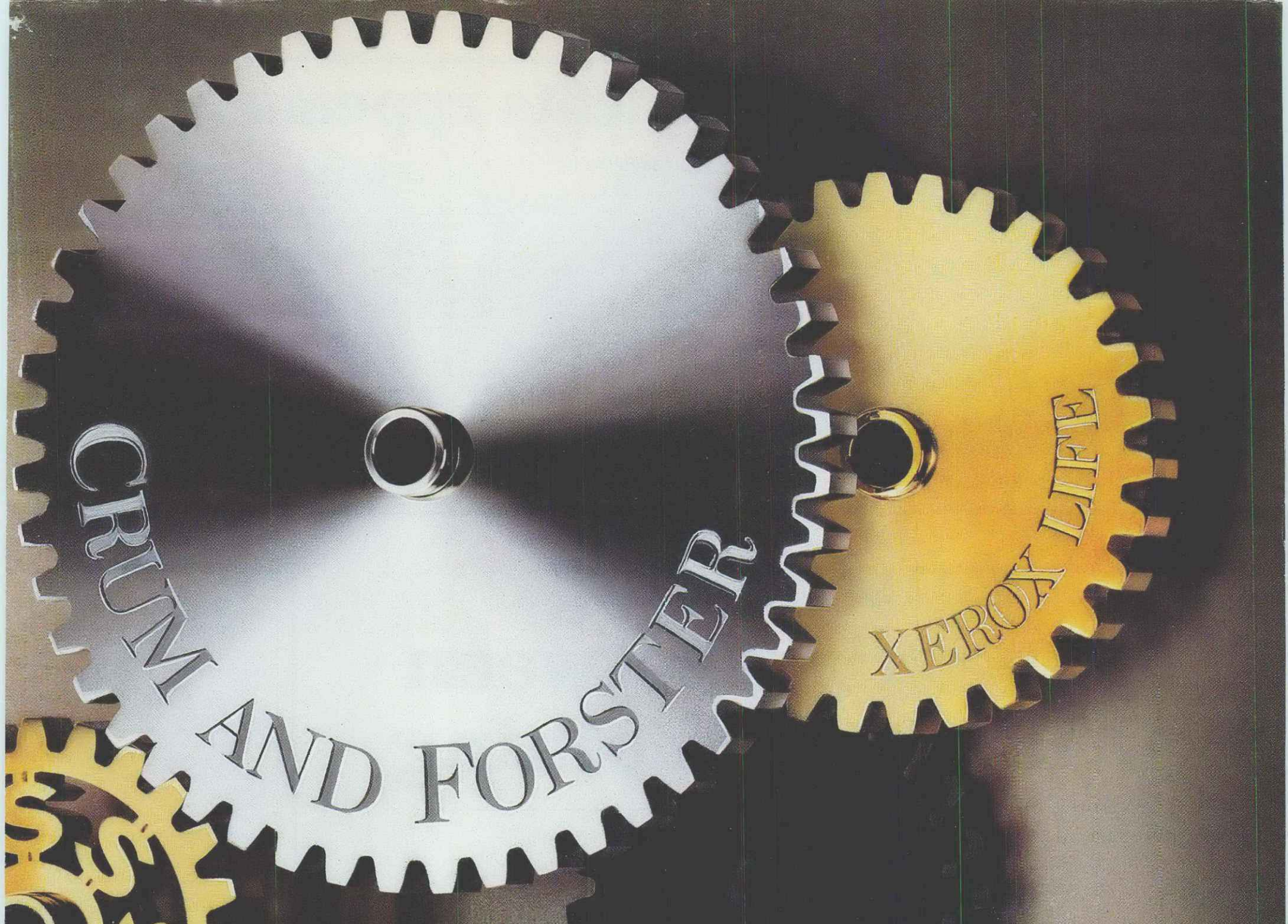
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20 years in my view

Future of flexible benefits appears bright



Photo: Michael Marcotte

Mr. Wood

By Thomas E. Wood

EXACTLY WHEN and where the idea of flexible benefits started I can't be sure. I do remember a conversation in Minneapolis with Peter Drucker in 1963.

We were passing time between a luncheon and dinner speaking engagement. The conversation turned to benefits, and I raised the possibility of choice, not as a way of making benefit dollars more tax-effective, nor even as a way of appealing to the diverse workforce. Such issues had not yet emerged. Rather, I posed the idea as a way of helping employers obtain better employee understanding of the value of their benefits.

Even then, management was questioning the value of the dollars being spent on benefits without an identifiable return. We were looking for answers through benefit communication with such themes as, "Your Hidden Paycheck," and "Your Other Paycheck," etc.

The idea of turning employee benefits into a less subtle form of pay, of giving it substance the employee could touch, of at least gaining understanding and greater perceived value of benefits, stuck with me. It was not until 1967, however, that the first opportunity to do anything about it became available. A company in Minnesota agreed to try the idea of choice making—not as a flexible benefit program—but as an executive perquisite program for 12 key managers. They liked what was designed and the experience fortified my enthusiasm for choice making. And, perhaps for the first time, we realized that the same amount of money could satisfy the varying needs of many; it wasn't necessary to give everything to everyone.

Changing laws have long since rendered inoperable the concepts in that executive compensation program, but the effort encouraged us. From that point forward, whenever we spoke we found a reason to bring up the concept of flexible compensation.

Then, in the early 1970s, several employers began to study in earnest whether the concept was workable. Could employees deal with choice? Could it change the way benefits were negotiated at the bargaining table (from bargaining benefits to bargaining costs)? Could benefits delivered in a flexible form become more motivational—like pay? Almost simultaneously, four organizations began to consider the viability of alternative benefit systems.

TRW Corp., at its Redondo Beach, Calif., facility began a study that lasted several years and culminated in what is considered the first workable program in 1974. TRW helped us learn that employees could, indeed, deal with choice. It was very exciting.

Meanwhile, I was working with Don Sharp of Cummins Engine Co. Inc. and their office committee union to see if employees would restructure benefits if given the chance, and to refocus the bargaining process. Ultimately, the union rejected the idea of choice making, but the lessons learned at Cummins were important. Employees make sensible, but not necessarily predictable choices when given the opportunity. Most—more than 90%—would change one or more elements of the traditional benefit program.

It was apparent that a uniform program failed to satisfy personal needs. Theories about benefits as satisfiers and potential dissatisfiers began to take on new and significant meaning.

Meanwhile, two other projects were under way to teach us more. Xerox Corp. wanted to study its benefit program from an employee perspective, not with the idea of introducing choice making, but to see how employees might build a new program if it could be rebuilt from scratch. Tom Paine of Hewitt Associates, and a Xerox team met with a stratified random sample of employees nationwide. The exercise taught us a great deal about employee attitudes concerning benefits, and provided insight for future planning, which is what Xerox was after.

The Xerox project took place in the early 1970s, about the same time TRW was launching its study and, shortly thereafter, we were called to Educational Testing Services of Princeton, N.J. ETS' benefit manager, Joan Brannick, had heard one of our partners speak on flexible benefits and was intrigued. Was there a role for it at ETS? The answer was "yes" and ETS is credited with being another pioneer coming on line late in 1974.

Continued on next page

Thomas E. Wood retired last year as a partner at Hewitt Associates, a consulting firm based in Lincolnshire, Ill., which he joined in 1955. Mr. Wood also has served as an adjunct professor at the J.L. Kellogg Graduate School of Management, Northwestern University, Evanston, Ill., and is a member of the management committee of the International Foundation of Employee

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Continued from previous page

Employee study groups helped design elements of that program and structured the credit system. The lesson: Employees are enthusiastic about the design they help to create, and benefit dollars take on new meaning when the employee can move them around.

The miniscule movement was abruptly halted in 1974 with ERISA. Section 2006 said no more cash/deferred profit-sharing, salary reduction or cafeteria benefits until Congress could study further these alternative compensation forms. They provided a year to conduct the study, but by 1977 nothing had happened and most observers pronounced flexible compensation dead. But not American Can Corp. (now known as Primerica Corp.). American Can was a company willing to stretch out, to see what could be done within the legal restrictions and still provide choice making.

The company had four major objectives:

- To stem rising benefits cost.
- To break the lock-step between union and non-union plans.
- To move from a non-integrated pension plan to an integrated one.
- To reshape the image of the employer as forward-looking.

American Can was a landmark because it demonstrated that flexible benefits were workable within existing law and could be applied not just in the campus-like environments of TRW in Redondo Beach and ETS in Princeton, but in the tough business environment of a manufacturing company. Hewitt's Tom Paine and Dick Wibblesman designed the program, tested employee response, made appropriate alterations, installed the program in 1977 and enlarged it to all salaried employees in the following year.

1978 was a watershed year for more than just American Can. It was the year Congress passed laws enabling trade-off between cash and deferred compensation, and between cash and welfare benefits. Regulations were issued in time, and the notion of flexible compensation was approved and re-approved through DEFRA, TEFRA and the 1986 Tax Reform Act.

It was during this period that health care costs rose precipitously, the nation was buffeted by foreign competition and a deep recession, the changing demographics had fully emerged in a powerful way and the economy moved through a period of extreme inflation that caused "tax bracket creep." Together, these forces caused an increasing number of employers to consider, and adopt, flexible compensation systems as a way of delivering the benefit dollar to employees most effectively.

Companies such as Northern States Power Co., Minnesota Power & Light Co., PepsiCo, The B.F. Goodrich Co. and others came on line as pioneers in this innovative, exciting way of providing employee benefits.

In 1980, Hewitt created the idea of the flexible spending account for its own employees, and that idea began to spread, especially as a helpful tool in introducing trade-offs among comprehensive health care plans and the movement away from first-dollar coverage.

In 1981, Honeywell Corp. and FMC Corp. announced 401(k) salary reduction plans and, all combined, we entered a new phase of acceptance for choice making.

That was the beginning—a long incubation period, to be sure. What about the future? There are a number of interesting developments to come. Some will be simple extensions of concepts now in place; others will be new and innovative. The following are likely:

- A continuation of the trend to view choice making applied to total compensation, rather than to benefits only. The ultimate probably will be a paycheck stub that shows gross income (including the value of all benefits) and then separate amounts the employee has elected to take in direct pay, deferred pay, non-taxable benefits and taxable benefits.
- Along with the notion of total compensation choice making, the considerable expansion of taxable forms of benefits, including true group auto, homeowners and many other forms of insurance. Elder care, education and retraining and personal financial planning will be in the package.
- The development of new approaches to flexible compensation design. Currently, there are only four basic designs. One is the opt up or down mode created by TRW; another mode was created for ETS, called the add-on approach; the American Can approach of cutting back to a core and rearranging is the third mode, and the creation of the flexible spending account is the fourth mode. The approaches can be used in various combination. All were developed before 1980. Little new has occurred since then, but there likely will be significant new developments.
- Broader acceptance by unions. A number of Taft-Hartley plans have adopted choice making and Carpenter Technology Co. negotiated a program with the United Steel Workers several years ago. The United Auto Workers has been willing to consider choice making in its contract at GM's Saturn Corp. operation. But, unions have been slow to accept flexible compensation notwithstanding the enthusiastic and thoughtful encouragement of Peter Drucker, who recognizes it as a way of greater satisfaction for union membership and greater efficiency of dollars spent by employers in an increasingly competitive labor market.
- Within the total flexible compensation concept, a re-balancing of the retirement system. Choice making provides the opportunity to reduce defined benefit pension plans (but not get rid of them, for that would be inefficient), enhance the defined contribution element of the program and balance both with Social Security.
- Enhanced systems to allow complete hands-on enrollment and fully computerized administration. We are moving toward this achievement rapidly. From those pioneering companies that developed first-generation software, we have moved to an era in which employers can purchase and install flexible compensation software, get on-line with existing services or build their own with experienced outside guidance. We now enter an era of sophistication of software with which employees can interface directly with the administrative systems.

In the 401(k) area, we will find commonplace the use of systems that enable employers to give daily instructions to move their defined contribution accounts from one fund to another, just as they would their private mutual funds.

Today, choice making in pay and benefits may not be widespread in practice. It is, however, widespread in acceptance. Ask any benefit specialist or human resource executive and you'll usually get a positive response about the growth of flexible compensation.

From my perspective, the future is more exciting than the past, for we know the parameters within which we can work, we've plowed the tough ground of administrative software, we know how to deal with adverse selection and we have developed expert ways to communicate. Thus, only imagination and good employee input limit our ability to develop good future design and delivery mechanisms. ■



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20 years in my view

Getting a grip on the 'wallet biopsy'

By Samuel X. Kaplan

OVER THE NEXT 20 years, the biggest challenge facing employers, health care consumers and claims administrators is the elimination of the most common medical procedure practiced today—the wallet biopsy. This procedure determines if there is money in the wallet. If there is, the health care services industry will remove it.

Twenty years ago, the wallet biopsy caused employers to begin taking an active interest in the cost of health care for their employees. As health costs began outpacing inflation and negotiated contracts placed a greater burden for health care on the employer, financial necessity should have forced employers to look at new and innovative methods for controlling heath care costs.

Thus, in 1967, we began developing model treatment screens, drug utilization screens, predetermination of length of stay, precertification of ambulatory procedures, provider profiles and a system for gathering all diagnostic and procedural data on each employee, spouse and child.

With this technological innovation, accompanied by the promise of reduced health care costs, I predicted 20 years ago that most employers and all insurance companies would be utilizing these programs.

I was wrong. None used these systems then and few do today. But these systems cannot continue to be ignored by administrators, insurance companies, employers and beneficiaries if this country's health care system's voracious appetite is to be curbed.

In 1967, it was difficult for most of us to believe that health care costs could top $50 billion annually, but they did. Today, these costs have passed the $500 billion mark and, with an estimated 10% growth rate per year, we will be facing health care costs of $2.5 to $3 trillion in 2007.

We must, therefore, learn from our mistakes of the past and implement the necessary systems and procedures in the next 20 years that will prevent a $3 trillion health bill in 2007. To improve our competitiveness worldwide, to consume less of our gross national product on health care and to get a grip on the wallet biopsy, employers must be dragged, perhaps kicking and screaming, into adopting the following policies and procedures:

- Data must be collected on each individual man, woman and child receiving benefits.
- There must be effective measures of the outcomes for each cost management program being used for each beneficiary.
- Benefit claims administrators must be required to place all or a portion of the administration fee at risk. Administrators will be rewarded with a portion of the savings exceeding an established norm.
- A continually declining workforce makes it imperative that employers make every effort to keep their employees healthy and productive. Thus, workers compensation, long-term disability and sickness and accident benefits will be administered through a single health care system. Personnel files indicating absences and sickness, together with performance and productivity information, will be integrated with the individual's health care file. Rewards will be established for the healthy and productive worker.
- Systems must be developed to track the prescribing practices of physicians as well as the patient's compliance. Approximately 12% of all hospital admissions are related to the inappropriate use of prescription drugs. This will necessitate the integration of all prescription drug and medical data, including the prescriber, the national drug code, quantities, directions for use and a determination of appropriateness for each diagnosis.
- All cost management programs including model treatment screens, precertification, concurrent review, discharge planning, case management, prescription drugs and other related data will be integrated into one system.
- Providers will be required to justify the medical necessity and appropriateness of treatment modalities.
- The quality of effectiveness of treatments will be required to meet a certain standard.
- As a condition of continuing their contractual relationship with employers, HMOs and PPOs will be required to provide information to determine rates of services; mix and frequency of services; and underutilization. This information, which is readily available today, will give employers the opportunity to evaluate the cost and quality of the services they are buying for their employees.
- Usual, customary and reasonable fees have been "gamed" and manipulated by groups of physicians so that there are unbelievable inequities. I predict that UCR fees will be eliminated, and we will return to fee schedules that were prevalent prior to 1967.

In addition, employers need to be cognizant of the decline in the workforce and the evolution of our litigious society, both of which can affect their health benefit programs.

I predict that the policy of shifting more of the health care financial burden to employees through increased deductibles and contributions will be reversed. Quality employees are becoming harder to find in a workforce that has been continually declining in number since the 1970s. In order to hire skilled and productive employees and keep them from competitors, employers will be forced to offer higher and greater compensation and benefits rather than continue to reduce them.

Employers must also re-evaluate their chosen policy for reducing health costs. Historically, employers simply paid for services and did not know or care who delivered them. Although this attitude is changing and employers are becoming more involved directly or indirectly in health care contracting, this involvement is often geared only to dollar savings. Employers use incentive methods for contracting with providers and direct their employees to those who have agreed to charge the least.

In many of these cases, the employer has made no effort to check the credentials of the providers; they are selected solely on the basis of their willingness to accept specified fees.

My prediction is that in the next 20 years, there will be a number of legal actions attempting to make the employer accept responsibility for directing the employee to a provider accused of malpractice, especially if the provider was selected without a credentialing or evaluation process. If nothing else, the threat of litigation will push employers into adopting reasonable evaluation procedures for selecting providers for their employee base.

I also predict that the government will continue to shift the burden of paying for health care for the unemployed, the indigent and the elderly to private employers.

Without the financial means or political backbone to provide expansion of publicly financed health programs, the White House and Congress will continue to mandate private participation in health care for the public. This trend has already started in COBRA and numerous bills with powerful sponsors are pending on Capitol Hill. This certainly will not happen all at once; however, little by little, employers will be faced with broadening their own health care benefits and opening their wallets to cover persons not in their employment.

Twenty years ago, I stated that insurance companies really did not insure risks in the group area since adverse claims experience was always followed by increased premiums. I also stated that self-insurance really made sense for large corporations.

Self-insurance has been increasing rapidly for the past 20 years, and it is becoming the most popular health care payment arrangement—with or without stop-loss protection—for large and small companies alike. There really is no alternative. Continually escalating health care costs coupled with increasing government regulation in the form of mandated benefits and congressional actions like COBRA serve to heighten the pressure to self-insure, and self-insurance will continue to take a larger share of the market over the next 20 years.

I would like to venture into a forecast that may sound exotic, but which I believe must be the wave of the future.

The Journal of the American Medical Assn. in its Oct. 25, 1985, issue, noted that "about two-thirds of all deaths in this country are premature, given our present medical knowledge, and about two-thirds of lives lost before age 65 are theoretically preventable given our current capabilities."

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Samuel X. Kaplan, chairman, U.S. Administrators Inc.

Samuel X. Kaplan is founder and chairman of the board of Los Angeles-based U.S. Administrators Inc., which specializes in health care cost containment and utilization reviews. He has been working with quality assurance programs for self-insured clients for 25 years.

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Risk management

Offering services can be a savior for smaller agencies

By LAURA MAZZUCA

The initial cost to small agencies of developing risk management services will be more than offset by just one of the benefits the agencies will reap—survival, many marketing consultants and risk management experts agree.

As agencies increasingly consolidate, insurers will require them to take on more of the responsibilities the insurers now handle, including risk management services and claims administration, says William Feldhaus, associate professor of risk management and insurance at Georgia State University in Atlanta.

The emphasis will be on employee versatility and "full-service" agencies that can offer a wide range of consulting services, Mr. Feldhaus said.

"You're starting to see insurance companies, agents and buyers become more savvy on what's required in this business," Mr. Feldhaus observed.

"For the good agencies, the informed buyer is an advantage, because they can appreciate what they're doing for them," he said. "Conversely, real schlock operations" will fall by the wayside, Mr. Feldhaus said. This shakeout will happen within the next five to 10 years, as both clients and insurers demand more from agencies, he predicted.

The concept of agencies and brokerages performing risk management functions is not a new one; the major brokerages have offered such services since the 1970s.

But as insurers eliminate many risk management services previously offered to their clients, smaller agents have stepped in with risk management programs of their own.

"It increases the agency's ability to win different and more complex accounts," said Timothy J. Cunningham, senior consultant at Hales & Associates Inc. in Oak Brook, Ill.

"It also has an impact on account retention and will hopefully take the agency out of the trap of the insurance policy being commodity-driven."

In addition, "We're going to see tighter swings in the market," Mr. Cunningham predicted. "As a result, the good account can appreciate better what the agency is doing to serve them."

This emphasis on service will help the agency hold on to its clients, which is probably the most important aspect of the risk management program, he said.

Risk management services will never be big money makers, but they are a powerful sales tool and essential in the retention of large accounts, according to Carol A. Hammes, consultant with Marsh, Berry & Co. Inc. of Mentor, Ohio.

As a result, these services are becoming attractive even to small agencies, especially as clustering takes place, she said.

"The things the big guys were talking about 25 years ago, the little guys are talking about in the '80s," Mr. Feldhaus said.

The establishment of a risk management program "provides an agency with a degree of uniqueness in service that the competition is not providing," said Jack Nordhaus, director of information services for Insurance Marketing Services in Santa Monica, Calif. "It can turn a policyholder into a client."

Today's softening insurance market is causing some smaller agencies to doubt the viability of adding or retaining a risk management department, but being able to offer such a service could even out the peaks and valleys of a volatile insurance market, observers said.

"Risk management as a trend peaked in agencies about six months ago," Ms. Hammes said. "But frankly, the best thing to happen to the insurance industry would be to have more of them."

Continued on next page

Risk management

Continued from previous page

The large alphabet-house brokers recognized the need to offer clients risk management services in the mid-1970s as insurance availability dwindled and insurance alternatives blossomed. Many brokers began offering risk management and loss control services through new and separate corporations to more clearly distinguish between services provided by the broker and the risk management arm.

But over the last seven to 10 years, medium-sized and small agencies also began to enter this new service market. Their interest grew for a combination of reasons, including the extreme fluctuations of and lack of stability in the insurance marketplace, more informed insurance buyers, an explosion of alternative insurance programs and the lack of markets for many specialized risks, Mr. Feldhaus said.

The risk management functions those agents and brokers offer include basic risk analysis; claims management; loss control audits surveys and programs; and feasibility studies of alternative loss-funding devices.

Although some agents and brokers believe that risk management is part of what their clients are entitled to, Mr. Feldhaus believes the addition of specific risk management services is a very effective marketing tool, "another way to enhance and broaden the revenue stream of the organization" and attract new clients.

The extent of risk management services offered by smaller agencies is not as great as at larger agencies. Whereas the alphabet houses have entire staffs of experts and separate risk management divisions, a smaller agency might, for example, add a single risk management expert who is versatile enough to perform other duties as well. Or, the agency may maintain risk management consultants on a commission basis as their clients need them. Even some agency principals get into the risk management act, if their risk management background is strong or they are willing to pursue a professional designation such as the Associate in Risk Management or the Chartered Property & Casualty Underwriter.

Mr. Nordhaus outlined the basics of setting up a risk management program as the following:

- Recruitment of risk management personnel.
- Motivation and training of risk management personnel.
- Creation of an organizational structure that can provide and market the services offered.
- Using a computer as a risk management tool.

The agency or brokerage should take a long-term view when deciding whether to beef up its risk management services. "It relates to their whole goal and mission and corporate strategies," Mr. Cunningham said.

He added that the most important question an agency owner must answer in this process is: "What do you want to be?"

Whether hiring a full-time staffer or a part-time consultant, the agency must carefully screen candidates, Mr. Cunningham says. 'The last thing you want to do is bring in some dunderhead.'

If an agency is going after the high-commission market, it "must be able to deliver more services," and a risk management development plan would be a good first step in attracting such business.

Agencies with an annual premium of $10 million or more can easily afford offering risk management services, according to Mr. Nordhaus. He suggested contacting state chapters of the Independent Insurance Agents of America, which offer information on establishing risk management programs, and the education department at the Professional Insurance Agents of America, which can furnish the names of risk management consultants.

Also, trade magazines and peers can provide invaluable information, Mr. Nordhaus advised.

After an agency decides what risk management services it can afford, it should examine any state regulations that might apply to the agency's prospective billing method for those services. Some states prohibit agents from charging both fees and commissions, which is why many larger agencies and brokerages set up their risk management departments as separate entities, Mr. Nordhaus pointed out.

The agency must determine how the state defines commissions, rebates and fees, Ms. Hammes said. The agency should also make it clear to state regulators that the fees the agency charges for its risk management services are not part of agency commissions by billing for those services separately.

"We have seen firms that have taken two approaches: a separate fee for (risk management) services, and where the agency sees it as an adjunct to other agency activities" the fees are included within agency commissions, Mr. Cunningham said.

In the future, more such agreements will be seen, even in small agencies, as risk management services become more complex, Mr. Cunningham predicted.

"It is the way for a good agency to really sell and use risk management as a competitive tool against others," he said.

For a small agency, the startup cost for a risk management program should be minimal, with the highest expenses being "people time in doing research and getting it set up," Mr. Cunningham said.

If an agency plans to hire a risk management consultant on a full-time basis, his or her salary—depending on geographic area and variables such as the risk manager's experience—could range from $50,000 to $80,000, plus an additional 25% of that amount for benefits and support staff, he said. This would put the total annual outlay at about $60,000 to $100,000 at the minimum, he said.

Alternatively, an agency could retain a risk management consultant on a part-time or per-assignment basis, Mr. Cunningham said.

When searching for a consultant, the agency principal should "talk to others within the industry, tap into trade publications, talk to higher-level people at insurance companies about contacts they have. It's a little bit like 'letting your fingers do the walking,' " Mr. Cunningham said.

Additional consultants can be commissioned for handling risk management aspects such as loss control, actuarial work, engineering, product safety and design and industrial hygiene.

Whether hiring a full-time staffer or a part-time consultant, the agency principal must carefully screen each candidate, Mr. Cunningham stressed. "The last thing you want to do is bring in some dunderhead."

An agency also may find a candidate to head its risk management division within its own ranks. If an agency employee has had experience in risk management and loss control, he or she could enhance that experience through workshops and seminars offered by professional associations, or by enrolling in a professional designation program, Mr. Cunningham said.

An effective and efficient automation system also is invaluable in establishing a thriving risk management division, especially when tracking complex and ever-changing data, observers pointed out.

This system can be as complex as those computer systems used by Alexander & Alexander's risk management arm, Anistics Inc. and its claims administration arm, Alexsis Inc. (see related story) or it can be a well-designed PC program for a small agency.

However, "You've got to be a big enough agency" financially to afford to offer risk management services, since it takes about a year before the program breaks even, Ms. Hammes said.

Mr. Cunningham cautioned agencies considering a risk management program to think it over carefully.

"Agencies, like any other business, tend to move in a herd mentality without asking why," he said. "But if that's the niche you want to be in, risk management can reap some real benefits." ■

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Producer risk management services vary

By LAURA MAZZUCA

Risk management programs offered by agents and brokers run the gamut from the small regional agent who adds a single loss control expert, to the major alphabet houses with their wholly owned subsidiaries devoted to risk management consultation.

While there are no quantitative figures on the growth of risk management and loss control consultation, it appears to be on the rise, based on conversations with professionals from both agencies and brokerages.

Below is a sampling of agencies and brokerages that provide risk management services, which they believe is no longer a luxury, but a necessity, for growth.

Cohen-Seltzer Inc.

Risk management services will be "demanded by the buyer" in the near future, predicts Robert S. Seltzer, president and chief executive officer of Cohen-Seltzer Inc., a commercial agency in Fort Washington, Pa., that generates $25 million in net premiums and more than $3 million in annual revenues.

"The clients are becoming much more sophisticated and their demands on the professionals have become much more complex," he says.

And although Mr. Seltzer predicts that the "typical Main Street agency won't get into it," he believes a risk management program is beneficial even for smaller agencies—especially younger, more aggressive agencies "hoping to crack into the middle market."

This medium market of clientele —companies with $50,000 to $2 million premiums—have discovered that insurance costs comprise an increasingly large percentage of their total expenses and want more for their money, according to Mr. Seltzer.

The first step an agency principal should take when establishing a risk management program is to "get smart" and educate himself and his staff, especially those involved in account work, Mr. Seltzer said.

"All our producers are CPCUs or A.R.M.s," he said of his agency's loss consulting program, referring to the Chartered Property & Casualty Underwriter and Associate in Risk Management professional designations.

"Not until you're exposed to those sort of disciplines can you do more than play-act at risk management," he said.

After an agency has mastered the educational basics of risk management, it can start pointing its marketing and sales efforts to that middle market, or to a target market the wants risk management services, observed Mr. Seltzer.

Corroon & Black Corp.

Corroon & Black Corp., the nation's sixth-largest broker, in 1977 was in the vanguard of the establishment of a risk management division.

Its Advanced Risk Management Services is a wholly owned subsidiary of the giant New York-based brokerage.

"The impetus to creating ARMS was that we felt increasingly that larger organizations needed to be self-insured. . .and that these various services were needed by clients and prospects," said James V. Davis, ARMS chairman.

Today, ARMS employs about 200 people and maintains its headquarters in Nashville, Tenn.

Mr. Davis explained that ARMS "ran significantly in the red" for the first several years because the start-up cost was high, but "it corrected itself over time."

He estimates that today ARMS will contribute "a couple of million dollars in pretax income to Corroon & Black this year. . . .It has grown significantly over the years."

ARMS consists of five units: research and development, national accounts services division, C&B Management Inc., RGI Inc. and Meridian Insurance Co. Inc.

Consulting services offered by the divisions include loss forecasting, loss retention and captive feasibility studies in the research and development division; program design and marketing assistance in the national account service division; claims adjusting exclusively in the management division; the placement of facultative reinsurance and E&S lines by RGI Inc.; and the design of alternative insurance programs through Meridian.

'Loss control is going to become more important,' says James V. Davis, ARMS chairman.

Clients are charged a fee for these services, the amount depending on the complexity of the project. While some brokers and agents do not charge for risk management consulting, C&B's philosophy is that putting a price tag on such services emphasizes the quality of work the client receives.

"We would devalue the quality of our work product in the mind our clients if we did not," Mr. Davis said.

Regarding future trends in risk management, Mr. Davis predicted that "loss control is going to become more important to risk management in the future."

ARMS will add loss control personnel to its staff next year, and this expansion may eventually result in the establishment of a separate loss control division, Mr. Davis said.

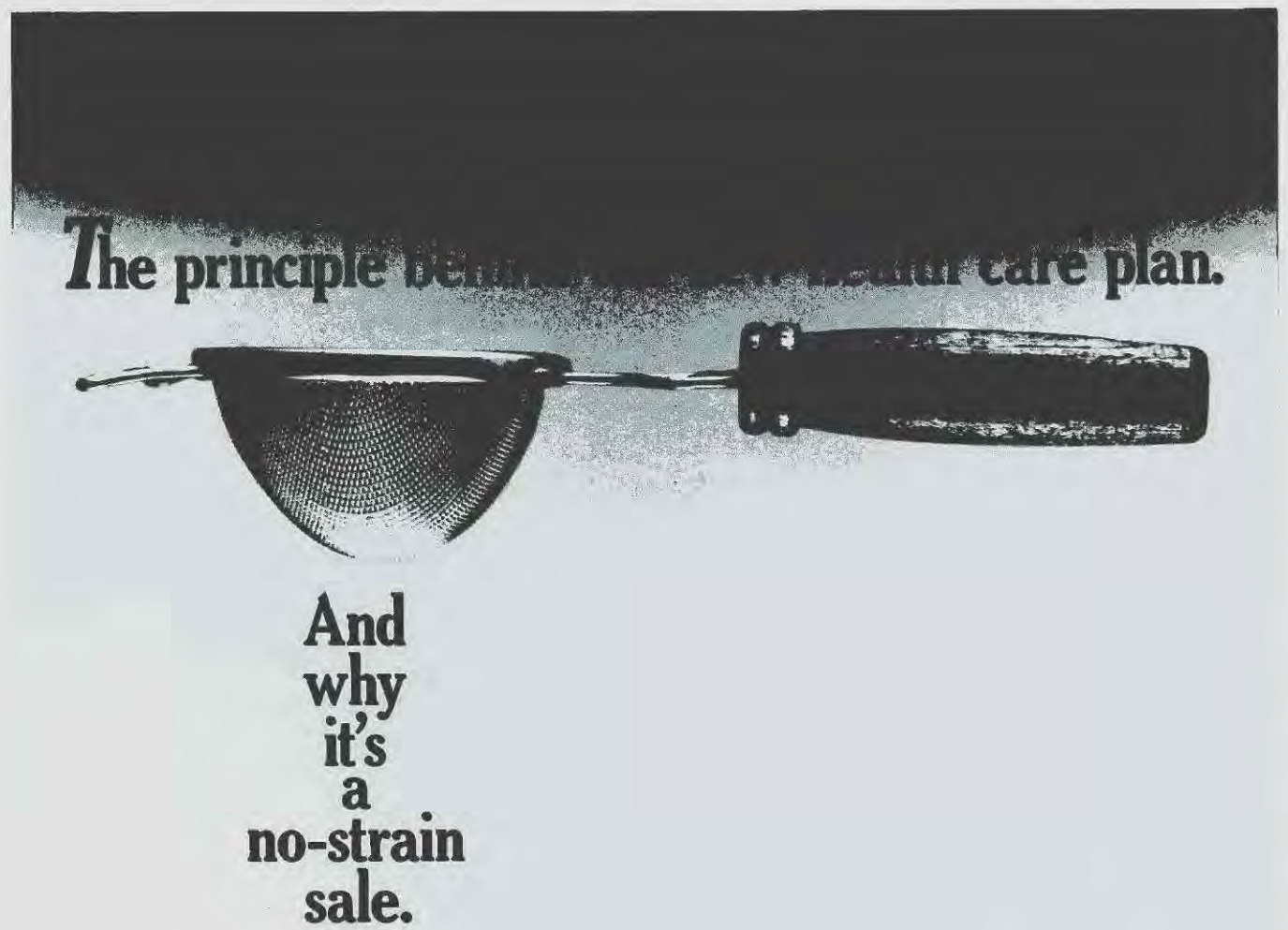
To survive and thrive, a consulting program must be highly adaptive, he said. As alternative risk financing becomes less attractive to clients because of loss of tax breaks, he predicts that risk managers will turn increasingly to loss prevention and control as an alternative.

Alternative risk financing is a trend that has grown for 10 years, but "the bubble is going to burst," he said. "It has become more and more of a commodity product. . . .While the business will continue to grow, it will not have the same importance attached to it."

AIM Inc.

Although ARM Inc., which specializes in risk management and loss control, operates under the same roof as its Reno, Nev., parent agency, AIM Inc., it is a completely separate corporation.

Continued on next page



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Ideas worth quoting.

Services

Continued from previous page

AIM President Lysle Winchester believes this separation is necessary to avoid a conflict of interests.

"In a community the size of Reno, it's too small to start playing games," he added.

AIM Inc. currently generates about $1.5 million in premium volume. The small agency (it employs three people) has been operative since 1979, serving the region of Southern California, Oregon, Utah and Nevada.

ARM Inc. was established in May 1982 "as a result of the Nevada Insurance Division not allowing one to bill for services in insurance agencies," he explained.

The Nevada law has since been changed, however, allowing agents to bill for certain services if the agent helps the client place his insurance. But risk management services are still not included in the billing process because the state does not regulate these services, Mr. Winchester added.

"Then we found, especially with the market shifting, that risk management was a growth area," said Mr. Winchester, because even if insurance is not placed with AIM, ARM can still bill a client for services rendered.

Services offered through ARM include the preparation of a proposal and "hands-on risk management service," including the identification of exposures, writing of risk management manuals and troubleshooting.

ARM's staff consists of one loss control/sales expert, a receptionist/secretary and two risk management consultants, one of whom is Mr. Winchester.

Mr. Winchester admits that he has no formal risk management background, but before ARM was established he consulted with a risk manager to "explore the activity."

He has been in the insurance business since 1974 and finds the risk management area stimulating.

"Insurance can become stagnant, a routine," he said. "Risk management is ever-changing because financial aspects of business are always changing."

The ARM staff is maintained on a contract basis, which gives them "incentive to gather more business."

ARM's financial growth was "initially very slow," said Mr. Winchester, though he added that its start-up cost was "virtually nothing."

He said that ARM took on two accounts on a full-time basis in 1983, and ARM's income went "from zero in 1982, to excess of $200,000 in 1985, doubled in 1986, and in 1987 we're hanging in there."

However, he said he won't invest a lot of money in ARM at this point. "I'm a little bit concerned if the market changes back to a soft area," he said. "We plan to continue as it is and see how much income it can develop. We're not looking to triple or quadruple the situation as it is now."

Alexander & Alexander Inc.

At Alexander & Alexander Inc. in New York, the country's second-largest insurance brokerage, risk management services are essential, especially to a new client, says Vp JoAnne Miller.

"The relation a broker has with the client is critical," Ms. Miller says. "Any client should have the best risk management system they can afford for their size.

"By helping a client, our ability to be prepared in the marketplace gives us greater flexibility. . .and I don't think it can be measured in terms of money."

The two most important aspects of risk management are information systems and loss control, she adds.

Services offered through ARM include the preparation of a proposal and 'hands-on risk management service,' including the identification of exposures, writing of risk management manuals and troubleshooting.

The automation revolution has really made intensive risk management possible, because with computers a broker can assimilate a wide assortment of data on production history, shelf life, etc.

"The better control you have of your account, the better you are perceived in the marketplace," she said.

Unfortunately, when traditional insurance is readily available, risk management can fall by the wayside, she said.

"But it should be done at all times," she said, adding that sufficient information could even out the corporate losses when the insurance cycles change.

A&A's Alexsis Inc. was established in 1977, and is A&A's risk analysis and management unit and provides risk analysis and financial planning, program design and audit, loss forecasting, claims administration and claims information reporting and loss control consulting and industrial hygiene services.

Anistics Inc. was established in 1970, and its name speaks for itself: Anistics stands for analytical statistics. The A&A unit provides loss forecasting, financial modeling and consulting services.

The most critical step in the risk management process is gathering the information, and the client must take responsibility for this as well as the broker, said Ms. Miller.

In this process, A&A deals closely with the client's risk manager as well as plant and general managers after the risk management program is in place, she explained.

The information, especially for larger clients, is periodically updated, and is simple to understand "if you set up the parameters correctly" in the first place, Ms. Miller said.

Pacific Insurance Agency

Pacific Insurance Agency President Glenn Dethloff may be a believer in risk management, but he has a problem with the term.

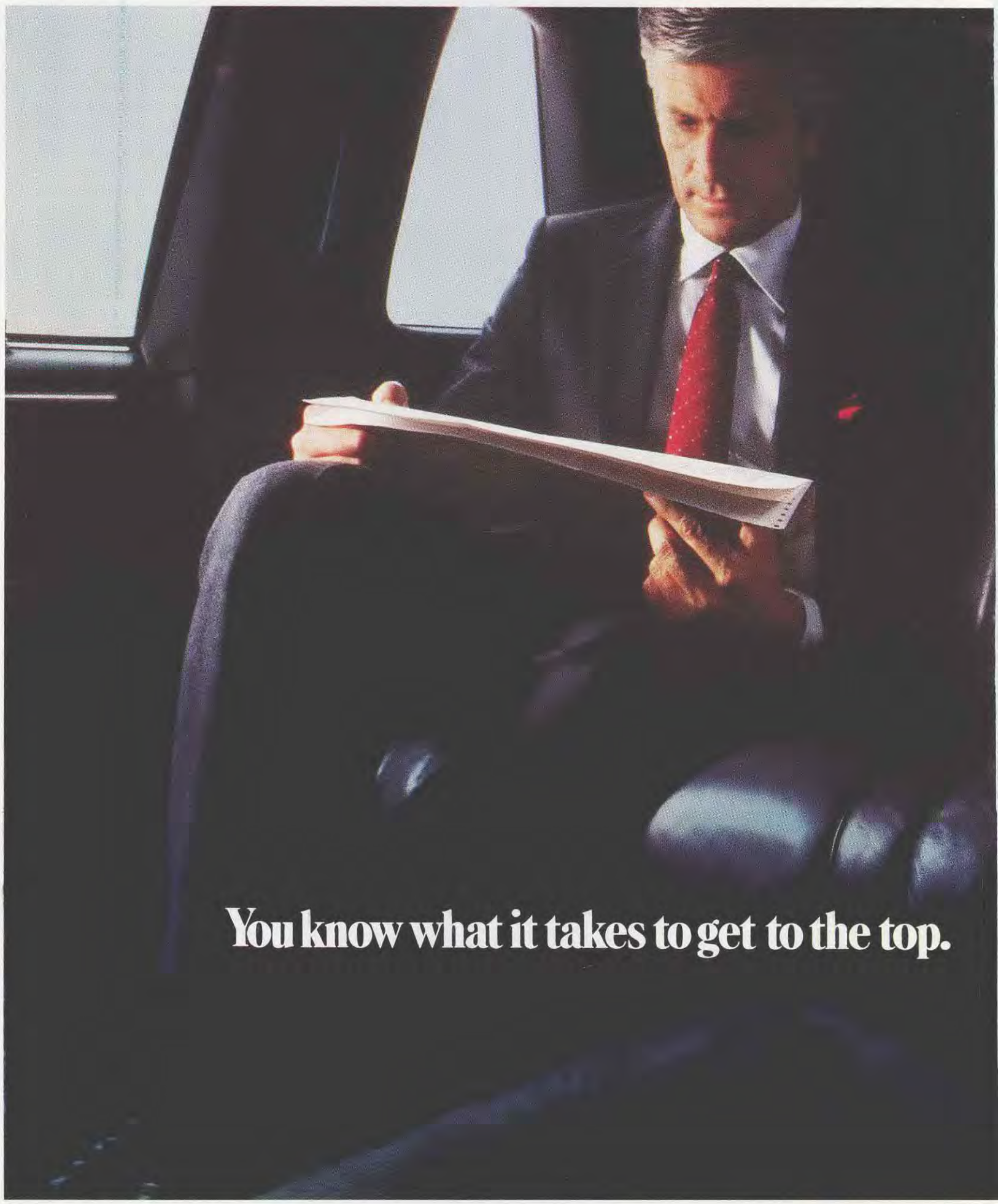
"It's a cliche that the agents like to use," he said. "That's our job as an agency, to present all sides of the options. We're trying to find risk acceptance levels of a client—to one guy $25,000 is a tremendous risk; to another, half a million" is negligible.

He believes that the term is used to apply to services that a client is automatically entitled to, not a privilege that can be billed separately.

The San Diego-based agency has five "very qualified" insurance people who perform risk management functions, Mr. Dethloff added. The agency is paid a fee to perform risk management functions for large corporation clients and to manage their portfolios. They also contract with large offshore captives to insure the first layer of liability.

The agency was founded in 1926 and generates about $35 million

Continued on next page



Continued from previous page
in premiums. It maintains offices in Santa Ana, San Diego and Phoenix, Ariz., with a total staff of 70.

Johnson & Higgins

Johnson & Higgins, the country's third-largest brokerage, started its risk management division in the late 1960s as part of the growing captive insurer movement, recalls Alan Page, senior vp of risk management services.

Clients wanted more services and more tools to manage their own risks for the first layer of loss, he explained.

In the 1970s, New York-based J&H branched out into risk information systems to control statistics. It supplied the risk information and hired actuaries to analyze it. This step eventually grew into loss forecasting for any application.

The next step in J&H's risk management plan is alternative markets, said Mr. Page.

'I always felt that if you were going to grow, you had to be marketing-oriented,' says Fred W. Berger, president of Insurance Planning Inc. in Hays, Kan. 'The key thing is people—if you have good people, you'll do well.'

The brokerage also provides captive feasibility studies as well as quantitative analysis and loss forecasting.

"There is a lot of demand for risk management and we're happy to provide it," Mr. Page said.

Financial Guardian Group

Kansas City-based Financial Guardian Group, ranked as the 21st-largest U.S. broker, instituted its "RiskSurance" program five years ago under the aegis of a special subsidiary called FG Technical Services Inc. in New York.

Financial Guardian launched the program because many clients had risk management needs that could not be met at the brokerage's local branch office level, according to Darrell Prater, executive vp and chief financial officer.

"Ninety-five percent of our accounts" are conventional, said Mr. Prater, but others go through FG Tech.

The initial start-up cost was high, he recalled, because a full-time staff of 20 was hired in anticipation of a heavy workload. But it was soon discovered that all those staffers were unnecessary and now FG Tech has a "very small, very qualified staff," with specialists available on a contract basis as needed.

Specifically, FG Tech employs five full-time people: Mr. Prater, two loss control experts, one heavy claim administrator and one risk management consultant who holds the CPCU and Chartered Life Underwriter designations. In addition, two part-time people negotiate contracts.

FG Tech does not charge for its risk management services, but instead makes a profit only when the insurance is placed.

Although he declined to say how much FG Tech's start-up cost was, Mr. Prater did say that the unit ran in the red for at least three years, and only began turning a profit in 1985.

However, the unit is a "cost center, not a profit center," he added, saying it is an "alternative to our sales offices" in servicing clients. FG Tech does not actively seek new business.

The RiskSurance procedure starts with the completion of a 30-page survey at a Financial Guardian branch retail office. If the account exceeds $500,000, or if there is evidence of unusual risks, it automatically goes to FG Tech for analysis.

Risk-financing alternatives, including guaranteed cost insurance programs, guaranteed cost insurance subject to deductibles, retrospective rating plans and paid-loss retrospective rating plans, are handled by the branch office.

More specialized needs such as the institution of a self-insurance plan or a captive, go through FG Tech.

Insurance Planning Inc.

Insurance Planning Inc.'s risk management program is closely tied to an aggressive marketing strategy, says Fred W. Berger, president of the Hays, Kan., agency.

"I always felt that if you were going to grow, you had to be marketing-oriented," said Mr. Berger. "The key thing is people—if you have good people, you'll do well."

So seven years ago, Mr. Berger hired Darrell Spittles as Insurance Planning's loss control expert. The small agency couldn't afford to hire an entire risk management department, explained Mr. Berger, so Mr. Spittles was chosen for his previous experience as a loss control manager for a Kansas insurer and for his 20 years in the insurance business.

As part of his risk management duties, Mr. Spittles completes a detailed analysis of a potential client's situation, he explained. He checks the physical premises: the building's age, its construction, heating and air conditioning units, electrical units, distance from fire hydrants.

After the physical plant is assessed, Mr. Spittles studies the employees: their number, their job descriptions, any history of heart or back problems and who has keys to the building.

After these and other factors are gathered, Mr. Spittles decides whether the potential client is an acceptable risk. If it is, he will make recommendations on how existing risks can be eliminated, using a scale diagram of the building to illustrate his points.

This analysis is performed periodically with the agency's clients, and there is no charge for the service, he said.

Mr. Spittles believes that careful risk management on the agency level is important.

"It is a necessity because it eliminates a lot of garbage you don't want to write," he said. "But sometimes you're not a well-liked individual in the eyes of the marketing department."

This close analysis also improves the client's chances of getting insurance easily, said Mr. Berger.

"When the company underwriter receives the submission it won't go to the bottom of the pile," he said. "The more complete the submission, the more acceptable it is to an underwriter."

The agency also uses its risk management expertise in attracting new clients, using a personalized slide presentation and a risk management booklet that outlines steps a client (or prospect) can take to cut costs and eliminate risks. Safety programs also are offered.

Most of the agency's clients do not have their own risk managers, so Mr. Spittles performs an essential service, said Mr. Berger. Insurance Planning Inc. generates $10 million in premium and serves the region within a 100-mile radius of Hays. The agency has been in business for 20 years. ■



E&O captive exceeds expectations

By LAURA MAZZUCA

'We are in business principally to insure standard property and casualty agencies that are large,' which generally means those with 80% of their business in property/casualty lines, with some life and group coverage, says Robert P. Ashlock.

PAR Holdings Ltd., a Bermuda captive specializing reinsuring errors and omissions risks for agents and brokers, is exceeding its founders' expectations as it wraps up its first year of operation.

"We're ahead; we're doing much better than we thought we would," said Robert P. Ashlock, president of Assurex International. "We've written and earned more premium than we projected."

Last year Assurex International of Columbus, Ohio, and the National Assn. of Casualty & Surety Agents established the captive, which has surplus of $2.9 million as of July 31.

Mr. Ashlock said that he expected the captive to produce $3.5 million in earned premium for the first year, but believes this goal already has been exceeded.

Since the captive wrote its first policy on Dec. 31, PAR has written 62 accounts and declined 44, writing 54% of its quotes, reported Mr. Ashlock.

Written premium for the period ending July 31 was $3.5 million, while earned premium totaled $1.4 million.

PAR estimates reserves for the period at $918,198, giving the insurer a pretax profit of $454,660.

The development of PAR—Professional Agencies Reinsurance—began last year when Assurex, NACSA and insurance company representatives formulated underwriting and eligibility guidelines for captive participants (*A/BT*, July 7, 1986).

Before embarking on the project, the principals met with management consultant Hales & Associates of Oak Brook, Ill., to discuss the feasibility of an agents E&O captive. The developmental process took almost two years, Mr. Ashlock said.

Fireman's Fund Insurance Cos. acts as the fronting insurer for the PAR program, issuing claims-made policies with limits of up to $5 million to agents and brokers meeting eligibility requirements.

Fireman's Fund then reinsures the entire book of business to a group of 10 insurers, which includes itself and American International Group Inc., CIGNA Corp., Crum & Forster Insurance Co., Maryland Casualty Co., Reliance Insurance Co., Royal Insurance Co., Transamerica Insurance Group, Travelers Corp. and Zurich Insurance Co.

These companies then retrocede to PAR the first $1 million layer of the coverage.

The criteria for participation in the PAR program are very strict, said Mr. Ashlock.

"We are in business principally to insure standard property and casualty agencies that are large," he said, which generally means those that are conducting 80% of their business in property/casualty lines.

However, PAR is closed to the major alphabet houses and publicly held brokerages, Mr. Ashlock said.

PAR also does not accept as policyholders any specialty companies, those doing predominantly wholesale business or agents or brokers that have "poor controls or poor claim histories," Mr. Ashlock added.

So far, no claims for reinsurance have been filed and no claims have been paid, Mr. Ashlock said. Although policyholders have reported some incidents to Fireman's Fund, they have been "small enough that they would well fall within the deductible of the agency," Mr. Ashlock said.

Participants are required to assume a self-insured retention of $50,000 or more depending on the size of the agency.

The minimum premium charged PAR participants is $40,000, with no maximum established. "We have written agencies with premiums in excess of $300,000," Mr. Ashlock said.

When an applicant seeks admittance into the PAR program, inquiries go first to Fireman's Fund for underwriting. If the applicant is rejected, underwriters from Fireman's Fund will contact the applicant for additional data that might affect acceptance.

If accepted and if a quote is issued, the policyholder will pay its first-year premium plus an initial capital contribution of 50% of premium, which will be invested in PAR stock for a minimum of five years.

Policyholders also must agree to participate in PAR's stringent quality control program, which includes mandatory audits and attendance at periodic quality control seminars.

"We require a great deal from these agencies," said Mr. Ashlock, and if they agree, "that agency is looking after his business very carefully."

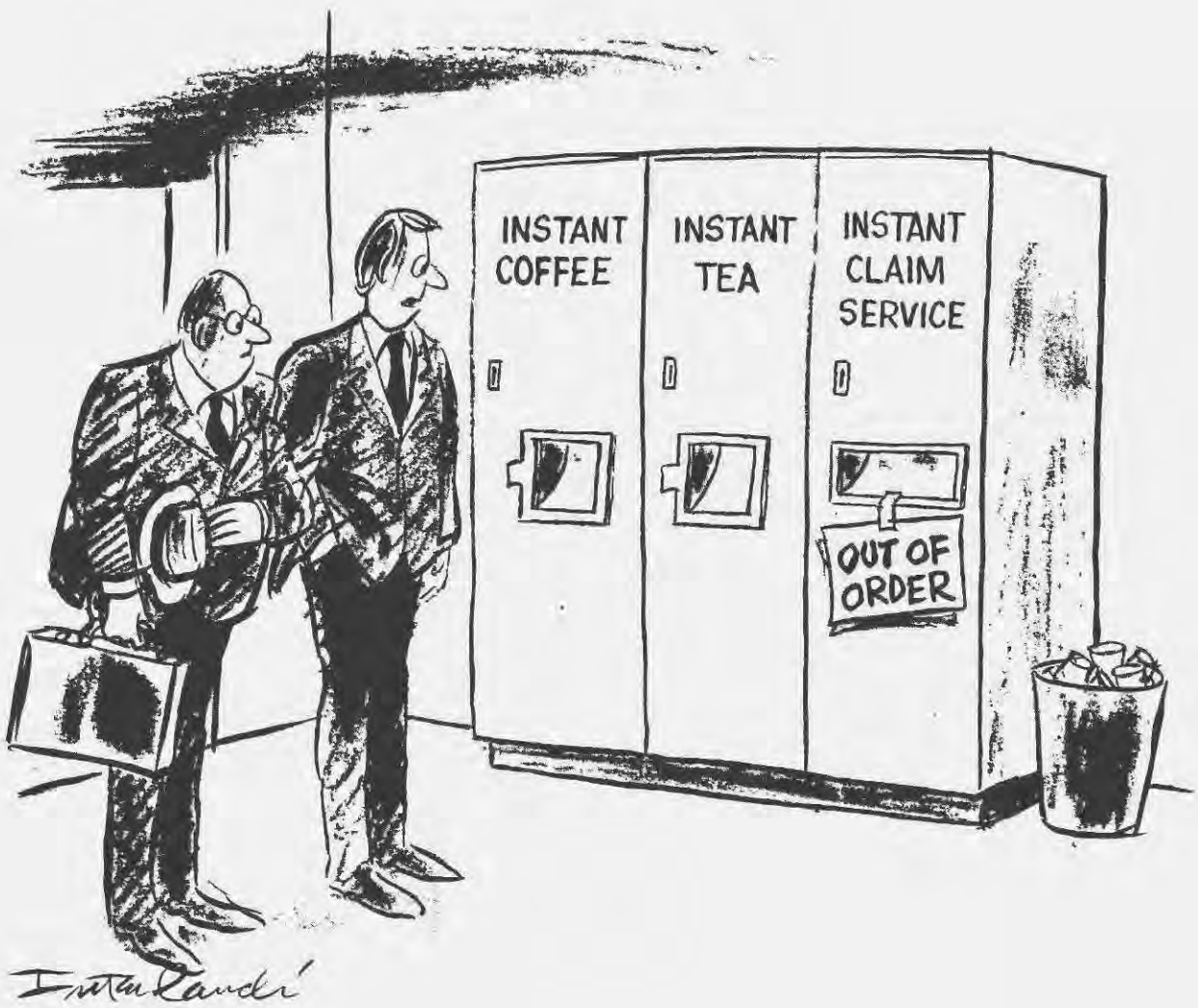
This is the second time that Assurex has established a captive insurer for agent and broker E&O risks, said Mr. Ashlock.

Assurex started a similar E&O captive in 1977, but as the property/casualty market softened, participants felt the captive had served its "short-term need" and the captive was liquidated, he explained.

"We did not have the emphasis on quality control," Mr. Ashlock added, though there was a relatively tough screening process in place for the first captive. "We did not have built into it the longevity" of the new program, he said.

Mr. Ashlock does not anticipate trouble with PAR if the market changes and commercial insurers again seek to write agents E&O coverage.

"We believe we have identified a specific market niche" for coverage availability, Mr. Ashlock said. "Certainly the availability of capacity from other companies will limit our growth, but we believe there are numerous agencies that believe in the long pull." ■



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Retain McCarran-Ferguson Act: NAIB

WASHINGTON—Reform or repeal of the McCarran-Ferguson Act would not contribute to marketplace stability, and government emphasis instead should be placed on reviewing state regulation of insurer solvency, according to a new report released by the National Assn. of Insurance Brokers.

In the report, "The McCarran-Ferguson Act: Marketplace Impact on Proposals for Change," the NAIB urges Congress to look at alternatives for improving state regulation of insurance, particularly in regard to solvency regulation, as an alternative to repealing the act.

The NAIB also suggests that the government focus on civil justice reform, which would improve liability insurance affordability and availability.

Agent/Broker Topics briefs

3 join IIAA group

NEW YORK—Three additional insurers have joined Future One, the Independent Insurance Agents of America's coalition of independent agency companies.

Hanover Insurance Co. of Worcester, Mass., Harleysville Insurance Co. of Harleysville, Pa., and Hawkeye-Security Insurance Co. of Des Moines joined Future One last month, bringing to 21 the number of participating insurance companies.

Future One was formed in 1981 to provide a forum to discuss government affairs, agency and consumer research, marketing, planning and education. Both producers and insurers comprise the membership.

The coalition recently adopted a sliding scale of membership fees to appeal to small and medium-sized regional insurers.

Consultant formed

LOS ANGELES—The Amasis Group Business & Systems Consultants has been formed in Los Angeles to offer consulting services to managing general agents, surplus brokers, reinsurance brokers and other agents and brokers.

Services include agency purchase evaluations for mergers and acquisitions, as well as consultations on reorganization after a merger or acquisition.

In addition, the firm specializes in agency automation and executive search and recruitment.

The firm is headed by Joanne Sheain, who was previously vp-finance at Western Insurance Associates in Pasadena, Calif. Ms. Sheain was also regional marketing manager for software company Delphi Systems Inc. in Westlake Village, Calif.

The Amasis Group is located at 1085½ W. Kensington Road, Los Angeles, Calif. 90026; 213-977-1389.

Office move planned

LAS VEGAS, Nev.—The national board of the Independent Insurance Agents of America voted at its annual convention to move its New York office to the Washington, D.C., area.

The move, which is targeted for September 1989, will combine the IIAA's national administrative offices in New York with its government affairs operation in Washington.

"Moving our New York operation to Washington will provide for more effective and efficient staff operations, facilitating interaction between the Washington and New York staffs," said Jeffrey Yates, IIAA executive vp.

Officers elected

WEST PALM BEACH, Fla.—The Florida Gold Coast Chapter of the Society of Chartered Property & Casualty Underwriters has made history of sorts—the officers elected for its 1987/1988 term are all women.

The Florida Gold Coast chapter's new officers are Hilda L. Bryson, marketing manager at Frank H. Furman Inc. in Pompano Beach, president; Pam Hubbart, president of Hubbart, Hudson, Smith Inc. of West Palm Beach, vp; Jean Hornyak, account representative for Cornealis, Johnson, Clark Inc. of West Palm Beach, secretary; and Irene McKee, insurance consultant, treasurer.

Licensing news

COLUMBUS, Ohio—The Ohio Department of Insurance and the Agent Pre-licensing Education Board have established rules, guidelines and course outlines for agent pre-licensing schools, required by H.B. 310, which is effective July 1.

Under the bill, applicants for an insurance license examination must have first completed at least 40 hours of educational requirements from a board-approved school, beginning July 1.

Requests and inquiries should be directed to Nancy Glaize, APEB Coordinator, Ohio Department of Insurance, Columbus, Ohio, 43266-0566; 614-481-5765.

New CPCU chapter

MALVERN, Pa.—The Society of Chartered Property & Casualty Underwriters has added a new Mount Diablo California Chapter, bringing the number of chapters to 143 throughout the United States and Puerto Rico.

The society's board of directors approved full-chapter status for the California group based upon effective leadership and successful program implementation while the group was a sub-chapter of the Northern California Chapter.

Michael E. Boele is the chapter's new president. He can be reached at Industrial Indemnity Group, 267 Betty Lane, Pleasant Hills, Calif. 94523; 415-933-0222.

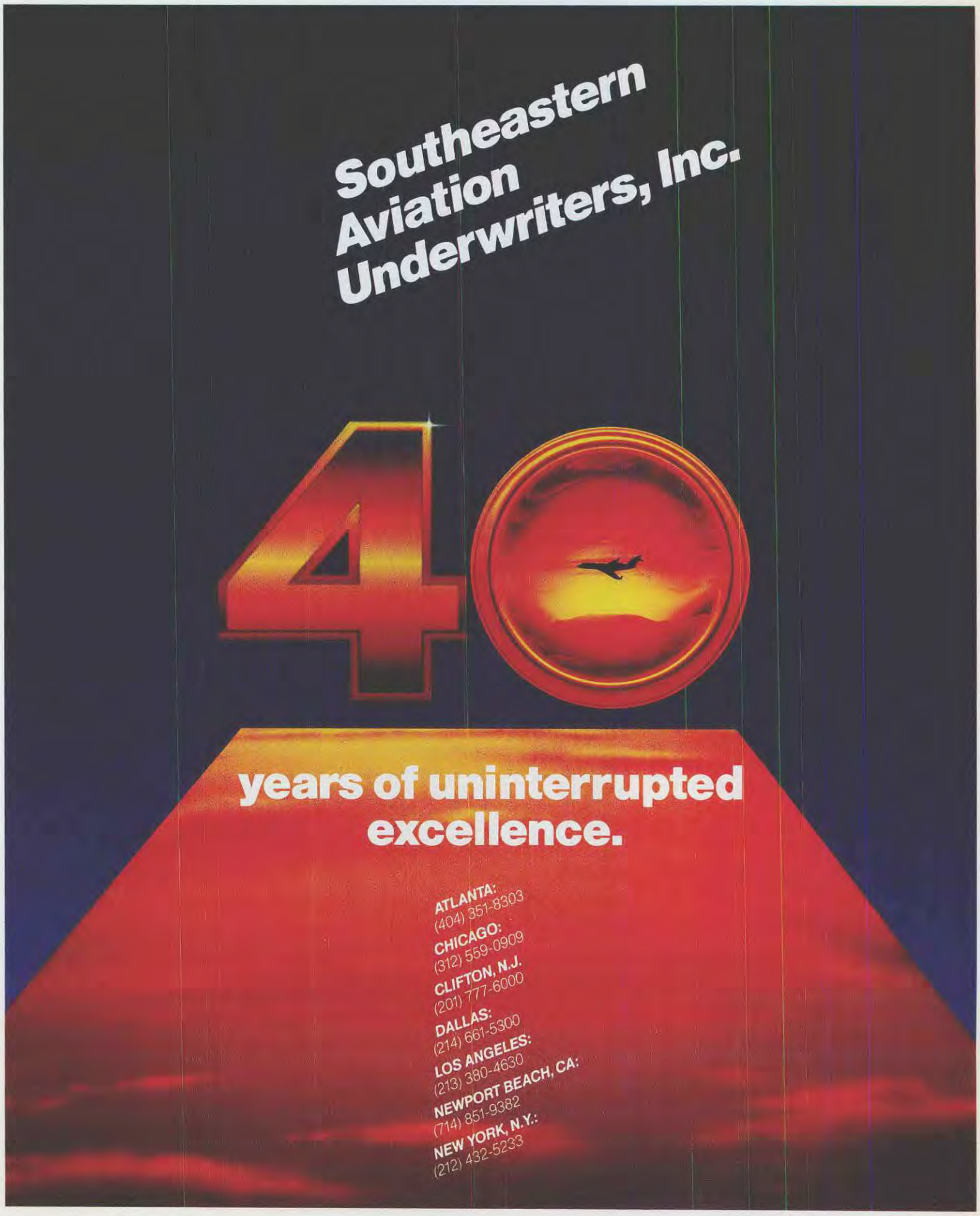
Legal expense exam

DES MOINES, Iowa—Applicants who wish to be licensed to sell legal expense coverage in Iowa will be required to pass a new legal expense examination as of Jan. 1, 1988.

Legal expense coverage, sometimes called pre-paid legal insurance, is treated as either an individual or group coverage.

Some employers offer the coverage as a benefit to employees who may need the services of an attorney.

Continued on next page



Agent/Broker Topics briefs

Continued from previous page

The new licensing examination was developed by the Insurance Testing Institute and is administered at three locations in Iowa. An outline describing the content of the exam is available from the Insurance Testing Institute, 720 Providence Road, Malvern, Pa. 19355-0770; 215-251-9966.

New CPCU officers

SAN ANTONIO, Texas—John P. Folsom, president of the San Francisco office of Fred. S. James & Co. of California, will serve as the 1987-1988 president of the Society of Chartered Property & Casualty Underwriters.

Mr. Folsom assumed the presidency at the CPCU organization's annual meeting held in San Antonio last month.

Richard L. Katten, executive vp of Ferd. Marks-Smither & Co. Ltd. insurance agency in New Orleans, was elected vp of the CPCU society. J. Wesley Ooms, assistant vp of State Farm Fire & Casualty Co. in Bloomington, Ill. was elected secretary-treasurer; and James L. Kirschbaum of Walnut Creek, Calif., is immediate past president and serves as an ex-officio member of the board of directors.

Paul A. Synnott Jr. will succeed James W. Hamilton upon his retirement as executive vp of the CPCU society in January 1988. He is now senior vp and chief executive officer of the organization.

Limits increasing

SAN ANTONIO, Texas—Liability insurance limits of more than $25 million are more available today than they were a year ago, thanks to the increasing use of captive insurers, pooling and other alternative forms of insurance, agents and brokers agree.

Careful underwriting, reasonable and consistent pricing and broad-based membership were suggested as variables contributing to the stability of captives, according to a panel discussion on excess liability presented at the annual meeting of the Society of Chartered Property & Casualty Underwriters last month.

"While capacity remains somewhat shrunken, the excess liability market is dramatically different than in 1985," said Paul Feldsher, vp of Trenwick Reinsurance Group in Bermuda. "A number of captive insurance companies have been formed to provide catastrophic coverage to a broad spectrum of risks. However, if these groups attempt to sell insurance as a commodity, the same problems experienced by the commercial market will result."

Problems like loss of reinsurance and reduced capacity for higher excess limits arose in recent years because of fragmented reinsurance coverage, easy entry and exit in the marketplace and long-tail exposures, said panel moderator Clinton N. Greene, president of Farmington Management Inc. of East Hartford, Conn., which manages the American Excess Insurance Assn., a line slip of 14 insurers. But with special facilities offered by insurers, broker-sponsored organizations or joint underwriting associations, excess limits—including pollution coverages—can now be found, he added.

Insurance buyers accustomed to paying moderate prices for high limits were caught by surprise when this availability dried up in the recent cycle change, said William T. Torpey, vp of American Risk Management Inc. of Fort Lee, N.J. But "buyers responded by making their own insurance such as by forming captives," he said.

The marketplace will continue to stabilize, predicted William L. Bradford, senior vp of Johnson & Higgins Inc. in New York, with capacity to write limits of up to $300 million; new participants in the under-$25 million market; and other pools being formed as knowledge of current successes becomes more widespread.

Agent interface study

BOULDER, Colo.—An extensive study on the feasibility of agent-insurer electronic interface is being conducted by the National Assn. of Professional Insurance Agents in Alexandria, Va., and the Independent Insurance Agents of America in New York.

The project will explore how close the industry is to achieving electronic interface through a standard batch system.

Other issues to be addressed include:

- Why is the interface process taking so long?
- Does interface create additional work and new problems for agents?
- Does the interface process ignore the practice needs of agencies?
- What are the interface problems faced by insurers and vendors, if any?

Research is now being conducted by Automation Management Group Inc. of Boulder. No date has been set for the study's completion, association spokesmen said.

Agent magazine

PHILADELPHIA—The Continental Insurance Agency Group is now publishing "InnerCircle," a quarterly magazine for its preferred agents.

"Strong agent relationships must be based on open, two-way communications," said Donald Scruggs, Continental senior vp. "This has always been one of the goals of our Circle Agent program, and it is built into the InnerCircle magazine. In fact, Circle Agents provided substantial input in developing the new publication."

The magazine, which debuted in September, will report on new developments at Continental, profile Circle Agents and leading industry executives, and provide a reader's forum for the preferred agents.

Risk retention fight

WASHINGTON—Professional industry associations have issued statements blasting a Department of Commerce recommendation that would change the 1986 amendments to the Risk Retention Act to make clear that licensed agents do not have to place coverage written by risk retention groups.

"We will fight this every step of the way," said Paul A. Equale, vp of government affairs of the Independent Insurance Agents of America in New York.

The Commerce Department recommends that in the the federal government would be able to preempt state commissioners in determining the qualifications of risk retention groups, claiming that the 1986 law did not state that licensed agents must be used in this process, said Robert Rusbuldt, IIAA director of federal affairs.

Since the act was amended last year, 26 states have adopted risk retention legislation, with most state statutes based on the National Assn. of Insurance Commissioners' risk retention model act. However, some state statutes differ from the model, which has a major effect on the formation and operation of the groups. ■

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Cash balance pensions will increase in popularity

By Lawrence T. Brennan

WHEN ASKED to predict some economic variable, the distinguished economist Walter Heller once said, "I'll give you a number or I'll give you a year, but I won't give you both."

In trying to forecast the outlook for cash balance pension plans over the next 20 years, I can't do any better. How can one estimate how many companies will have adopted them by 2007? No one knows how many have them *today*, although a rough extrapolation of our firm's experience to the corporate world at large indicates the total probably is around 50 to 75.

Nonetheless, I will venture an estimate that the next couple of decades will see such plans adopted widely in the United States and, for that matter, in a number of other countries as well. I believe many companies will substitute them for traditional final average pay pension plans for essentially three reasons:

- The degree of management acceptance to date.
- The indications of cash balance plans' popularity among employees.
- The expected business environment.

Given there are as many as 2,350 corporations whose shares are listed on the New York and American stock exchanges alone, the estimate that 50 to 75 firms now have cash balance pension plans may not seem impressive. But it *is* impressive when you consider that the concept is only 2 years old and that corporate managements do not quickly make major changes in pension plans without a government mandate.

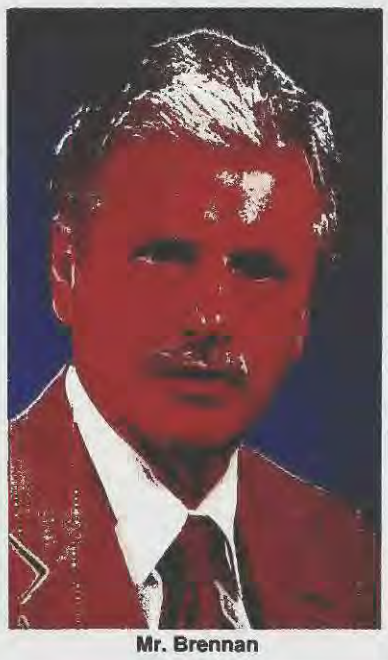
In projecting how many other companies may replace their traditional defined benefit plans with cash balance plans over the next 20 years, it is useful to bear in mind what led the present users to adopt cash balance plans. They expected that, above all, cash balance plans would:

- Give management a greater opportunity to control and perhaps to reduce pension costs by avoiding overfunding, the major financial deficiency of final average pay pension plans from an employer's viewpoint.
- Help to retain and to recruit employees because cash balance plans are more appreciated by all employees, because the benefits are easier to understand than those of final average pay plans, and by younger employees, because the benefits in earlier years are more substantial.

Users indicate their expectations have been fulfilled so far. "We are very pleased," says Daniel C. Rowland, director of compensation and benefits for Bank of America, whose cash balance plan was the first to receive a favorable Internal Revenue Service determination letter regarding its qualified status. "Management is pleased that the corporation has been able to keep costs to a minimum because of successful investments. Our rate of return in 1986 was 17% while we had guaranteed employees 9%; this year we're guaranteeing 8%. Our employees are also pleased because the rates are attractive when they see what, for example, they get from CDs. It's a win-win situation."

Others also focus on employee response. Michael P. Miller, director of employee benefits at Borden Inc., recalls that his company had switched to cash balance, in part, because its traditional pension program had not been well understood. Borden saw in cash balance the opportunity to adopt a pension plan that not only would be as popular as its savings plan but also as beneficial to employees as to the company. "Reaction has been very positive," he says.

Continued on page 66



Mr. Brennan

Lawrence T. Brennan is a partner with Kwasha Lipton, an employee benefits consulting firm in Fort Lee, N.J. Mr. Brennan designed the first cash balance pension plan as a vehicle to give employees more understandable benefits and employers more predictable pension costs.

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Photo: Ken Heinen
Mr. Seidman

Labor to seek benefit advances

By Bert Seidman

THE 1980s HAS been a difficult decade for American workers, but the period when labor has been on the defensive appears to be ending and unions are repositioning themselves to win back what they have lost and make new gains.

Here is what may be expected in pension, health care and other important benefit areas in the next 20 years:

• Retirement income—pensions and Social Security.

With the aging of American society, pressure will increase for adjustments of retiree pension benefits. The decline in the pool of younger workers and the resulting demand for continued service of older workers may bring revisions in pension plans that will allow retirees to work part-time without losing full-time pension credits. Pension benefits would continue to accrue for part-time workers by prorating benefits according to the number of hours worked.

The growing importance of pension funds as financial institutions, generally managed by third parties who often invest in ways not in the best interests of the participants, will cause unions to insist on a greater role in how these funds are invested.

Legislative efforts will be made to make pensions more portable and more generally available and to prevent the increase in the age of eligibility for full Social Security benefits scheduled to take place in the next century. We can also expect changes in Social Security to match women's enhanced roles in the economy.

• Health care.

The major issues in health care are access, quality and cost. In recent years, the emphasis has been almost exclusively on cost reduction measures. To counter employer efforts to shift medical care costs to their employees, unions have emphasized the need to adopt such cost control measures as second opinions for surgery, pre-admission testing, ambulatory surgery and alternative delivery systems such as HMOs and PPOs.

But unions, and increasingly other elements in society, are also concerned with access and quality of care. Nearly 40 million Americans have no health insurance, private or public, and at least two-thirds of them are employees or their family members are employees. The number uninsured Americans has been growing not only because of Reagan-inspired cutbacks in Medicaid and other public programs but because millions of displaced workers have lost their health benefits along with their jobs and because of structural changes in the economy. Quality of care, traditionally bad in nursing homes, has deteriorated in other health care sectors as a consequence of cost pressures.

In collective bargaining, unions that are not yet implementing cost control measures are moving to do so in the face of a new wave of double-digit health insurance premium increases and renewed employer demands for cutbacks. Unions will seek to negotiate wellness programs, substance abuse and mental health programs and alternative delivery systems like HMOs and PPOs, as well as retiree health benefits and long-term care.

Organized labor will vigorously support legislation to require all employers to provide minimum health care benefits along the lines of the bill recently introduced by Sen. Edward Kennedy and will press for retiree health protection, inclusion of long-term care in Medicare and improved standards for nursing homes.

The ultimate goal will be a national health plan comparable to those already in place in every industrialized nation except the United States and the Republic of South Africa.

• Other benefits.

Unions have had some success at the bargaining table in winning provision of child care benefits, though negotiations on this issue tend to be extremely arduous. Since approximately 65% of mothers are in the workforce, child care will be a frequent bargaining issue.

For the same reason, unions will be seeking through both collective bargaining and in legislation to win parental leave benefits. The first step would be enactment of the Family and Medical Leave Act, which provides job-protected unpaid time off to meet parental responsibilities and to deal with serious family health problems.

Fifteen years after the National Commission on Workers Compensation, appointed by President Nixon, made 84 recommendations for workers compensation improvements, including 19 that were deemed "essential" for an effective work comp system, not a single state has met all of the essential conditions.

The commission said in 1972 that if the essential recommendations were not implemented, Congress should enact minimum federal workers compensation standards. The first post-Reagan Congress should do so at once.

While some expansion of health and safety protection can be achieved at the bargaining table, Congress must act to make the Occupational Safety and Health Act do its intended job and adopt new legislation where needed. Right-to-know protections now guaranteed to workers under federal and state laws must be implemented effectively.

On the regulatory front, new

Continued on page 66

Bert Seidman is director of the AFL-CIO's Department of Occupational Safety, Health and Social Security in Washington, D.C. Mr. Seidman has played a key role in shaping organized labor's positions on employee benefit legislation.

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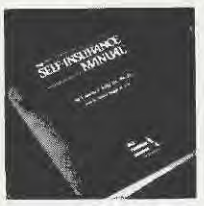
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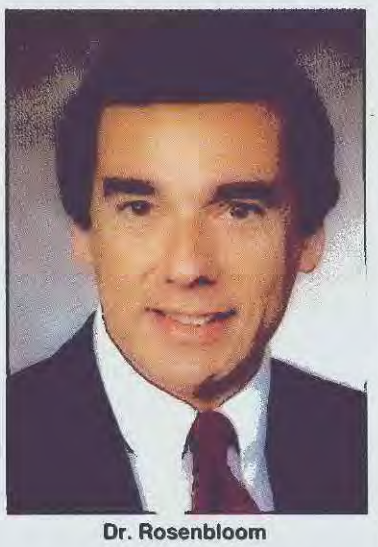
Need for experts to push benefit education program

By Jerry S. Rosenbloom

THE FIRST stirrings of interest in a professional designation for the employee benefits field began more than 20 years ago in discussions between the International Foundation of Employee Benefit Plans and the Wharton School of the University of Pennsylvania. However, it was not until the passage of the Employee Retirement Income Security Act in 1974 that the idea received serious attention.

At that time, the employee benefits field entered a new era of complexity, and it was recognized that new dimensions in education would be needed to equip plan managers and other benefit specialists to cope with the more complex environment.

It also was recognized that there should exist in employee benefits,



Dr. Rosenbloom

as there did in other fields, some form for measuring the level of knowledge and competence of those working with benefit plans. Research uncovered a glaring void; there was no advanced regimen of education through which a person could prepare for a career in the employee benefits field.

Consequently, the IFEBP's board of directors appointed a subcommittee on higher education. Their work concentrated on what kind of educational program the employee benefits field needed and how such a program might be conducted. The subcommittee investigated existing educational programs to see if they could be adapted to adequately meet the needs of the employee benefits community. It was decided that they could not.

Thus, a search was undertaken to affiliate with an institution of higher learning that already possessed the capability for developing and presenting college-level courses of study.

Because of its broad experience in employee benefits-related subjects and its outstanding reputation, the Wharton School of the University of Pennsylvania was selected.

Initially, the Wharton School and the IFEBP investigated the idea of offering a special master's in business administration track for benefits professionals, but they decided against this option. Instead the subcommittee recommended the development of a totally new professional designation program, the Certified Employee Benefit Specialist Program.

The co-sponsorship agreement forged in 1976 established a dual arrangement of responsibility. The IFEBP is responsible for overall administration of the program, and the Wharton School is responsible for its academic content and standards, including complete control over the level and quality of course materials, the development and confidentiality of examinations and the academic relationships with students.

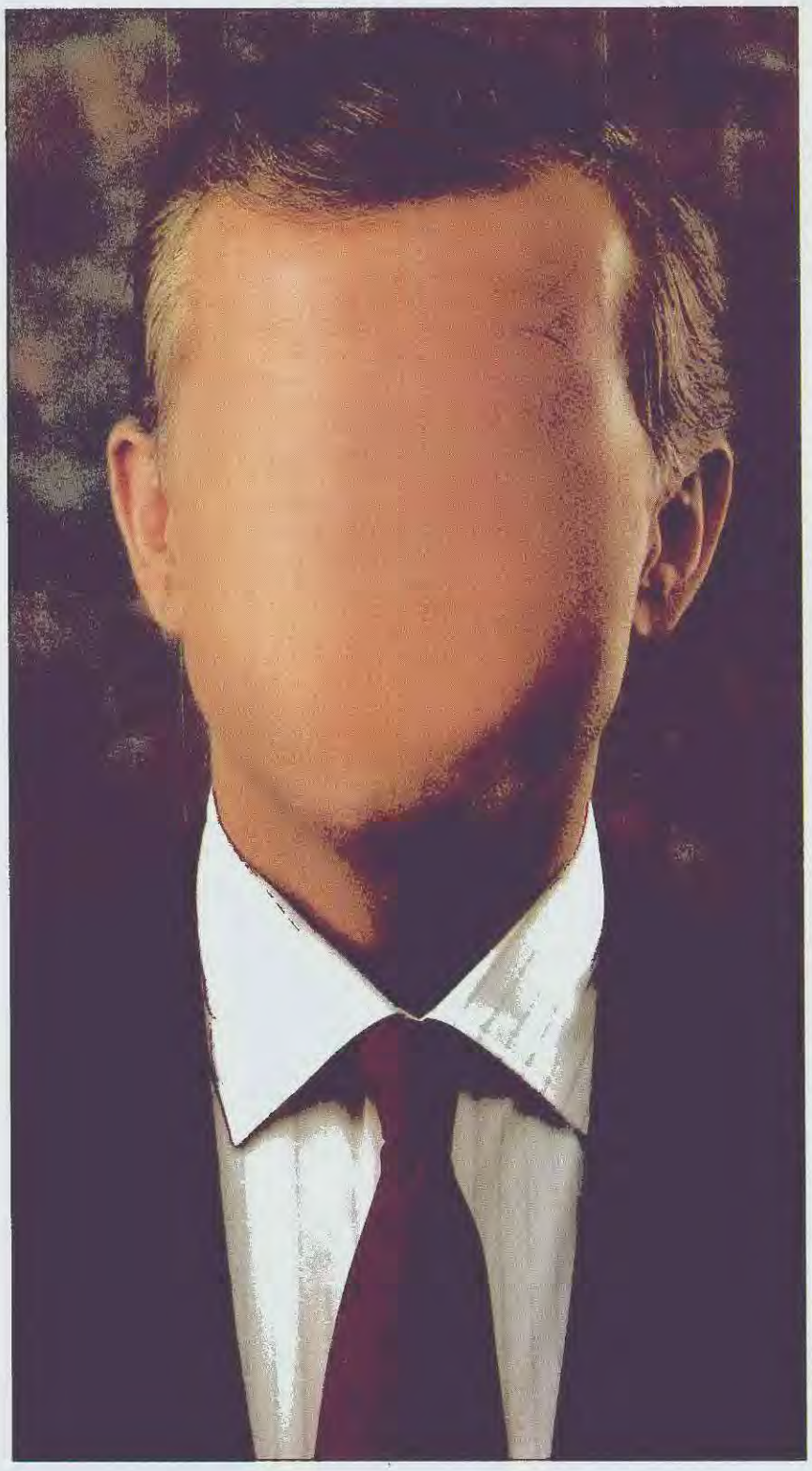
Optimistic projections were that a total of 200 individuals would enroll in each of the first few years of the CEBS program. However,

Continued on page 67

Jerry S. Rosenbloom is academic director of the Certified Employee Benefit Specialist program at the Wharton School of the University of Pennsylvania. Dr. Rosenbloom holds a doctorate degree in applied economics from the university, where he is a professor of insurance.

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20 years in my view

Wellness can help create model employees

By William E. Hembree

WELLNESS WILL profoundly affect employees, employee benefit and compensation plans and even the workplace itself over the next several decades.

Consider the contrast between today's worker and the worker in 2007 and beyond. Tomorrow's "healthy" (in the wellness sense) worker will be characterized by:

- A high energy level, obvious vitality and motivation.
- A willing commitment to his or her work and strong support of the employer.
- Self-sufficiency and self-reliance.
- Involvement in community and support networks (like church, schools, service clubs, etc.).
- Use of seat belts and moderate use of alcohol, if at all.
- Physical fitness, weight at intended level, good eating habits.
- Stress largely under control.
- No smoking.
- Virtually disease-free for most of his or her career.
- And, if medical care is used, the patient is in control, forging a partnership with providers and seeking the most quality-and cost-effective care available.



Photo: Drake Sorey
Mr. Hembree

Utopian and unattainable? Certainly—if we expect all of tomorrow's workforce to fit the foregoing model healthy employee description. But it is not only possible, it is highly likely that most workers will be considerably closer to this model than they are today, largely because of wellness programs sponsored by employers.

Employers are coming to realize that virtually all employee benefits —even compensation and productivity—are greatly affected by employees' health (or more correctly, lack of health). Obviously, workers who are unhealthy cost employers more than healthy employees in direct costs and in lost productivity/profitability. Research abounds with reliable statistics documenting additional costs caused by poor health habits:

- Workers who smoke cost their employers $624 more in annual medical care costs and their premature death rate is somewhat higher.
- Smoking-related cancers kill more than 325,000 yearly and cost the nation more than $30 billion in direct medical care expenses alone. In 1987, more than 135,000 new cases of lung cancer will be detected and 117,000 lung cancer deaths will occur.
- Smokers average two to three more days of absenteeism per year than non-smokers and heavy smokers use the medical care system 50% more than non-smokers.
- Heart attacks are estimated to result in 132 million lost working days annually.

Recruiting for executives to replace those who have suffered heart attacks costs nearly $1 billion annually.

- Alcoholism costs industry more than $25 billion annually. The rate of absenteeism for alcoholic employees is 250% greater than non-alcoholics and the rate of accidents is 3.6 times that of non-alcoholics.
- Drug abuse is conservatively estimated to cost $26 billion a year.

Continued on next page

William E. Hembree is director of the Health Research Institute in Walnut Creek, Calif. The institute conducts a biennial survey of 1,500 of the largest employers in the United States.

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Continued from previous page

As further documentation, the following are the chief causes of death—and medical care costs—in the United States, according to 1981 provisional mortality rates calculated by the National Center for Health Statistics' Division of Vital Statistics:

- Heart disease (336.0 deaths per 100,000 people).
- Cancer (183 per 1,000).
- Strokes (75.1 per 1,000).
- Accidents (46.7 per 1,000).
- Chronic obstructive pulmonary disease (24.7 per 1,000).
- Pneumonia and influenza (24.1 per 1,000).
- Diabetes mellitus (15.4 per 1,000).
- Chronic liver disease and cirrhosis (13.5 per 1,000).
- Arteriosclerosis (13.0 per 1,000).
- Suicide (11.9 per 1,000).

Since all the foregoing problems are lifestyle-associated, is it possible for employer programs to help employees change the risk factors leading to these diseases? Consider:

- New York Telephone has calculated its savings from nine health promotion programs at $5.54 million vs. a cost of $2.84 million for a net gain of $2.7 million.
- General Motors' employee assistance program enrolled 44,000 workers and, as a result, the company reported a 49% reduction in lost work time, 60% reduction in grievances and a 20% reduction in disability costs.
- Control Data Corp.'s Staywell program has documented that program participants have lower health care costs than non-participants.
- A New York Education Department health/fitness program reduced risk factors, eased health problems and cut employee absenteeism by 55%.

Importantly, what wellness programs will make possible over the next several decades is the redistribution of a company's proportion of healthy and unhealthy employees.

Recent research using data based on large numbers of people shows that a relatively small number create a disproportionately large percentage of total medical costs and productivity/profitability losses as well. For example, it is not unusual for less than 15% of the covered population to cause more than 85% of medical care costs during a given period. And when data is thoroughly analyzed, researchers have learned a handful of medical conditions cause the majority of most employers' medical care costs. Most of these conditions are associated with the patients' lifestyles during the years prior to the event that hurled the person into the serious illness or mortality category.

Another dimension of this model is its dynamic nature. Except for the few healthy individuals who truly know what it feels like to be healthy, most workers are in a constant, seemingly inexorable movement from a healthy to an unhealthy status. Most workers start to work relatively disease-free, but they regress to early warning stages, then through chronic and acute conditions to disability and to death.

What also must be kept in mind is the difference between cost containment and wellness.

In the earlier days of cost containment, efforts were focused on the "price" of medical care. Longstanding measures like reasonable and customary provisions and new measures like shifting cost to employees were expected to cause the medical care system to operate in a more price-sensitive manner. Unfortunately, although certain prices did moderate, costs still increased.

The medical care system quickly adapted to employer cost-control measures, and the level of revenues targeted by providers that could not be achieved through price alone was achieved through additional units of service, especially in the hospital.

Most cost containment and even most competitive measures, seek to hold down the price of care. And although managed care attempts to hold down utilization, even when utilization is controlled, the nearly inevitable outcome is still higher costs per hospital admission since little in this equation forces the hospital to reduce its costs.

Consequently, most employers are finding today's conditions "frustrating" to say the least. And to make matters worse, health maintenance organizations and preferred provider organizations have shadow-priced, community-rated and cream-skimmed to a point where their credibility and acceptability is low, and some employers are simply removing them as options.

In addition, the best cost-containment tools can do little to moderate cost shifting from public to private payers, from large plans to small plans and from uncovered employees to covered employees. And, cost-containment measures do too little to reduce the fraud, abuse and undiscovered duplicate coverage problems that are all too prevalent in the health care delivery system.

The fundamental problem with

Continued on next page

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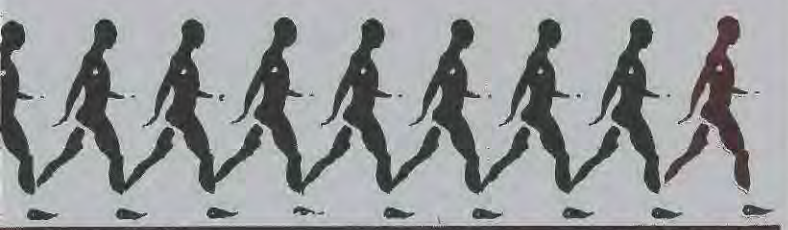
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Hembree

Continued from previous page

the past and many of today's efforts is the assumption that we're destined to continue to experience a relatively fixed level of utilization. Consequently, we've concentrated on price and done too little to reduce the demand placed on the medical system, in the short term as well as over the longer term.

The obvious key to demand reduction over the long term is healthy employees, which is the result of healthier lifestyles. Pivotal in a short- and medium-term demand reduction strategy are empowered medical consumers. And, neither of these will be achieved without large changes in employee behavior. These changes will be much more likely to be made if they are in response to positive incentives than sickness-avoidance or penalty-based measures.

Faced with the frustration of less effective cost controls than expected, some leading-edge employers are beginning to consider whether changing the relative proportion of unhealthy to healthy employees and dependents could help control costs. For example, regardless of the means used, if the absolute number of persons in the high-cost category is lower, the consequence is lower cost since:

- Less demand is placed on the system.
- Costs can be shifted to fewer covered individuals.

This wellness-induced reduction in demand for health care services will be seen as one of the most significant components in ultimately controlling medical care costs.

One means to reduce short- and medium-term demand on the medical system is to thoroughly educate employees about when and how to use the system. Empowered, health-educated employees don't use the system unnecessarily—too early and for self-limiting and self-treatable conditions—or too late—well after recognizable symptoms have appeared.

As a partial result of knowing what illness conditions create the need to use the medical care system, empowered medical consumers will correctly ascertain that prevention—or wellness—is the key to reducing long-term use of the system.

Another means to accomplish the change in the ratio of healthy to unhealthy workers is to seek to hire healthier workers and to make the workplace a place where health is obviously rewarded. For example, a large number of companies have already restricted or banned smoking from the workplace, and others have vowed publicly that they will not hire or retain future workers who are smokers.

Although these measures may seem extreme in the short term, they are a positive and distinct part of a wellness strategy that will result in lower costs, higher productivity and increased profitability, especially for those that adopt these measures early since those who adopt them later will be hiring the unhealthy workers who couldn't find employment in the health-oriented companies.

Many of the wellness ideas that will be used over the next several decades haven't even been considered yet. But once the objective of rewarding wellness as a way to encourage employees to voluntarily and willingly halt the downward spiral to "unhealth" is established, the tools will fall into place as a natural outcome of seeking the wellness objective.

Consequently, nearly all of today's concepts about employee benefits will be changed considerably. For example:

- The importance, cost and use of medical care plans will be greatly diminished since fewer people will be unhealthy enough to need medical care.
- Today's rigid, fixed-level deductible plans will have given way to full choice-making systems.
- Generally, medical benefits will not be paid on a "process" basis as they are today. Medical care expenditures will be largely based on a DRG-like payment system, and adjustments will be made for successful vs. unsuccessful outcomes.
- Surgical benefits on a reasonable and customary or scheduled basis will be a historical artifact since most future payments will be DRG-based.
- Similarly, short-term disability and long-term disability plans will be less frequently utilized. For a workforce generally wishing to return to work, many of the benefit reduction approaches—used to force employees back to work—will no longer be necessary, and in fact, would be counter to a healthy company's approach to treating employees as responsible partners.
- HMO offerings will be considerably different as well. The concept of community rating will be seen as useful only as a means to ensure the early viability of emerging HMOs. But the era of the '80s will have shown HMOs, PPOs and their successor organizations will have had to compete in a free marketplace. Consequently, alternative delivery systems will be offered on an experience-rated basis, and these options will actually deliver far more in prevention, health improvement and wellness programs than have been promised in the past. It is only in this way that the alternative delivery system can operate efficiently within a DRG-based payment system.
- The "dark ages" approach to mental health care will have given way to financing psychological care on a prepaid basis. In this way, providers of psychiatric care benefits will be increasingly at risk as a patient's condition worsens. This is in strong contrast to the approach to mental health care from the 1960s to the '80s.
- The concept of time away from work will have evolved toward the paid time-off concept. In short, means will be available to reward individuals who seldom use short-term disability and long-term disability benefits. These changes will be made along the line of General Electric's positive approach to absenteeism called "presenteeism."
- Tomorrow's employees will participate in savings and rewards for wellness. Regardless of the tax policy at the time, medical expense accounts or other cash savings methods will be available to help finance the employee's and his or her family's future chronic/elderly care, etc.
- Because healthier employees are able to more effectively contribute to their organizations' profitability, additional cash or in-kind bonuses will be payable based on contribution to profitability. In this way, all employees will have a significant opportunity to become "owners" of the enterprise as well as to be rewarded for their wellness.
- In the early days of the transition toward wellness-oriented benefits, employers will have adopted measures to begin to shift the reward system toward healthy employees instead of penalizing them. For example, because employees with unhealthy risk behaviors and/or poor actual health status create costs disproportionate compared with healthier employees, the unhealthy employees will receive proportionately smaller amounts from the plan and/or contribute more to the cost of the plan. This recognizes an emerging philosophy that those who contribute to their own future medical care costs through unhealthy lifestyles should pay a larger share of the cost of these behaviors.
- The means of administering plans will have changed considerably as well. In each of the Health Research Institute's biennial Health Care Cost Containment surveys since 1979, there has been constant movement toward use of in-house, self-administered claims systems. As the medical plan claims administration function diminishes and as employers continue to experience frustrations with insurers' bureaucratic delays, errors, lack of responsiveness, etc., the third-party administrator industry will have grown considerably, as well as use of in-house self-administration.
- Hospitals themselves will have changed considerably by 2007. Over the next several decades occupancy levels will have fallen further, and many hospitals will close. But the "lean and mean" survivor hospitals will provide a far more patient/payer-responsive service than ever before. In addition, what was seen as excess hospital capacity in the '80s will have been converted to health improvement programs, elderly care arrangements, etc.
- Physicians' practices will be considerably different as well. The solo practitioner of the pre-'80s era will have virtually given way to organized delivery of medicine in one form or another. Current research strongly suggests less than 20% of the U.S. population will use today's traditional fee-for-service based system by the year 2007. The remaining

Continued on page 67

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Employers to define retiree health benefits

By Thomas J. Kuhlman

THE FINANCIAL Accounting Standards Board in 1988 is expected to release its exposure draft calling for pension-type accounting of post-retirement welfare benefits for current and future retirees. Because this change in accounting treatment could raise current expense levels for many companies five to 10 times, I believe more employers will recognize that a review of retiree welfare plan costs and design is in order.

Compounding the need for reassessment are:

- The high costs of post-retirement benefits. Because of the way most retiree plans are structured, they represent an open-ended and steadily increasing cost commitment for employers. Costs are also increasing as the number of retirees grows due to down-sizing and early retirement incentive programs.
- Changes in the nature and level of Medicare benefits. Al-



Mr. Kuhlman

though legislators currently appear interested in expanding Medicare benefits to provide more catastrophic protection, the government has signaled its belief—through COBRA legislation—that employers have the primary responsibility for health care coverage for pre-age 65 retirees.

- Post-retirement welfare benefit programs that do not adequately support employers' objectives in terms of current and future cost levels, the ability to control costs and the method of benefit delivery.

In the coming months, as companies look more closely at this critical benefits issue, I believe some may find a viable solution in a plan design that allows the employer to establish a fixed dollar contribution toward the annual cost of retiree medical benefits.

Basically, a company would provide a specified dollar allocation to retirees, who would use this money to buy medical, dental and/or life insurance coverage. If the total cost of coverage exceeded this allocation, retirees would pay the difference. If the total cost of coverage was less than the allocation, the unused portion could be deposited into a health care spending account for reimbursement of non-covered health care expenses. All of the employer's benefit allocation would be used for non-taxable benefit choices.

Under this approach, an employer can control the dollar amount it spends for retiree benefits each year, as well as the extent to which the fixed contribution will escalate in future years. The company can increase the allocation at its discretion, when and if such a step seems appropriate. Thus, employers control their cost and expense levels and gain the flexibility to be conservative or liberal in the level of benefits they offer to retirees.

As part of such an approach, some employers may want to redefine the nature of their obligations to different employees. Some companies, for example, will vary their benefit allocation by length of service, giving longer-service employees a bigger allocation than short-service employees. Many will also probably provide larger allocations for employee coverage than for dependent coverage. And most will grant different allocations for pre-age 65 and post-age 65 retirees to take into account the lower cost of care after age 65 when Medicare benefits commence. In addition, employees might be required to take a reduced allocation for early retirement or for survivor coverage.

In essence, the post-retirement welfare obligation would be defined in much the same way that the pension obligation is currently defined.

Although this approach will give employers greater control over the allocations, cost and expense of retiree welfare benefits, I do not believe that companies will overlook the issue of plan design. We should see more frequent changes in design through automatic updating of plan provisions whenever there is a change in the provisions for active employees. We also should see better cost management capabilities built into the plan through:

- Utilization review.
- Limits on covered expenses and eligible reimbursements.
- Incentives to use preferred provider organizations, health maintenance organizations and other managed care systems.

This defined dollar benefit approach should also make it easier for employers to extend flexible benefit options to retirees. Flex

Continued on page 67

Thomas J. Kuhlman is a principal with Towers, Perrin, Forster & Crosby in Minneapolis. He helped design the first flexible benefit plan to be implemented specifically for retiree welfare benefits, which was adopted earlier this year by Pillsbury Co.

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20 years in my view

Duva

Continued from page 47

plans and their tax advantages is not over. In addition to the changes required by the Tax Reform Act of 1986, these plans continue to be an area of possible revenue enhancement to the government. With a record federal deficit and a Congress looking for ways to reduce it, 401(k) plans will again, in total or in part, come under fire. One recent suggestion by the Joint Tax Committee for raising additional tax revenue was to treat plan loans under 401(k) plans as a taxable plan distribution.

In effect, the Tax Reform Act restructured 401(k) plans to be pension supplements. Major companies will conclude over time that 401(k) plans are retirement plans and they will, in fact, reposition them to be included as part of the total retirement income program. The balancing act between defined benefit and defined contribution plans over a period of time will shift back to defined benefit plans. Also, 401(k) plans will be less appealing over time when compared to other compensation and employee benefit arrangements.

My conclusion is that there will be less growth, and even a possible decline, in 401(k) plans in the future even though the $2,000 individual retirement account deduction will not be available to many qualified participants. ■

Maher

Continued from page 48

the doctors and hospitals participating in these plans and they can maximize their benefits by going to them. While our financial results to date have not been spectacular, we believe we have accomplished a major change in the mind-set of our employees. Many of them now go to their Chrysler PPO/HMO directories instead of the Yellow Pages when they select a doctor. That ostensibly subtle change in our employees should not be underestimated.

Unfortunately, much more is necessary. We have really just made some timid first steps. However, I am convinced we are on the right track. The buyers of health care simply must get themselves much more involved. After all, some of them are *very big* buyers with lots of clout. However, the only way for this clout to be exercised effectively is for the buyers to start setting some rules for the sellers to play by. The sellers, of course, will cry "regulation." But since when is it wrong for a buyer to lay down some rules?

What is terribly awkward here, however, is that these major buyers (and hopefully rule-setters) also happen to be governments and employers, while the health care consumers are also most often constituents and employees. This sets up some potential major political and employer/union relations problems. Patients, obviously, want everything that may be helpful to them, and believe they are entitled to it. Physicians are ready and willing to provide any services that may be good for the patient. And the bill-payers want lower costs. If America is going to win this battle to control health care costs, these problems must be overcome.

For example, should hospitals that have no business staying open have their bills covered by public or private insurance plans? Should these same public and private insurance plans cover the bills of physicians and hospitals that do not subscribe to reasonable utilization and quality standards established by the buyer? These appear to be reasonable "rules" for a buyer to establish.

Governments and employers cannot adopt a laissez-faire attitude toward the health care cost problem. I believe the strategies my company and many others are now implementing represent a good compromise between a fully regulated governmental system and one wherein we surrender to the sellers. Health care delivery can remain in the private sector if buyers and sellers deal with one another on the basis that sellers must compete to meet buyers' requirements. In addition, benefit plans must be structured so that health care consumers will have to pay more attention to the rules of the game established by Medicare, Medicaid or their employers *if* they want their health care bills paid by these third parties.

With these reforms in place, health care buyers should be able to control costs more effectively and take comfort in that the bills they are paying are for medically necessary services and that the amount paid represents a fair fee for the services rendered. ■

Myers

Continued from page 54

this is the pressure from budgeteers, who wish to use the recurring excesses of income over outgo to make easier the problem of balancing the budget. Note that, although OASDI was removed from the Unified Budget in 1986, anomalously it is included in the Gramm-Rudman-Hollings targets for necessary deficit-reduction measures.

On the benefits side, I believe that the controversial retirement earnings test will, in effect, be eliminated in the next few years for persons aged 65 and over. In theory, retirement pensions should not be paid to persons who are not substantially retired.

However, under the present relatively flexible provisions, individuals earning in the range of $10,000-30,000 have great disincentives to work because the additional net income arising therefrom is relatively small. The test should not be completely eliminated but, rather, persons who go on working substantially should receive actuarially equivalent higher benefits when they retire later. Present law provides for this treatment for those who reach the normal retirement age in 2009 (then age 66). This change should be advanced to 1988, and this can be done at relatively little cost.

As to the hospital insurance portion of Medicare, financing problems will arise in the next 10-15 years unless the presently scheduled level tax rate is increased (or benefits reduced). This is a problem that is not unique to Medicare, but rather is also present for the private health insurance coverage for active workers and their dependents. In some way or other, the nation must face the problem of escalating health care costs (even though they are not rising as rapidly now as they did in the early 1980s)—either controlling utilization and unit costs, or paying the higher cost involved.

The supplementary medical insurance portion of Medicare (primarily relating to physician services) is now soundly financed from an actuarial standpoint, because it is on a "one-year renewable term" basis. Nonetheless, the fiscal problem is present that its cost is rising rapidly, for both the enrollees and the General Fund of the Treasury. This is evidenced by the 39% rise in the premium rate promulgated for 1988 (although part of the rise is due to the technical reason that the 1987 rate was intentionally kept low so as to use up excessive reserves that had been accumulated in the past).

The major problem in the area of health care for the aged is long-term custodial nursing home care. As the proportion of very old aged within the population aged

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It sh... recognized that many
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econo... ladder do not have as
good li...g conditions in their
homes as they would in a well-run,
high-quality nursing home.

Accordingly, the answer to this problem would seem to be a significantly liberalized public-assistance basis, but with strong, well-enforced provisions for recovery of governmental program costs from the assets of the individual after death. ■

Ferguson

Continued from page 55

A very different type of adequacy issue comes from a basic structural defect in private plans: their inability to keep up with the cost of living.

Congress has begun to focus on the problem created when workers in a final pay plan change jobs and are left with benefits frozen at their then current salary levels. One solution to this wrongly labeled "portability" problem, recently put forward as an option by the Congressional Budget Office, is to follow the lead of Great Britain and require indexing of deferred vested benefits. At the moment, this approach is perceived as "politically unrealistic," but that could change fairly quickly.

The most difficult adequacy issue and the one likely to attract the most widespread public attention is the absence of indexing of pensions.

Grass-roots retiree groups around the country have already begun to organize to protest their companies' failure to preserve the real value of their pensions. The retirees contend, very persuasively, that it is wrong for them to be paid in "yesteryear's dollars"—particularly at a time when plan portfolios have grown so dramatically. They have been joined by active workers who are protesting raids on their pension plans —the stripping from plans of assets that might otherwise have gone to improve benefits.

It is unlikely that, given the persistence of underfunded plans, Congress will mandate automatic COLAs in the near future, but there are alternatives. In the context of the plan raiding debate, the retirees are asking that employer access to "surplus" assets be conditioned on restoration of the original value of their benefits. As long-term solutions they point to a Labor Department study suggesting adoption of "performance indexing" and the possibility that the Treasury could issue "index bonds" for purchase by pension plans.

Finally, all of the equity and adequacy reforms will be illusory unless individuals can enforce their rights to the benefits conferred by the laws. Changes are urgently needed in many of ERISA's procedural provisions, particularly those relating to remedies, attorneys' fees and standard of review. Protections against discriminatory discharge and misrepresentation by plan officials are also in need of review.

The changes that are still needed in the areas of equity, adequacy and enforcement are matters of common sense. They are reasonable and, for the most part, modest, and will not cause companies to jettison their pension plans—how else can employers assure themselves of lifetime funded benefits of $90,000 a year?

This does not mean that employers will not be angered by the need to amend their plans to conform to additional changes, and bewildered by the complexity that is the inevitable product of congressional compromises "splitting the difference" between plan consultants seeking to preserve the status quo and participant representatives advocating change. But, unfortunately, this appears to be the price of progress in pension policy.

What about companies that do not have plans? Certainly, additional reforms will not encourage more companies to set plans up. But the companies now without plans tend to be the very smallest businesses where conventional plans are often inappropriate. If coverage is to increase among these companies, it will have to be the result of efforts by the administration and small business advocacy organizations to educate small employers about the availability of easy, low-cost "starter" plans such as Simplified Employee Pension Plans. ■

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Kaplan

Continued from page 56

Given this thesis, health care will begin to consume 12% to 14% of our gross national product by the year 2007 if we do not face several crucial challenges that confront us in the health care field.

Employers, administrators and consumers need to encourage the further development and expansion of behavioral medicine and health promotion. Generally, behavioral medicine refers to programs that involve lifestyle changes and medical interventions to cope with human disease. Health promotion focuses on lifestyle changes to prevent disease and achieve optimal health.

There is a growing interest by health researchers and clinicians in behavioral medicine and health promotion, underscoring the seriousness of the major health problems facing our nation, including cancer, heart disease, addiction and stress.

The work of these researchers and clinicians has revealed the importance of psychoneuroendocrinology, the study of hormones and their effects on psychological and physiological health, and psychoneuroimmunology, the study of the relationship between psychological processes and immunological functioning, to the fields of behavioral medicine and health promotion. Recent advances in medical and psychological research have forced us to evaluate previous treatment methods.

Psychoneuroendocrinologists have found that synthetic hormones, which mimic those produced naturally in our brains, can help to alleviate the symptoms of withdrawal and the desire for substances habitually consumed by addicts.

Without recourse to exogenous drugs or chemicals that stimulate neurotransmitters, Evelyn Patrick Silvers, a California psychotherapist, in her work with substance abusers has been able to develop a short-term psychotherapeutic approach based upon the natural chemistry of the brain. Her technique is being utilized to achieve uncomplicated withdrawal and to alleviate addiction. The therapy involves three or four visits. Follow-up after 11 months has shown no relapses. Patients so far have been from upper middle class and executive backgrounds. There is no apparent reason to assume the treatment would not be equally effective with all economic groups and educational levels. The technique allows individuals who would not be comfortable in an Alcoholics Anonymous-type program to regain control over their lives.

Research in the field of psychoneuroimmunology has demonstrated

Continued on next page

Kaplan

Continued from previous page

that stress can reduce the body's ability to fight disease. And finally, researchers in behavioral medicine have found that physiological and psychological health are significantly affected by a person's behavior, personality and environment. During the last decade, key discoveries have been made about many specific interactions between mind and body in health and disease. Researchers have traced the vital, inextricable links between the central nervous system and the immune system. Using their findings, clinicians have developed programs in behavioral medicine and health promotion which complement standard treatment of cardiac disease, diabetes, pulmonary disease, hypertension and other chronic maladies.

Probably the most successful example of this development for cancer patients is The Wellness Community. With the discovery in the field of psychoneuroimmunology that positive emotions and mental activities may increase the possibility of recovery from cancer, The Wellness Community has taught over 5,000 cancer patients how to use the health-enhancing techniques that have evolved from this scientific breakthrough.

The next 20 years will focus on the application of these recent developments. There is a major change taking place in the realm of basic research, clinical application and public policy for health care. This change will enable us to develop and evaluate the health and economic efficacy of the new medical plans and health promotion programs in the workplace. And, hopefully, behavioral medicine will lead to good health promotion which will replace the wallet biopsy as our most common medical procedure. ■

Brennan

Continued from page 57

Howard C. Weizmann, manager of benefits planning and design for Sun Co. Inc., is especially taken by the equity of the career average formula of cash balance. Noting that final average pay plans favor long-term employees, he remarks, "Each year's work ought to be worth the same toward retirement income."

He also prefers cash balance plans to defined contribution retirement plans. Benefits under the latter are not guaranteed and "can be wildly unpredictable," Mr. Weismann points out, whereas under cash balance plans "we can protect employees from down-side risk."

Given such favorable reaction and the likelihood that business conditions that have been conducive to the adoption of cash balance plans will prevail for the foreseeable future, I am confident that other companies will follow.

Although inflation, the least controllable and least predictable cost of final average pay pension plans, has subsided, the fear of a new inflationary spiral remains. This concern will continue to make companies receptive to a pension plan concept that affords management a better ability to forecast long-term costs and at least some flexibility to moderate them in the short run.

Moreover, as U.S. corporations continue to reorganize, dispose of marginal operations and acquire or launch new ventures to become more competitive, labor costs—including employee benefit costs—will remain under scrutiny even if high inflation is not feared.

Whether acquiring businesses or becoming candidates for acquisition by others, companies will find cash balance plans advantageous in other respects. Cash balance pa.
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powerful inducement raditional pension plans, benefits in the early years barely perceptible. While itional plans may be more popular with long-term employees, their preferences may be subordinated to recruiting needs inasmuch as such employees can be accommodated in the transition from a final average pay to a cash balance plan. In fact, current developments indicate cash balance plans may be a popular benefit with hourly employees as a substitute for traditional lock-step flat dollar pension plans.

As powerful as it is, the sight of capital accumulation every time an employer's quarterly statement comes out is not the only aspect of cash balance plans that will appeal to employees in the future. In all probability, people will continue to seek to achieve greater job satisfaction by changing employers or be obliged to switch jobs because of mergers, restructuring and other employer actions. The portability feature of cash balance plans will be very important to them, as it is to participating employees today. This feature alone is not likely to determine whether people change jobs, but given that they will do so, it will help to assure them adequate retirement income to a far greater degree than traditional pension plans now do.

Having fused the best features of both defined benefit and defined contribution plans, cash balance plans have a bright future indeed. ■

Seidman

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OSHA standards are needed for major safety and health hazards such as formaldehyde, methylene chloride and confined space hazards. AIDS and hepatitis B in health care settings are also major concerns which must be met by regulation and educational efforts.

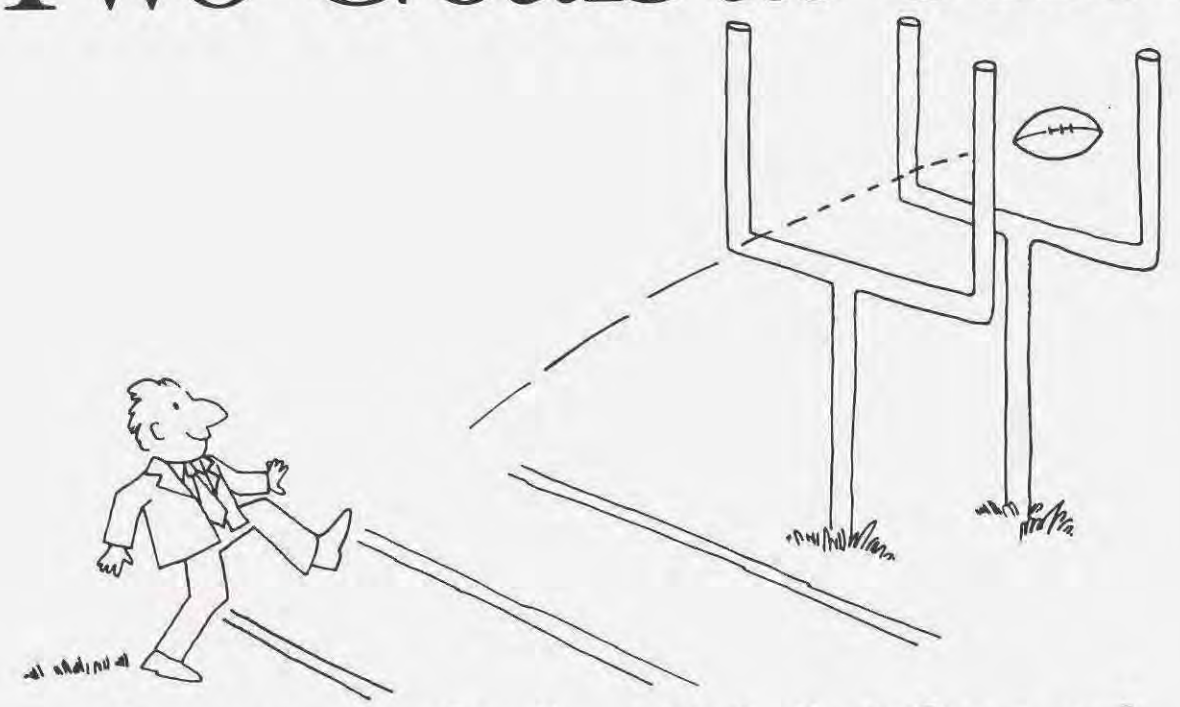
Passage of the High Risk Occupational Disease Notification and Protection Act, approved by the House last month, is urgently needed to establish a modest federal government program to notify workers who are at increased risk of occupational disease and provide them the opportunity for medical surveillance to detect these diseases.

Legislation is also needed to protect farm workers exposed to pesticides, and workers in nuclear facilities of the Department of Energy should be given the full protections of the OSHA law.

This is our agenda for preserving basic protections for workers and their families and expanding them wherever possible. Will labor succeed in these efforts? Not in a climate hostile to employee interests in which employers seek to destroy unions by every method at their command. Nor will we be successful in an economy which leaves millions of workers jobless or in involuntary part-time employment or forces them out of decent jobs into employment at poverty-level wages and with no benefits.

Workers can make progress only when their legitimate needs and aspirations are recognized and there is an expanding economy and full employment. Those are the objectives that labor seeks as the soundest foundation for decent employee benefits. ■

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Rosenbloom

Continued from page 59

when the first course in the program was introduced in January 1977, there was an exceptional response of interest from the benefits community and the introduction and development of the complete CEBS program was shortened from five years to three.

By 1980, the 10 courses were in place, and a charter class of 167 individuals received the first CEBS designations.

Shortly thereafter, realizing the importance of continuing education in this dynamic industry, the IFEBP helped establish the International Society of Certified Employee Benefit Specialists. The society's mission is to assist the nearly 2,000 CEBS graduates in keeping their designation current and meaningful.

The society has a network of 18 local chapters, publishes its own scholarly journal, Benefits Quarterly, and offers a continuing education course and examination affording a route to the status of Fellow.

In addition, its annual meeting has become the setting for the annual CEBS conferment ceremony for new graduates.

Today, thousands of individuals are pursuing the CEBS designation. The program has matured from just an idea into an important ongoing activity and an established medium of education in the employee benefits field. In 1987 alone, more than 11,000 examinations were administered. Courses

Dramatic growth and progress have been the watchwords of the CEBS program since its inception.

in the program are now recommended for undergraduate and graduate college credit by the American Council on Education. Each year CEBS classes are taught at more than 70 colleges throughout the United States.

Dramatic growth and progress have been the watchwords of the CEBS program since its inception. Continual course revisions have become mandatory to keep pace with the endless stream of legislative and regulatory activity. If anything, today's benefits field has become more complex than ever, and professional development is the only way for practitioners to keep abreast of new developments.

For this reason, we expect CEBS participation to become even more widespread throughout the employee benefits industry within the next 20 years.

Senior benefits positions in both provider firms and plan sponsor organizations will be staffed by CEBS graduates. If mandatory continuing education requirements are established in the future for all benefit professionals, continuing education through organizations such as the International Society of Certified Employee Benefit Specialists will take on greater significance.

Also, international expansion started with the Canadian CEBS program in 1985 and further international programs are a distinct possibility in the future.

The future of the employee benefits field and the CEBS program seems rosy. The need for qualified individuals to design and administer employee benefit programs will be even more essential in the future as all the regulatory changes enacted take shape and benefits become even more of a major component of everyone's financial security. ■

Hembree

Continued from page 62

80% will be enrolled in alternative delivery systems.

- Mandatory second opinion programs also will have faded since employees will be empowered enough to thoroughly research not only the necessity/advisability of the procedure, but also data will be available that will allow employees to improve the expected outcome of a medical procedures by careful selection of providers. In addition, since the majority of employees will be in alternative delivery systems, this will help ensure that the procedure is needed.

Some of the vital ingredients necessary in creating and adopting these profound changes are:

- Overcoming resistance to change.
- Top management support and leadership.
- Employee involvement in the planning/implementation process.
- A long-term commitment.
- Clearly defined and measurable objectives.
- Family involvement.
- A strong monitoring and evaluation component.

Without question, wellness will positively affect employee benefit/compensation programs, the workplace and the worker enormously over the next several decades. The only real questions are: Who will benefit the most and can the transition occur quickly enough to avoid a mandated universal health care system induced by health care cost increases?

Kuhlman

Continued from page 63

choices that were meaningful during an employee's working life may also be attractive post-employment. And the cost management opportunities of flexible benefits would apply for post-retirement welfare benefits.

I believe that many employers will link retirement income plans and retiree welfare benefits under a total post-retirement strategy. The strategy would address the appropriate mix of defined benefit, defined contribution and welfare plans in meeting total post-retirement obligations. In addressing this mix, employers would need to analyze:

Employers will link income plans and welfare benefits under a post-retirement strategy.

- The total post-retirement needs of retirees, including the need for new benefits and long-term care.
- The extent to which the employer, the government and the employee are responsible for meeting these needs.
- The cost of the employer's share of the total responsibility, and the expensing and funding mechanisms needed to fulfill this obligation.
- The vehicles required to enable employers to save annually to meet their share of the obligation.

Employers can look toward the development of benefit strategies that allow them to offer meaningful benefits to retirees at manageable costs. ■



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Time capsule: 1970

A recent report prepared for the Civil Service Commission says that health insurance premiums for federal employees will rise between 10% and 35% every two years between now and 1976.

The report says the increases probably will average between 20% and 25%. And, because federal workers' health benefit plans are considered to be industry bellwethers, experts note that premiums for non-government health insurance plans can be expected to increase a similar amount (*BI*, March 2, 1970).

* * *

Health insurers generally agree that group and individual health plans will cover the costs of abortions if a liberal law on the procedure is enacted in New York.

The most liberal abortion law in the country appears on the way to passage in the state Legislature, and the insurers agree that they will have to cover whatever abortions are allowed if the bill becomes law. As one insurer put it, "I don't see how the hell we could exclude it from coverage" (*BI*, March 30, 1970).

* * *

A Labor Department study of private pension plans reveals that 19.5 million people were covered under such plans in 1969, up 25% from 1962 and up 12% since 1967.

The study also showed that multiemployer pension plans are growing faster than single-employer pension plans; non-contributory pension plans are growing faster than contributory pension plans; and that the number of people covered by pension plans with vesting provisions also is increasing (*BI*, March 30, 1970).

* * *

A unique new vision care plan has been developed for members of the Plumbing, Heating & Cooling Contractors of San Francisco Inc.

The vision plan, which is the first in the nation provided by a trade association to its members, also allows individual members to include their dependents for an additional small premium (*BI*, May 11, 1970).

* * *

Robert Finch, the secretary of health, education and welfare, has urged that the country move slowly on a program of national health insurance.

In presenting what is seen as the Nixon administration's position, Mr. Finch says that to move too quickly "would invite literal chaos" (*BI*, May 25, 1970).

* * *

During 1968, the nation's employers spent an average of 6% of total compensation costs, or 24 cents per hour, on retirement plans, making it the single largest non-wage cost.

The survey by the Bureau of Labor Statistics also reveals that employers spent 15 cents per hour, or 3.7% of total compensation, on health care and insurance programs, an increase of 25% over 1966 costs (*BI*, May 25, 1970).

* * *

Sen. Abraham Ribicoff, D-Conn., has asked for a general study of the private health insurance industry.

The senator has requested a federal investigation of the more than 1,200 private health insurance plans operating in the country, including group health insurance for employees, in an attempt to help consumers better understand the coverage they or their employers provide (*BI*, June 8, 1970).

* * *

A bill recently passed by the House that calls for automatic cost-of-living increases in Social Security also will encourage the growth of health maintenance organizations.

The bill permits Medicare beneficiaries the option of having their health care provided by an HMO, in a move designed to stimulate the formation of physician group practices (*BI*, June 8, 1970).

* * *

President Nixon's task force on aging has recommended that an independent pension commission be formed to protect employees' rights and that a voluntary system of pension portability be devised for employees in occupations in which conventional group pensions are rare.

The proposed pension commission would be similar to the Securities and Exchange Commission, except that it would be financed by fees paid by the plans (*BI*, July 6, 1970).

* * *

A United Steelworkers Union local in Pittsburgh has agreed to withdraw a suit charging antitrust violations against Ling-Tempco-Vought Inc. in its proposal to acquire Jones & Laughlin Steel Corp., after personal assurances from LTV officials that they would not "raid" the union pension plan.

The union brought the suit in the wake of rumors of layoffs, plant closings and raids on the pension plan if Dallas-based LTV succeeds in its acquisition plan (*BI*, July 6, 1970).

* * *

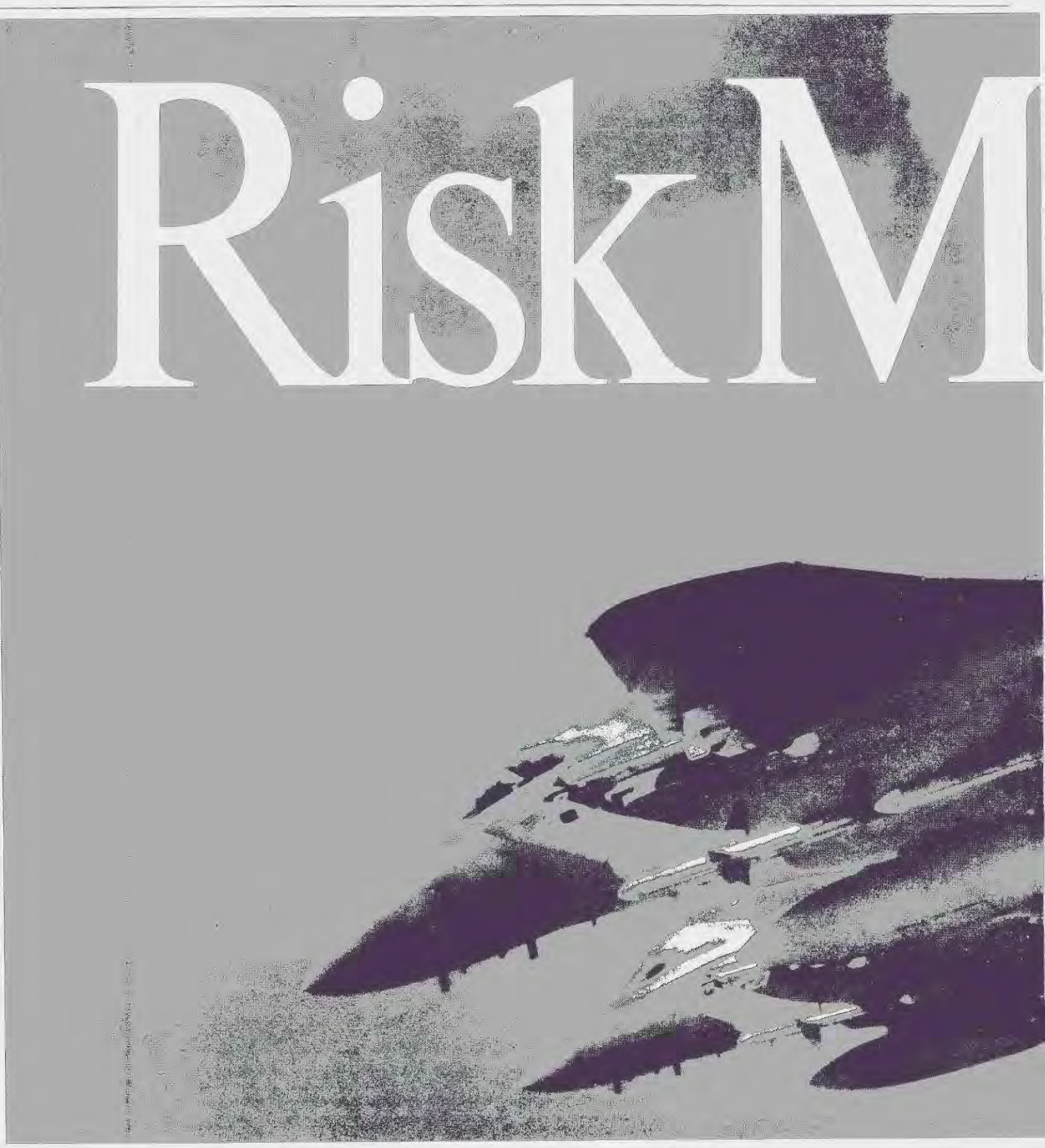
Employee benefits spending reached an average of 31% of payroll for U.S. employers in 1969, according to an employee benefits official for Quaker Oats Co.

He said that employers' expenditures for employee benefits was about $40 per employee per week in 1969, up from $20 per week in 1959 and $10 per week in 1949. And, he predicted that the benefit expenditures would continue to increase (*BI*, Nov. 9, 1970).

* * *

The United Auto Workers, in a major victory for older workers, has succeeded in including the principle of "30 and out" in its new three-year contract with General Motors Corp.

Under the new contract, GM has agreed that years of service, not age, should be the factor for determining employee pension benefits. GM employees will be eligible to retire with a pension after 30 years of service at age 58, and a reduced pension at less than age 58. The age requirement will be reduced to 56 effective Oct. 2, 1972, the second year of the plan (*BI*, Nov. 23, 1970). ■



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Time capsule: 1971

While the Baltimore Colts were beating the Dallas Cowboys in Super Bowl V, the 1,200-member NFL Players Assn. reached a tentative agreement with team owners to provide players with a pension at age 55.

Under the tentative agreement, a player with 10 years in the league would be eligible for a pension of $50 per month for each year played. The pension question had been disputed earlier in the season when the players' association threatened to strike over that and other issues (*BI*, Feb. 1, 1971).

* * *

President Nixon has called on Congress to approve legislation that would require private insurers to reimburse the Veteran's Administration for care it provides to their policyholders. In most cases, insurance policies presently bar reimbursement to a veteran in a VA hospital (*BI*, Feb. 15, 1971).

* * *

Business interests in New York City are lodging a strong protest against a tentative agreement reached last week by the city and the Uniformed Firefighters Assn. that would give firemen a full-pay pension after 40 years of service.

Business interests had lobbied against any pension plan improvements for uniformed city employees, claiming they could lead to "economic disaster" for the city (*BI*, April 12, 1971).

* * *

A survey of private pension plans says that 65% of covered employees are expected to qualify for pension benefits and an additional 19.6% are young enough to qualify for a pension in subsequent employment.

The study, prepared by A.S. Hansen Inc. for the U.S. Treasury Department, was designed to answer congressmen's criticisms of private pension plans and stave off pension reform measures in Congress (*BI*, May 10, 1971).

* * *

The Nixon administration may sponsor a pension reform bill that would require "50-point" full vesting.

Under the proposal expected to be advanced by the administration, workers would be fully vested in their pensions when their age and years of service total 50 (*BI*, May 24, 1971).

* * *

Powerful Republican Sen. Robert A. Taft has joined some of his more liberal colleagues in urging pension reform.

Sen. Taft called on Congress to take "affirmative steps to protect the pension rights of America's working men and women." Specifically, he said Congress should act to assure reasonable vesting and actuarial soundness, control actions of plan trustees and prevent cuts in private pensions in the wake of increases in Social Security benefits (*BI*, July 19, 1971).

* * *

Illinois Gov. Richard B. Ogilvie is expected to sign a bill calling for a fully paid health plan for the state's more than 86,0000 workers.

The plan, which would take effect Jan. 1, 1972, is expected to cost $16 a month per employee (*BI*, Aug. 16, 1971).

* * *

Employers and their insurers still are looking for answers to their questions about the wage-price freeze, nearly two weeks after it was announced by President Nixon.

However, it is clear the edict freezes increases in employee benefits and allows no pension plan increases or new profit-sharing plans to be implemented. And, although premium levels for custom-rated corporate insurance programs can be adjusted based on the loss experience of the buyer, rating principles applied must be those in effect in July or August of this year (*BI*, Aug. 30, 1971).

* * *

A Labor Department survey shows that 25 million Americans work for private employers who provide no retirement plans to supplement Social Security.

Most of these workers, the study notes, are employed by small, non-union firms that pay low wages. In contrast, 30 million workers are covered by private pension plans, and most of them are in unionized companies (*BI*, Aug. 30, 1972).

* * *

The nation's health insurers say they cannot support proposed federal standards for the regulation of the health insurance industry.

The proposal, offered by Department of Health, Education and Welfare Secretary Elliot L. Richardson, would set several federal regulatory standards and would set up a compulsory health insurance program paid for by employers and employees and underwritten by private health insurance companies (*BI*, Oct. 25, 1972).

* * *

The federal Pay Board says it is "fairly final" that the 5.5% wage increase ceiling under Phase II economic policy includes benefits.

The board says that, at least so far, it has found no situation to justify changing its position that "everything you get as an employee working for someone comes under that single 5.5% limit" (*BI*, Nov. 22, 1971).

* * *

Both business and labor appear to support a recent Supreme Court decision that employers are not required by law to bargain with unions on benefits for retired workers.

The decision reverses a ruling by the National Labor Relations Board and is hailed by employers as making the negotiation process more workable. Most union leaders agree (*BI*, Dec. 20, 1971).

* * *

The Nixon administration has proposed a pension reform package that includes rules allowing vesting when an employee's age and years of service total 50, and tax breaks for employee pension contributions.

The proposal to Congress does not include any provisions on pension portability, and says that further study is needed on the subject of funding of pension plans that terminate (*BI*, Dec. 20, 1971). ■



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Managed health care continues to evolve

By DONNA DiBLASE

In its relatively short history, the concept of managed health care has changed tremendously, at the same time forcing dramatic shifts in the American health care delivery system.

The concept of managed care—including the use of health maintenance organizations, preferred provider organizations, utilization review and multiple option health plans—has evolved from a cost management technique used only by the most sophisticated and largest employers to a commonplace and necessary part of most employers' benefit plans.

And, most health care experts predict more changes in the near future in managed care plans, the nation's health care system and the role of employers in the management of health care costs and quality.

"Managed care has evolved from a dynamic awareness of how illnesses are treated and the need for objective accountability" by health care providers for the quality, necessity and cost of the services they deliver, said Dr. Robert J. Becker, chairman of HealthCare COMPARE, a Lombard, Ill.-based health care management firm.

The first step toward what is now known as managed care was the HMO, a prepaid health care plan in which to receive coverage enrollees must receive health care only from providers participating in the network.

HMOs have existed in some form since the 1930s, when Dr. Sidney Garfield offered a prepaid health care program to workers constructing an aqueduct in the Los Angeles area.

In 1933, the premium was 5 cents a day or $18.25 annually (*BI*, Dec. 19, 1983).

Shortly after that, Dr. Garfield was asked to run an industrial health plan for workers at Kaiser Steel Corp.'s steel companies and shipyards on the West Coast. By 1945, the Kaiser-Permanente Health Plan provided health care to about 200,000 people in San Francisco and Fontana, Calif., and Portland, Ore., a Kaiser spokesman explained.

Today, Kaiser-Permanente has more than 5 million enrollees in 16 states, he said.

Some 40 years later, the Federal HMO Act of 1973 was enacted to assist in the expansion and establishment of HMOs.

Among other things, the law includes provisions requiring employers to offer employees enrollment in a federally qualified HMO, when one available in its area requests to be offered. The law also establishes certain requirements that have to be satisfied by an HMO seeking federal qualification.

Under the law, employer contributions toward the premiums of any federally qualified HMOs they offer have to be equal to contributions to any indemnity plans.

Since 1973, the HMO market has expanded dramtically. As of March, there were 654 HMOs with a total enrollment of 27.7 million, according to Interstudy, a health research organization in Excelsior, Minn.

Some health care and benefits experts say employers were partly responsible for the rapid growth of HMOs.

"Employers were facilitators of HMO growth in the sense that they welcomed and offered them to their employees because they believed" in the concept of managed care, said Laird Miller, president of Health Systems Management Inc., a Minneapolis-based health care consulting firm.

As the development of HMOs picked up speed, "employers started to realize that maybe managed care wasn't draconian, as they saw large numbers of employees willing to live in a managed care environment," said David Rahill, vp at Johnson & Higgins' HealthGroup in Princeton, N.J.

But, as HMOs became more prevalent, employers also became more sophisticated in both analyzing whether the prepaid plans really were saving them money and in negotiating premiums with HMOs, benefits experts say.

"Over the last six or eight years, employers have become a lot more sophisticated. They realized they were subsidizing HMOs while their indemnity plan costs continued to skyrocket," observed Elliott Segal, principal and manager of health care consulting in the Washington office of William M. Mercer-Meidinger-Hansen Inc.

And, once employers experienced increasing premiums and realized the effects of adverse selection—when all of an employer's young, healthy employees enroll in an HMO, leaving older or more frequent utilizers of health care in the indemnity plan—several changes occurred, health care experts say.

"I think that HMOs are going to change radically over the next 10 years. They will have to produce management information, flexible rating and the cash-flow alternatives employers are used to with their insurers," predicted Laird Post, consultant and leader of The Wyatt Co.'s group and flexible benefit practice in Los Angeles.

Not only have HMOs been forced to become more efficient, but also some health experts say employers' frustration with HMOs and growing sophistication in health care management may have contributed to the rise and rapid expansion of PPOs.

"There are stampedes toward fads, and the first stampede was toward HMOs. But, when questions about underutilization of health care, quality and freedom of choice of providers arose, the next stampede was toward PPOs," observed Dr. Becker of HealthCare COMPARE.

"A lot of people really rejected the lock-in feature of HMOs and this may be why employers really embraced PPOs," said Ruth Stack, executive director and president of the National Assn. of Employers on Health Care Action in Miami, referring to the fact that HMO enrollees must receive health care only from providers in the HMO network to receive coverage.

"There is more recognition of the importance of choice today. That's why we'll see more growth of PPOs," predicted Robert Chernow, president of Hartford, Conn.-based Corporate Health Strategies Inc., a managed health care subsidiary of Metropolitan Life Insurance Co. in New York.

The PPO market grew the most in the early 1980s, when several states passed legislation permitting the development of the delivery systems.

A PPO is a contractual agreement between a health care purchaser-such as an employer or an insurer-and health care providers. Under most agreements; providers agree to deliver health care services for prospectively negotiated fees in return for a certain market share of patients. The arrangements also include mandated utilization review of health care services.

PPOs, which basically are modified indemnity plans, do not require covered individuals to be enrolled and offer them freedom of choice of providers with incentives-such as lower out-of-pocket expenses-to use preferred providers.

As of June, there were 570 PPOs, most of which were developed between 1983 and 1986, according to the American Medical Care Review Assn. in Bethesda, Md.

The PPO market was dominated in its early years by PPOs sponsored by entrepreneurial groups and health care providers. Providers saw PPOs as an opportunity to regain or retain slipping market share resulting from government and private-sector cost controls.

However, the major hospital corporations that developed and offered their own insured managed care programs failed, turning the market almost entirely over to the major health insurers (*BI*, Sept. 29, 1986).

And, some benefits experts note that insurers may be the best at managing PPOs and other managed care plans.

"PPOs really are a managed version of an indemnity plan, which is what insurers know best," Mercer's Mr. Segal contended.

"Insurers have really become the backbone of managed care. I'm hoping they'll take advantage of their skill in managing data and have an impact on medical care delivery," said Dr. Paul Ellwood, chairman of Interstudy.

However, Wyatt's Mr. Post said that "PPOs are only a transition. I don't think PPOs will be the end result in the development of managed care."

In fact, most insurers have already taken their managed care products a step further, introducing what is known as the triple option or multiple option managed care plan.

Under these plans, an employer can purchase an indemnity plan, a PPO and an HMO for one experience-rated premium. Insurers tout the easier administration and one-stop-shopping advantages of these plans.

The plans usually offer employees the option of a quarterly or annual enrollment in the HMO, or the choice of remaining in the indemnity plan with financial incentives for using providers in either the HMO or PPO network. The indemnity plan usually includes strict utilization review requirements.

However, the plans, which were introduced about a year ago, have been slow to catch on, some benefits experts say.

"We see some growth in this area, but this is really a niche product who's growth will be dictated by local markets," predicted Mr. Rahill of Johnson & Higgins.

While these plans can offer employers a completely managed health care plan, employers may have to give up some of the indemnity plan controls they've become used to, like self-funding, one expert says.

"One of the trade-offs of these plans is that insurers may ask the employer to give up self-funding because the insurer may need the premium for the plan upfront. Employers have to be extremely cautious of giving this up," said Mr. Post of Wyatt.

"Insurers want employers to come back to them because in the 1970s, we saw a lot of employers go to self-funding—and they saved a bundle. We advise employers to be skeptical and very careful before jumping into a plan like this," he explained.

Many health care experts predict even more changes in the managed care market in the near future.

For example, some believe that utilization review-which has typically been used to determine the necessity of inpatient health care-will become more sophisticated and will be used to monitor outpatient care as well.

The concept of utilization review originated with the professional standards review organizations set up by the federal government to monitor care delivered to Medicare beneficiaries and by state governments to monitor the care of Medicaid patients.

As managed care continues to evolve, "there is going to be an incredible recognition of the importance of having good information in order to set up managed care arrangements," predicted Mr. Chernow of Corporate Health Strategies.

Managed care companies and providers will then be forced to compete on the basis of quality instead of merely on the basis of price, experts agree. ■



Time capsule: 1972

An expert predicts that the number of Americans with group dental coverage will grow to between 75 million and 100 million in the next decade, from the current 7 million.

Roy L. Lindahl, chairman of the Council on Dental Care Programs, called dental care "one of the major medical problems of the '70s," and added that group dental care should help curtail the more than 100 million man-hours lost in 1971 because of dental problems (*BI,* Jan. 3, 1972).

* * *

Rep. Wilbur Mills, D-Ark., chairman of the House Ways and Means Committee, told members of the Assn. for Advanced Life Underwriting that, despite years of discussion and months of formal testimony, it is unlikely that Congress will enact pension reform or tax legislation this year (*BI,* Feb. 28, 1972).

* * *

Major league players are taking the field again after a 13-day baseball strike, and they are coming back with an 8.5% increase in their pension benefits.

Under the agreement between the players and the owners, $500,000 of the existing surplus in the pension fund will be used to increase benefits to offset the 17% cost-of-living increase since the plan was negotiated three years ago. Players had requested that the whole surplus of more than $1 million be used to increase benefits (*BI,* May 8, 1972).

* * *

The Committee for National Health Insurance, chaired by United Auto Workers President Leonard Woodcock, charges that six major group health insurers reaped "windfall" profits of $96 million last year as a result of the wage-price freeze and the poor job market. Insurers deny the charge.

The committee says the six insurers, which write about half the group health insurance for all U.S. workers, realized the financial gain because the premiums they charged for 1971 and many 1972 health insurance contracts anticipated that health care costs would continue to increase. However, those costs were frozen, meaning that the premiums charged by the insurers were inflated, according to the committee (*BI,* July 3, 1972).

* * *

A congressional commission has recommended major changes to keep the nation's 37-year-old railroad retirement system from going bankrupt.

The commission's recommendations to President Nixon and Congress include an immediate 2% payroll tax on both employers and employees to keep the system solvent. The problem, according to the panel, is that there are not enough active rail employees to support the retirees: About 600,000 active employees currently contribute to the plan, which is paying benefits to more than 1 million retirees (*BI,* Aug. 28, 1972).

* * *

More than 1 million union workers in California and their dependents are now covered by health care plans that are fully employer-funded.

Some 421 major plans help pay hospital, surgical and other medical costs for 1,070,790 workers, which represent 98% of non-farm wage and salaried employees in California who belong to unions (*BI,* Aug. 28, 1972).

* * *

Democratic presidential candidate Sen. George McGovern is proposing his own set of pension reforms, including full 10-year vesting.

Sen. McGovern charges that the Nixon administration and the U.S. Chamber of Commerce have teamed with the Senate Finance Committee to "cheat American workers" by undercutting the proposed Williams-Javits pension reform bill. He is calling for a standard requiring that employees be vested in 50% of their pension benefits after five years of service, and vest at a rate of 10% a year for the following five years (*BI,* Oct. 9, 1972).

* * *

Proponents of the concept say flexible benefits, which allow employees to choose all or some of their benefits from a list of options, will be worth the effort.

Benefit experts say that flexible plans will not increase employers' benefit costs, and actually may help slow their increase.

In addition, they say flexible benefits will improve the relationship between employees and employers and may provide more opportunities for good employee benefits communication (*BI,* Dec. 4, 1972). ■

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STATUTORY SURPLUS (000 Omitted)	COMBINED RATIO
1987 – $61,783*	1987 – 77.2*
1986 – $53,063	1986 – 84.1
1985 – $37,037	1985 – 99.7
1984 – $16,739	1984 – 97.0
1983 – $12,238	1983 – 94.9
1982 – $11,084	1982 – 99.1

5 YEAR COMBINED RATIO: 92.9 (1982-1986)

ASSETS (000 Omitted)	LOSS RESERVES (000 Omitted)
1987 – $157,388*	1987 – $50,402*
1986 – $159,568	1986 – $46,243
1985 – $105,993	1985 – $22,784
1984 – $ 48,719	1984 – $ 9,150
1983 – $ 35,156	1983 – $ 4,985
1982 – $ 36,171	1982 – $ 4,455

*Six months results ended June 30, 1987

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Self-insurance propels growth of TPAs

By DEBORAH SHALOWITZ

Employers over the past 20 years have increasingly self-insured their group health benefits, turning their backs on group health insurance plans written by commercial insurers.

And, this trend has spawned a new industry—third-party claims administration—that provides services for employers that self-insure their group health plans.

"The growth of the TPA market can be traced directly to the self-insurance market," said David Rahill, vp of Johnson & Higgins HealthGroup in Princeton, N.J.

"Twenty years ago, for someone to self-insure was a rarity," observed Robert O'Meara, a consultant in the group benefits area of Lincolnshire, Ill.-based Hewitt Associates, referring to employer-sponsored group health plans. "Now, for people to insure is a rarity."

According to an annual survey, the "Employee Benefits in Medium and Large Firms," conducted by the Labor Department's Bureau of Labor Statistics in 1986, 37% of the workers with employer-sponsored major medical benefits were covered by self-insured plans.

The survey covered approximately 21 million full-time workers at companies with more than 100 employees.

In contrast, 20% of the workers were covered by self-insured major-medical plans in 1982 and 11% were covered by self-insured plans in 1979, according to the Labor Department.

But the actual percentage of workers whose employers self-insure their health benefits may be even larger than the Labor Department survey indicates, some benefit experts contend.

"Across the country, we're probably looking at 50% to 60% of participants in health plans under something other than a traditional insurance plan," estimated Jay Catlin, a benefit consultant in the Harmon Meadow, N.J., office of Buck Consultants Inc.

The trend toward self-insurance has been especially strong among medium-sized and large employers.

During the early 1970s, 'employers. . .started to look at the reserves being held by insurance companies on their behalf,' Mr. Catlin says. They realized that 'if they could get some control over these dollars, they could affect the bottom line.'

According to a survey conducted in 1984 by the U.S. Health Care Financing Administration, the percentage of organizations with self-insured health plans rises with the number of employees in the organization.

HCFA found that of organizations with between one and 99 employees, only 6% self-insured their group health plans.

The percentage of companies self-insuring their group health plans grew to 24% in companies with between 100 and 249 employees; to 43% in companies with between 250 and 999 employees; to 71% in companies with between 1,000 and 4,999 employees; and to 80% in companies with more than 5,000 employees.

Employers began to consider self-funding their group health benefits in the late 1960s and early 1970s because of several financial influences.

"It was the economy in general and the cost of money specifically that drove people from" traditional insurance for group health plans, pointed out Hewitt's Mr. O'Meara.

Mr. Catlin of Buck agreed. He explained that during the recession of the early 1970s, "employers who were having trouble with cash flow and profits started to look at the reserves being held by insurance companies on their behalf."

"It dawned on them that if they could get some control over these dollars, they could affect the bottom line" of their own companies positively, he continued.

Charles Dixon, principal in the Morristown, N.J., office of William M. Mercer-Meidinger-Hansen Inc., pointed out that many chief executive officers in the 1970s had a financial background.

In contrast, Mr. Dixon explained, during the 1950s CEOs generally had a manufacturing background and during the 1960s many CEOs had a marketing background.

With a "financial type" heading a company in the 1970s, there was increased attention paid to finances, Mr. Dixon said.

Mr. O'Meara pointed out that a cash-flow advantage to self-funding is that while premiums are usually due to an insurance company at the beginning of the month, self-insured companies have use of that money until claims must be paid.

Furthermore, by switching from traditional insurance for group health plans to self-insurance, companies do not owe state premium taxes, Mr. Catlin explained. In many states, this tax is approximately 2%.

Another factor contributing to the appeal of self-insurance is the pre-emption from state regulation granted by the Employee Retirement Income Security Act of 1974 to companies that self-insure their group health plans, observers noted.

Before the growth of self-insurance, insurers handled the administration of group health plans. However, as employers increasingly chose to self-fund these plans, new companies formed to offer plan administration services to those employers.

These new companies—third-party administrators—"fill a niche" in the administration of group health plans, said Robert Shomer, executive vp of ALTA Health Strategies Inc., a Salt Lake City-based company founded in 1960 that provides claims processing and other health care management services to employers.

Originally, many TPAs "sprung up as claims people only," or basically "check-writers," said Mr. Catlin of Buck.

Some even charged companies a fee based on the dollar value of the claims they processed, so they did not have an incentive to keep claims costs down, he pointed out.

Samuel Kaplan, chairman of U.S. Administrators Inc., a Los Angeles-based health care management company that was founded in 1962, related that some of his earliest clients were multiemployer health plans and labor unions that had just begun self-insuring their group health plans.

He explained that these groups became interested in reducing the costs of their group health plans so they could provide more benefits to plan members.

While U.S. Administrators was computerized from its inception, according to Mr. Kaplan, many experts said the turning point in the TPA industry occurred in the mid-1970s with advances in automation.

Johnson & Higgins' Mr. Rahill noted that because TPAs "didn't have long, ingrained manual payment methods," they could buy computer systems to process claims faster without losing years of investment.

According to the 1984 HCFA study, 51% of organizations with self-insured health plans hired a TPA to conduct administrative activities, 23% administered claims in-house, 20% bought these services from a commercial insurer and 6% bought these services from a Blue Cross/Blue Shield plan.

During the 1980s, the TPA industry has evolved into a sophisticated industry selling many different kinds of services to employers.

Many TPAs offer such services as claims processing, premium collection, claims review, accounting and consulting.

Mr. Rahill also noted a recent trend for TPAs to go "beyond claims payment to medical care administration."

In fact, many of the companies that traditionally were known as third-party administrators even prefer to call themselves health care management companies.

Mr. Kaplan of U.S. Administrators specifically noted that his company was not a third-party administrator. He called U.S. Administrators a "fourth-party administrator," explaining that the company maintains relationships with three other elements in the health care equation: the employee, the health care provider and the employer.

ALTA's Mr. Shomer called his company "an integrated, managed health care firm." In addition to claims processing, ALTA provides pre-certification and utilization review to its approximately 800 clients.

A recent trend in the TPA business is the development of TPA services by insurers or the acquisition of TPAs by insurance companies.

Since early 1986, Travelers Insurance Co. has been acquiring and developing TPAs, bringing its latest tally up to 11 TPAs with offices in 13 locations in 11 states, according to William R. Horne, president of The Travelers Plan Administrators Inc., the insurer's TPA subsidiary.

Mr. Horne explained that Travelers is trying to develop a national network of TPAs that will have access to the resources of a large company but will still maintain the local, entrepreneurial flavor of a small company.

Mr. Shomer predicted other insurers will follow Travelers' lead.

Eventually, this will lead to "a lot of fallout in the TPA industry," he predicted, because with the resources of a large insurer behind a TPA network, "it's going to be very difficult, at least on the major accounts, for the smaller TPAs to compete." ■

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Time capsule: 1973

A St. Louis County Circuit Court has ruled that Monsanto Co.'s self-insured medical plan is illegal because it contains "all the elements of insurance" and Monsanto is not a licensed insurer (*BI*, Jan. 15, 1973).

* * *

The U.S. Supreme Court has let stand a lower court ruling that 350 former employees of Phoenix Steel Plant in Harrisburg, Pa., are not entitled to pension benefits not approved for them by a retirement board designated by Phoenix. This decision leaves many of the steelworkers with few or no pension benefits after Phoenix folded.

The Supreme Court decision is being touted by pension reformers as further evidence of injustices in the system, but others say the case is not representative (*BI*, Jan. 29, 1973).

* * *

International Business Machines Corp. has added an adoption assistance plan to its employee benefits program.

The ground-breaking plan, which will pay 80% of eligible expenses up to a total of $800 for each adoption, was implemented because "it seemed like a good, equitable thing to do," according to IBM (*BI*, Feb. 12, 1973).

* * *

The Treasury Department has called "a big mistake" what had been thought to be a Nixon administration proposal that employer contributions to sickness, accident and disability insurance be considered taxable income to employees.

The Treasury says the proposal was included by mistake in printed tax suggestions presented to the House Ways and Means Committee by Treasury Secretary George P. Schultz. A Treasury official says the proposal was one of many that had been "kicked around in discussion, but it never should have made it into the form presented on the Hill" (*BI*, June 18, 1973).

* * *

The Senate and the House both have approved amendments to the Taft-Hartley Act to allow prepaid group legal services as a negotiable, jointly administered employee benefit.

A joint conference committee will have to meet later this month to reconcile differences in the Senate and House versions of the bill (*BI*, July 2, 1973).

* * *

The Nixon administration is studying a proposal that would require employers with more than 25 employees to offer their employees membership in a health maintenance organization as an option to traditional medical coverage.

The proposal is included in a national health insurance "action memorandum" issued recently within the Department of Health, Education and Welfare and leaked to the press by Sen. Edward M. Kennedy, D-Mass. The memo says there has been no "formal decision" on the HMO requirement (*BI*, Sept. 10, 1973).

* * *

In its current negotiations, the United Auto Workers union is demanding some form of auto industry-financed pension termination insurance.

The UAW hopes to include the pension protection provision in its negotiations on new contracts for 700,000 autoworkers at the nation's three largest car makers (*BI*, Sept. 10, 1973).

* * *

The new contract between the United Auto Workers and Chrysler Corp. includes dental coverage and a "30-and-out" retirement plan, under which a worker can retire after 30 years of service, regardless of age.

The pact also includes an agreement that Chrysler will pay any taxes levied on workers if a national health insurance program is enacted (*BI*, Sept. 24, 1973).

* * *

A bill that would limit private expenditures for medical care in the case of catastrophic illness has been introduced in the Senate.

The measure, introduced by Sens. Abraham Ribicoff, D-Conn., and Russell Long, D-La., would limit individuals' expenses to $2,000 and the first 60 days of hospitalization in the case of serious illness. It also would make available a "certified private insurance policy at a reasonable cost" to cover those initial expenses. And, low-income people would have all their expenses covered by a federal program (*BI*, Oct. 8, 1973). ■



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By 1996, corporations will provide health care benefits to one retiree for every two active workers, double today's ratio.

This demographic shift takes on even more daunting dimensions when medical cost trends are examined. Costs rose seven times faster than the Consumer Price Index last year for 1,466 employers responding to the 1986 Johnson & Higgins HealthGroup study of corporate health care benefit plans.

Meanwhile health care obligations to retirees reached $98 billion in 1986, according to government estimates. Others place the figure considerably higher. Should the FASB require recognition of current and future retiree health plan obligations, the impact on corporate balance sheets will be pronounced.

Surprisingly, only about four out of ten corporations measured their liability last year. Fewer still tried to project obligations through the next decade, J&H found.

Many employers have postponed measurement because interpretations of several court decisions seem to leave little—if any—room to deal with retiree programs.

In actuality, major opportunities lie in redesigning medical plans for future retirees and in effecting alternative funding arrangements with current retirees.

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20 years of employee benefit innovations

Flex plans surmount early obstacles

By STACY ADLER

Like so many innovative ideas, flexible benefit plans initially were the right idea at the wrong time.

But today, flexible benefit plans are overcoming the hurdles that slowed their growth.

In the late 1960s, benefit consultants—including Thomas Paine at Hewitt Associates, who is considered one of the creators of flex plans—began tossing around the idea that employers could more easily meet the diverse needs of their changing employee populations by offering employees their choice of benefits from a list of options, much the same way a person chooses a meal at a cafeteria.

But until the mid-1970s, "cafeteria plans" were only dinner talk—stalled because the first plans were extremely complicated and because there was no computer software to help administer the plans.

The first cafeteria plans were launched in 1974 at TRW Systems & Energy Group, now called TRW Inc., in Cleveland, and Educational Testing Services in Princeton, N.J.

But, other employers viewed those early plans as unique solutions to special problems. TRW, long known as a human resource innovator, was meeting the benefit demands of its highly educated employee population, which largely consisted of engineers and analysts. And, ETS used its flex plan to attract qualified personnel.

It was not until American Can Co. of Greenwich, Conn., now called Primerica Corp., launched its flexible benefits program in 1978, that other benefit managers began to take an interest in flex plans: Employers no longer perceived the benefit plan as a unique resolution to a special situation.

However, the American Can program also showed employers the problems that could arise in launching a flex plan.

First, the American Can plan was an extremely complex benefit program that led to dozens of administrative problems for the company. The employee handbook explaining the new benefit program contained more than 200 pages.

"We tried to throw in everything but the kitchen sink," said Dick Wibbelsman, a partner in the Atlanta office of consulting firm Hewitt Associates who helped design the program.

It "scared many employers," said Jim Waters, vp-employee benefits at Towers, Perrin, Forster & Crosby Inc. in New York.

Compounding American Can's problems was that there was no computer software available then to help it administer the plan.

Most of the early plans were administered on mainframe computers. Employers had to write their own computer programs—which was time-consuming and expensive.

In light of this, Wawa Inc. of Wawa, Pa., which operates a chain of convenience stores, decided in 1981 to phase in its flex plan over several years while it waited for the development of software that would help administer the plan.

Frank DiBernardino, a vp and principal with Johnson & Higgins in Princeton, N.J., who helped design Wawa's flex plan, said that when the software was developed, it helped the employer reduce its startup and administrative costs by two-thirds.

The complexity of the American Can program also alerted other employers to possible employee communication difficulties.

Although American Can developed a comprehensive employee communications campaign, the enrollment process was a nightmare, according to Mr. Wibbelsman.

Many employees made changes on their enrollment forms each time they were sent a confirmation notice of their benefit selections, he said.

Employers that considered offering flex plans in the early years also feared that these programs might have been illegal.

The first legal hurdle employers faced was the Employee Retirement Income Security Act of 1974.

Section 2006 of ERISA prohibited the development of individual salary reduction plans, cash option profit sharing and cafeteria plans that contained taxable benefits. Existing plans that contained those benefits were grandfathered, but no new plans containing those benefits were permitted.

Flex plans as known today were codified under Section 125 of the Miscellaneous Revenue Act of 1978, which permitted employers to offer employees choices between taxable and non-taxable benefits, as long as the plan did not discriminate in favor of highly compensated employees.

Under Section 401(k) of the act, employers were allowed to offer employees a choice between taking a profit-sharing contribution up front in the form of cash or deferring it into a qualified profit-sharing trust.

But there were flaws in the act: A section 125 cafeteria plan could not contain a deferred compensation option, and compensation from a section 401(k) plan could not be put toward health benefits.

These problems were corrected in the Miscellaneous Revenue Act of 1980, which permitted a cafeteria plan to include deferred compensation as long as the non-discrimination requirements of a 401(k) plan were met.

And, the Tax Reform Act of 1986 confirmed the use of salary reductions for benefit purchases.

Today, "the legal framework is now in place" for the continued development of flexible benefit plans, observed Lance Tane, chairman of the group flex practice committee in the Washington, D.C. office of The Wyatt Co.

The first employers that offered flex plans also faced other important issues: Would employees make wise choices, and would adverse selection hurt the plan? Employers feared that employees would make poor choices, such as not choosing life insurance or selecting inadequate health insurance.

In fact, one prominent, private Southeastern university, which Mr. DiBernardino of J&H declined to name, decided not to implement a flexible benefit plan because it feared that many of its employees would make poor choices.

But Wyatt's Mr. Tane said that fear was "one of the least valid concerns," because most benefit plans prior to flex plans required employee contributions and thus involved employee choice.

But Mr. DiBernardino of J&H said that flex plans are more than a repackaged version of employees' choices, since many plans offer employees a cash rebate if they opt out of certain coverages.

"These rebates give employees a stronger financial incentive than before not to participate and increases the potential" for poor benefits selection, he said.

The first employers that considered offering flex plans also were concerned about adverse selection. They feared, for example, that only employees with bad teeth would choose dental insurance.

Carson Beadle, a managing director at consultant William M. Mercer-Meidinger-Hansen Inc. in New York, said that fear was valid because "many of the early plans didn't properly price each benefit to minimize adverse selection. Multimillion-dollar mistakes in pricing were made."

To minimize adverse selection, employers since have implemented underwriting techniques, including bundling benefit choices and limiting the number of times employees can change their benefits.

Employers also have overcome many other early problems with flex plans by using a wide variety of software and pricing techniques when setting up cafeteria plans.

Hewitt estimates that more than 600 flexible benefit plans are operating today and several trends will push this number higher.

For example, many employers today are interested in expressing benefits to employees as part of their total compensation, because the percentage of compensation provided by benefits represents between 30% and 40% of total compensation, according to Wyatt's Mr. Tane.

Still, some employers with weak benefit plans may be reluctant to implement a flex plan. These employers may not want employees to see their small hidden paychecks, benefit consultants said.

This was the scenario at a professional service firm in New York that had a slim pension plan and required large employee contributions to its health care plan. Many female employees of the firm opted out of coverage entirely. When the firm's average contribution per employee to the plan was tabulated, the number was very small, so the company rejected the idea of offering a flex plan, explained Mr. Waters of TPF&C.

Adding to the increasing popularity of flex plans among employers is the rise in merger and acquisition activity. Flexible benefit plans allow employers that are merging to combine their benefit plans without changing the benefits for either group of employees, because all of the choices of both companies' plans can be included on the menu.

Similarly, as companies grow, they may find that employee benefit demands will vary either in each industry in which those companies are involved or in each region in which they operate.

Employers also can control their benefit costs through flexible benefit plans, benefit consultants say. For example, if the cost of providing a benefit under a flex plan escalates faster than the employer's contribution, employees are forced to pay the difference.

But some employers question the ethics of shifting this responsibility to employees. In fact, one Fortune 50 manufacturer rejected the idea of implementing a flex plan because it felt a moral obligation to provide insurance for its employees regardless of the cost, one consultant said.

Today, many consultants fear that too many companies are implementing cafeteria plans because they are in vogue. Consultants caution that flex plans should serve their original purpose: to meet the diverse needs of a changing employee population. ■

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Appeal of vision care benefits declines

By KARI BERMAN

Vision care coverage—one of the hot, new benefits of the 1970s—is losing its appeal, and benefit experts expect that an increase in the small percentage of employers currently offering the benefit is not in sight.

"Vision care coverage is not very popular anymore and I don't think it will expand in the future," said Tom Billet, senior consultant at the New York office of Johnson & Higgins. "Whatever does exist is left over from the 1970s," he added.

In fact, only 20% of the 818 employers responding to the William M. Mercer-Meidinger-Hansen Inc. 1987 survey on "Miscellaneous Group Benefits and Total Benefit Costs" reported offering any vision coverage at all.

Hewitt Associates' "Comparison Survey of Salaried Employee Benefits, 1981 to 1986," also confirmed the low popularity of vision care as a benefit, reporting that only 22% of the 256 major U.S. employer respondents to the survey offered the benefit.

Some experts connect employers' disinterest in vision care plans with the mounting economic pressures that were building in the early and mid-1970s, when the benefit was first offered.

Like dental care benefits that were introduced in the late 1960s, vision care coverage was first offered to unionized employees following union contract negotiations. However, unlike dental coverage, which was introduced in a period of stable economic conditions, vision care benefits were introduced just before the recession of the 1970s.

"Vision care is a solid benefit, but it didn't penetrate the market like dental did because of employer concern over inflation in medical care costs occurring simultaneously," explained Jennings Hart, senior vp in the benefits division of McDonough Caperton Insurance Group in Charleston, W.Va.

"Some people believed that vision care would be the dental of the 1980s," said Mark Schwehr, partner and actuary at Hewitt Associates in Lincolnshire, Ill. "Employers, however, don't feel that they can afford the extra expense for a benefit employees can budget for on their own."

For example, at multinational employer Smith & Nephew Inc. of Elk Grove Village, Ill., no vision care coverage is offered to employees, but the employees do not seem to miss it, said Charles Ingram, corporate insurance manager.

"We did a cost analysis on vision coverage, but it was not feasible for us to pursue," he said. "If anything, we will include it as an option in the flex plan we are currently looking at."

Experts agree that vision care benefits, if offered at all, will most likely appear as an option on the menu of a flexible benefits plan.

"It makes sense to offer vision as a flex option. If employees need the benefit, they can take advantage of it with flex dollars," said Mr. Hart of McDonough Caperton.

Vision care coverage through a flexible spending account has been the answer for employees at Barnett Banks Inc. in Jacksonville, Fla. In response to employee demand, Barnett established a medical care flex account, which allows employees to finance their vision expenses with pretax dollars.

"Because we don't offer an independent vision care benefit, this has been the answer and employees are happy with the outcome," said Catherine Corse, assistant vp/manager of employee benefits for the bank holding company.

Among companies that do cover employees' vision care expenses, the range of benefits provided vary greatly.

For example, San Francisco-based Pacific Gas & Electric Co. provides all employees a vision care plan under which all costs are covered for both employees and dependents, according to Sally Gottlieb, supervisor of benefits administration.

At Miller Brewing Co. in Milwaukee, vision care coverage includes $50 per examination yearly, $80 for bifocal lenses biennially, $125 for trifocal lenses biennially and $25 for frames biennially.

Although Miller employees are satisfied with the vision coverage, they want an increase in the allowance for frames, pointed out John Van Vliet, Miller's corporate benefits manager.

An alternative to providing vision care to employees at reasonable costs is managed care programs, noted Ted Wood, vp of Fred S. James & Co. in Portland, Ore.

"We normally advise our clients to offer a vision service plan—VSP—if they are going to offer anything," he said.

A VSP functions like a health maintenance organization in that a panel of optometrists provide care to VSP members at pre-determined prices, Mr. Wood explained. ■

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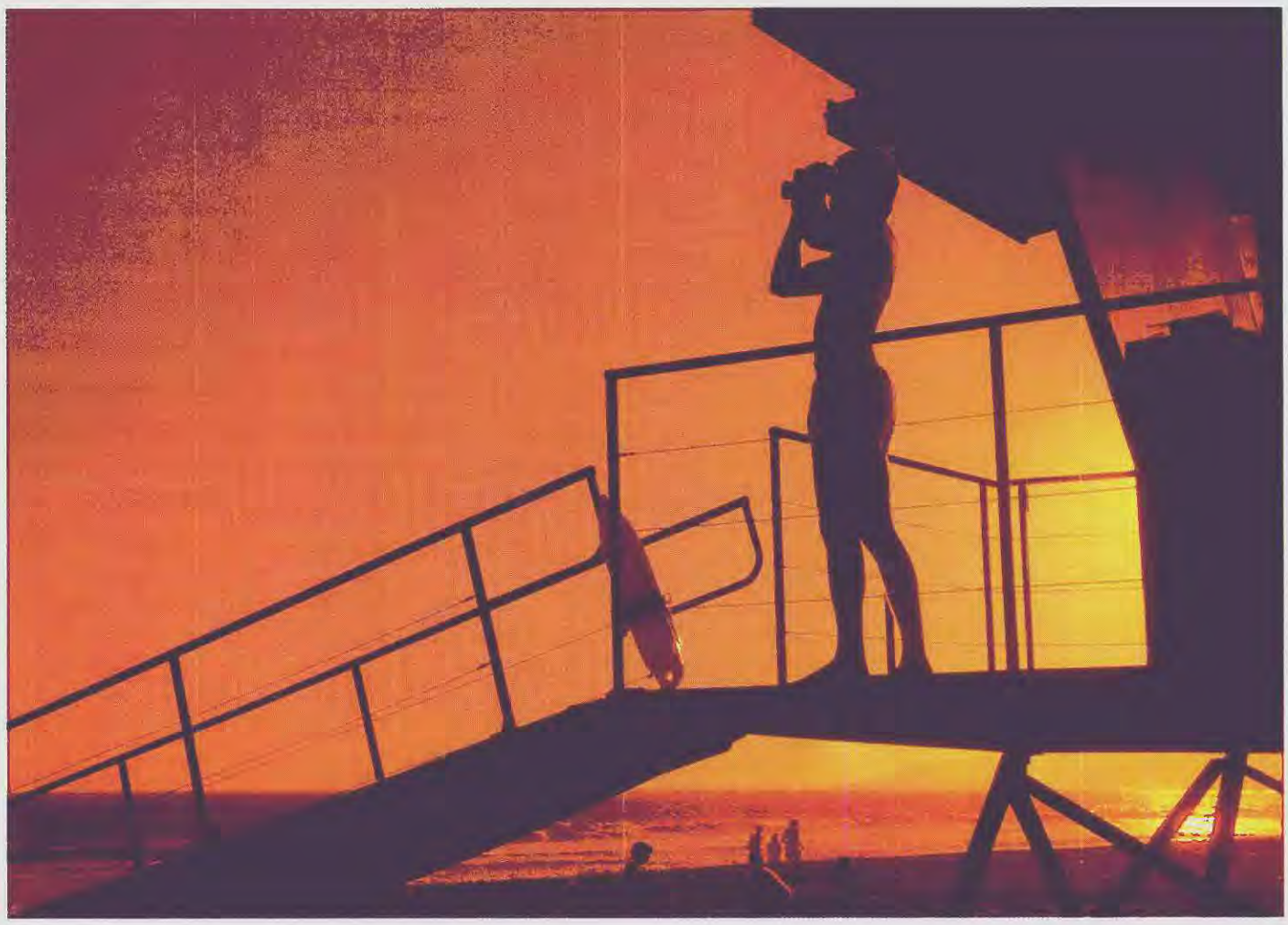
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Time capsule: 1974

President Nixon is expected to propose in his State of the Union address a two-tiered national health insurance program.

The program, which would cost an estimated $37.5 billion by 1975, would consist of a government plan to provide coverage to low-income people and those who have trouble getting health insurance, and a private plan that would require employers to provide health insurance coverage at levels set by the government.

Employers would have to pay 75% of the costs after a start-up period, with employees paying the rest of the premiums, which are estimated to cost $320 per worker by 1975 (*BI,* Jan. 21, 1974).

* * *

More and more employers nationwide are adopting flexible work hours, as companies see "flex-time" as a cost-free employee benefit.

Flex-time, which includes a core period in the day during which all employees work and two bands of flexible time each day, costs employers nothing but is a benefit employees appreciate, its proponents say (*BI,* March 4, 1974).

* * *

A new group has been organized to spearhead the push for equal benefits and wages for working women.

The Coalition of Labor Union Women was formed in Chicago by about 3,200 women from 58 unions and labor groups to organize women in a grass-roots effort for better representation in their unions and in negotiations with their employers (*BI,* April 15, 1974).

* * *

A U.S. District Court judge has ruled that General Electric Co. is guilty of sex discrimination because it denied disability benefits to its pregnant workers.

General Electric is expected to appeal the decision, which, if it stands, could cost the company millions of dollars in back pay for pregnant workers.

In addition, if the decision is not overturned, it will have a significant impact on maternity policies at companies nationwide (*BI,* April 29, 1974).

* * *

President Nixon has made it clear that he wants a national health insurance program enacted this year, even if he has to compromise to get it.

One area of possible compromise, according to administration officials, would be in the 75% of the cost of national health insurance premiums that would be borne by employers under the current proposal (*BI,* May 27, 1974).

* * *

The additional work and expense created by the implementation of "cafeteria" benefit plans are keeping many companies from taking the plunge, even when they agree with the concept.

Most benefit experts agree that employees would like the plans, which allow workers to choose from a variety of benefit options. But, employers are concerned about the additional expense and administrative problems involved in the plans.

"It's a very attractive concept, but it is a very expensive one to administer and (will cause) a lot of headaches that make the employee benefit manager's job much harder," said Jean-Pierre Provencher, senior actuary for Metropolitan Life Insurance Co. of Ottawa (*BI,* July 8, 1974).

* * *

By his resignation, President Nixon preserved his employee benefits, which include an annual $60,000 pension for life.

Mr. Nixon probably would have lost his benefits if he had been impeached and removed from office.

And, the former president still could lose the benefits if he is indicted and prosecuted for his role in the Watergate cover-up (*BI,* Aug. 19, 1974).

* * *

President Ford is expected to choose Labor Day to sign into law the Employee Retirement Income Security Act of 1974.

This massive pension reform measure finally will become law more than 12 years after President Kennedy established a Cabinet-level task force to investigate the private pension system (*BI,* Sept. 2, 1974).

* * *

The new Pension Benefit Guaranty Corp. created by the Employee Retirement Income Security Act of 1974 is still waiting for the appointment of its first boss.

And, while the search for a leader continues, the PBGC already has a backlog of claims for pension benefits from almost 200 terminated pension plans.

The final decision on a director will be made by the secretaries of labor, treasury and commerce, who make up the PBGC's board of directors.

While the field of candidates has been narrowed down to three principal contenders, their identities and their backgrounds are being kept under wraps (*BI,* Oct. 14, 1974).

* * *

Major U.S. corporations say that their employee benefit costs have increased an average of 10% to 15% in 1974, though some cite hikes as high as 40%, according to a *Business Insurance* survey.

The country's double-digit inflation rate appears to be the main culprit, as employers say that the most common causes of their higher benefit costs in 1974 were cost-of-living supplements to retirees, increased limits for hospitalization coverage and rate hikes for their group health insurance plans (*BI,* Dec. 9, 1974). ■

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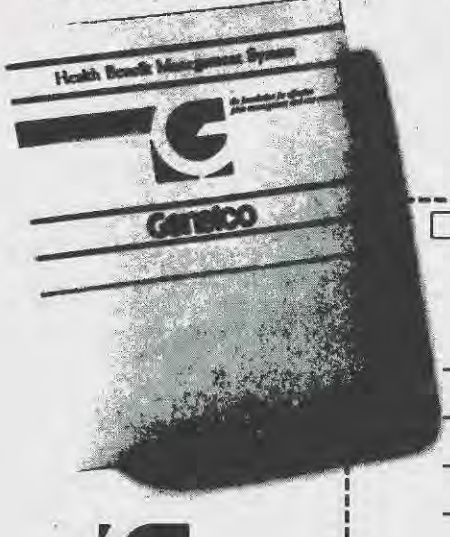
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Time capsule: 1975

The Ford administration is opposed to any national health insurance plan this year.

The administration says it will not propose such a plan in 1975, and President Ford is "almost certain" to use his veto power if Congress enacts a national health insurance plan.

The White House says the decision was based on the state of the economy and on President Ford's intention to place a one-year moratorium on new federal spending (*BI,* Jan. 27, 1975).

* * *

U.S. employers spend 32.7 cents of every payroll dollar on employee benefits, according to a study by the Conference Board.

This is up from 25.6 cents 10 years ago.

The study says the increase is due in large part to the fact that many employers are liberalizing their benefit plans. For example, more employers are paying the full cost of benefits for their workers, and more are supplying the same benefit package to their blue-collar and white-collar workers (*BI,* Feb. 24, 1975).

* * *

More companies are using self-insured employee benefit programs, according to a Fortune Market Research study of the top 1,000 U.S. industrial corporations.

In addition, the study says, about half the companies that insure their benefits have changed their insurer within the last five years (*BI,* March 10, 1975).

* * *

The House Ways and Means Committee may vote to levy a special 1% tax on all group health insurance premiums to finance health care coverage for millions of laid-off workers.

The committee also may act to force employers to extend coverage to laid-off employees for at least 90 days after a layoff. These actions would raise employers' group health insurance premiums by 7% to 8%.

The new tax and the coverage extension are included in the Emergency Health Insurance Extension Act of 1975, introduced by Rep. Dan Rostenkowski, D-Ill. (*BI,* March 24, 1975).

* * *

The Pension Benefit Guaranty Corp. has proposed regulations on what basic retirement benefits the PBGC will cover, a move that is critical to determining whether a pension plan has sufficient assets.

The PBGC has proposed covering normal-age retirement benefits, certain early retirement benefits, disability retirement benefits and pensions for survivors of deceased plan participants (*BI,* June 30, 1975).

* * *

There is a bipartisan effort under way to amend the Health Maintenance Organization Act of 1973.

Identical bills have been introduced in the Senate and the House to change the act to reduce the burdens it places on employers and to cut the cost of the benefit programs HMOs must offer (*BI,* June 30, 1975).

* * *

Blue Cross/Blue Shield officials warn that group health insurance premiums in the Washington, D.C., metropolitan area could double by 1980 if hospital costs continue to increase at their current rate.

BC/BS says that daily hospital charges increased 18.5% between 1974 and 1975, spurred by an oversupply of available hospital beds. And, BC/BS rates in the area increased about 18% this year for groups of fewer than 50 people, and up to 50% for larger groups (*BI,* Sept. 22, 1975).

* * *

General Motors called a special meeting of all its executives who hold public-service positions in the health care field to urge them to help find ways to hold the line on rising health care costs.

GM took the unusual move after it was hit with an increase of about 21% in the cost of its employee health insurance. GM, the nation's largest industrial employer, will pay about $800 million for health insurance in 1975 (*BI,* Nov. 3, 1975).

* * *

Inflation and government regulations, especially the Employee Retirement Income Security Act, appear to have put employer interest in cafeteria benefit plans on the back burner.

ERISA puts a freeze until 1977 on the establishment of new cash or deferred profit-sharing plans, critical to the cafeteria plans. Other problems with the plans, which allow employees to choose from among a variety of benefit options, include increased administrative and benefit costs, which are especially unpopular with employers in these highly inflationary days (*BI,* Dec. 15, 1975). ■

Some benefit offerings attract few employees

By KARI BERMAN

While the popularity of some employee benefits have boomed over the past 20 years, other benefit innovations never have gotten off the ground.

One benefit that experts anticipated would take off but instead had its wings clipped is group legal coverage.

Group legal plans typically provide participants with free legal advice by telephone. An attorney will handle minor legal procedures for the employee, but major litigation often is not covered.

One reason these plans have not been adopted, observers say, is that legal coverage is not a benefit that employees consider as important as other, medical-related coverages.

"People worry more about getting sick than they do about incurring a legal problem," says Melvin W. Borleis, managing director at the Deerfield, Ill., office of William M. Mercer-Meidinger-Hansen Inc. There has never been a tremendous pressure on employers to offer it, he explains.

Neil Waldron, assistant vp-group marketing at Metropolitan Life Insurance Co. in New York, attributes part of the failure of group legal coverage to employers' attempts at cost containment.

"Now with medical insurance costs always rising and benefits in turn costing more, employers can not afford to bear additional expenses," Mr. Waldron says.

Experts concur that when an employer does offer group legal coverage—a rarity—the benefit will in most cases be offered as an option in a flexible benefits plan.

However, some companies have not completely written group legal coverage off as a flop.

According to Sally Gottlieb, supervisor of benefit administration at Pacific Gas & Electric Co. in San Francisco, surveys of PG&E employees indicate that about 20% have an interest in such a plan.

"We are still reviewing the prospect of group legal coverage," Ms. Gottlieb said.

And, some managed care health plans are also attempting to incorporate a group legal coverage option into their programs.

Sanus Corp. Health Systems, a New York-based health maintenance organization, is currently trying to create a preferred provider organization-styled system of providing legal aid to its members, according to John Staelin, national marketing director. "We would contract with a group of lawyers and offer a 25% discount for services to participants," he said.

In addition to group legal plans, group auto coverage and company van pooling are other benefits that ran out of gas shortly after their introduction in the marketplace.

"Group auto and van pooling were popular in the late 1970s and early 1980s when the oil crunch occurred," but then declined in popularity, explains Tom Billet, a senior consultant at the New York office of Johnson & Higgins.

Under van pooling, a company uses vans to provide for employees' transportation to and from work.

Some experts say that group auto insurance failed when it was unveiled in the late 1960s because of pricing difficulties.

"Only a few states would allow group-rated coverage. Because individual rating remained, it never really became a group benefit. Back then, computers were not advanced enough to calculate the (individual) ratings," explains Mr. Borleis.

Other experts agree that the lack of support from state insurance regulators hindered the benefit's ability to penetrate the market. "Some states actually outlawed group auto," according to John Wickens, vp-group underwriting at the Roseland, N.Y., office of Prudential Life Insurance Co.

Another obstacle to the success of group auto coverage was employers' fear of being involved with an insurance plan that is often frustrating for policyholders.

"People are always complaining about expensive car insurance premiums and employers didn't want their employees associating negative feelings with the company, wrongly blaming it for the high costs," says Mr. Borleis. ■

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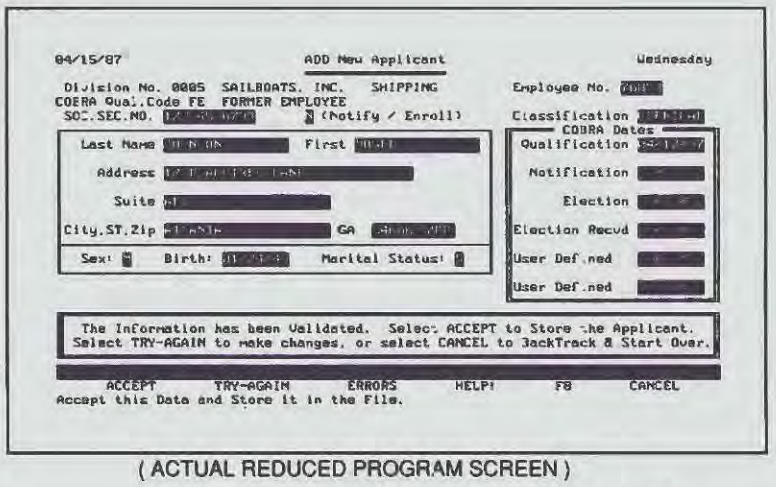
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Unions' role as benefit innovators declines

By GLENN HUNTLEY

Some call the 1960s and early 1970s "the golden age" for labor unions, when organized labor was the innovator and the initiator of unheard-of pension and health care benefit programs.

"Labor got very rich contracts" and employers were forced to pay for them, said Dan McGinn, a managing director at William M. Mercer-Meidinger-Hansen Inc. in Los Angeles.

But, the two-decade-long trend toward generous new benefits for unions slowed as the 1980s unfolded and employers became more conscious of the cost of their benefit programs during an era of high health care inflation, employers, union officials and consultants agree.

During the so-called golden years, unions were at the leading edge in crafting employee benefit programs and in pushing for employee benefit legislation.

For example, the United Auto Workers Union won the first outpatient psychiatric care benefit in a Chrysler Motor Corp. contract in the mid-1960s, when such care was thought to be uninsurable, pointed out William S. Hoffman, director of Social Security for the UAW in Detroit.

The UAW also blazed the trail for benefits for skilled nursing care, nursing home coverage, prepaid dental plans and hearing aid and vision care, primarily obtained from the major automakers between 1967 and 1976.

The union's past accomplishments are still reflected in what is now billed as the new wave of benefit innovations, Mr. Hoffman said.

While many view health maintenance organizations and preferred provider organizations as recent trends in cost containment, those features were built into some UAW contracts as early as the 1950s and 1960s, he said.

Unions also made great inroads in legislative arenas. For example, the United Steelworkers, the UAW and other unions were strong supporters of legislation like the Employee Retirement Income Security Act of 1974.

"We were one of the prime movers (of ERISA). We're very proud of it," said Shirley Clark, benefits analyst for the United Steelworkers in Pittsburgh.

Other landmark legislation supported by labor unions included Medicare laws and the Multiemployer Pension Plan Amendments Act of 1980 (see story, page 90).

In the 1960s and 1970s, it was easy for unions to obtain improvements in benefits because most employers at that time had barebones benefit plans, observers say. Today, though, unions face tougher battles to gain benefit improvements as employers have become sharper health care consumers and are keeping a keener eye on benefit dollars.

"I think there was a (union) attitude that 'whatever we want, by God, we're going to get it and the employer is going to pay for it,' " said Mercer's Mr. McGinn.

Some labor experts even contend the unions have lost some of their clout and have taken a defensive position when negotiating both benefits and pay.

But Mr. Hoffman of the UAW dismisses any notion that organized labor has lost its ability to win new benefit concessions from management.

"We are not retrenching," Mr. Hoffman said. However, unions "are trying to be better caretakers of our resources," he explained, pointing out that the UAW recently concluded negotiations for new contracts with Ford Motor Co. and General Motors Corp. that provide improved health care, disability, pension and profit-sharing benefits (*BI*, Oct. 19).

But other observers say there is a new attitude expressed by unions in dealings with contract matters.

It is not so much that the labor groups are less active in pursuing additional benefits, but rather that company managers are taking a more active role in determining and safeguarding benefits, particularly pension funds, said Dan Cohen, senior vp of Martin Segal Co., a New York-based benefit consulting firm.

The world of employee benefits has become more complex, with legislation guiding pension plans and rising medical costs striking health plans, Mr. Cohen said.

"Right now, it's a matter of retrenchment. . .more of the same," Mr. Cohen said, referring to the level of benefits over which unions and employers negotiate today. "Now (employers) are just trying to maintain costs."

Until the public was made aware of huge unfunded liabilities of some pension plans, and federal laws such as ERISA and the Multiemployer Pension Plan Amendments Act were enacted, "many employers were asleep at the switch," Mr. McGinn said. Employers were "somewhat passive" about pensions until 1980 and have since become active participants with union leaders in working on pensions, he said.

The cooperation between organized labor and management on pension issues has been "a remarkable change" from more contentious relationships in earlier years, Mr. McGinn pointed out.

In fact, even in the most adversarial situations, unions have shown the ability to compromise on some benefits to make improvements in other areas.

Such was the case in the hard-pressed steel industry. Thousands of workers lost their jobs and at least two dozen steel companies filed for bankruptcy when the industry was staggered by foreign competition and domestic recession.

"We had to fight to maintain what we had at every turn," said Ms. Clark of the Steelworkers union.

In some cases, the union was able to maintain some benefits only by agreeing to the reduction or elimination of other benefits. That was the case in some contracts negotiated by the Steelworkers last year that dropped vision care programs, Ms. Clark explained.

"You get into a situation where you don't have any choice" but to compromise on some issues, she said.

But, the Steelworkers union, a longtime innovator in pensions and health care benefits, continues to work for benefit improvements and supports cost containment and employee education as ways to institute savings, Ms. Clark said. And the union strongly resists management proposals to shift costs to workers, she said.

At Detroit-based Chrysler Corp., the UAW played a major role in the automaker's comeback from near bankruptcy in the late 1970s. A series of contracts with the UAW starting in 1979 brought cost controls to benefit programs and compromises on several other issues that helped the automaker survive, said Walter B. Maher, who is responsible for employee benefits at Chrysler as director of employee benefits at subsidiary Chrysler Motors Corp.

"I think the evolutionary process we have seen since 1979 is quite significant, and it couldn't have happened without employer/union cooperation," Mr. Maher said.

The UAW historically has been "extremely instrumental in benefit designs" and was instrumental in contract provisions such as a triple-option health program included in the 1984 agreement, Mr. Maher said.

Under a triple-option plan, an employer offers its employees a choice from among traditional indemnity plans, an HMO or a PPO (see story, page 70).

While organized labor has been successful in winning significant benefit improvements over the last 20 years, it still does not mean that all is well, said John Zalusky, economist for the AFL-CIO.

"I don't think our level of benefits in this country is terribly high. That's not a good commentary on what's happening," Mr. Zalusky said.

While the UAW and other large industrial unions have long been leaders in benefit improvements, many other labor groups have worked hard and made advances, too, Mr. Zalusky pointed out.

"We tend to be the leading edge of change in this culture, as slow as it is," Mr. Zalusky said, referring to all organized labor.

As it has for many years, organized labor supports a national health care plan or mandated health care benefits, and another effort to enact such legislation is expected next year. For example, labor supports a bill introduced by Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., the would require employers to offer a minimum health care plan (*BI*, Aug. 17; May 25).

While unions have fought for and gained major benefits for their members, many Americans without that organized clout go without health insurance, the UAW's Mr. Hoffman said.

"I think what you are seeing now is a lack of a national health care plan and a problem out of control," he said.

Unions will continue to fight for their own, but the fact that many others do not have similar care "demeans the program," Mr. Hoffman said. "We always felt we were carving out what was society's responsibility." ■

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Time capsule: 1976

Group health plans could save millions of dollars by requiring a second surgical opinion, according to a House subcommittee investigating unnecessary surgery.

Based on the study of a New York union's second-opinion program in which 17% of the operations recommended by the first physician were discouraged by the consulting doctor, the committee estimated that 2.4 million of the 14 million elective surgeries performed annually in U.S. hospitals are unnecessary. And, those unnecessary operations cost $3.9 million (*BI*, Feb., 9, 1976).

* * *

The United Auto Workers' demand for increased health care benefits appears to be the major obstacle in the upcoming contract talks between the UAW and the major automakers.

The UAW already has announced that its benefit demands in the July negotiations will include prepaid vision care, coverage of visits to doctors' offices, improved dental coverage and the extension of prepaid dental coverage to retirees. These demands are opposed by automakers, who have been hit with huge medical care cost increases in recent years (*BI*, May 3, 1976).

* * *

The United Auto Workers and major U.S. automakers have agreed to a pilot second surgical opinion program in an effort to curb rising health care costs.

The experimental program, offered through Blue Cross/Blue Shield of Michigan, is scheduled to begin this September in the Detroit area and to include 1.2 million workers. The automakers say the program is not related to contract negotiations set for July (*BI*, May 31, 1976).

* * *

The U.S. Supreme Court will allow re-arguments in a controversial pregnancy-as-disability case, indicating the justices are fairly evenly split on the issue of whether excluding pregnant women from disability coverage is a violation of laws against sex discrimination (*BI*, May 31, 1976).

* * *

A majority of U.S. employers offer dental benefit plans, according to the first-ever *Business Insurance* Employee Benefit Board survey.

The survey of 90 Benefit Board members shows that more than 60% have dental plans, covering a total of 1.5 million workers, and other companies intend to implement the plans in the near future (*BI*, Sept. 6, 1976).

* * *

Private employers' benefit costs rose 23% between 1973 and 1975, according to a survey by the U.S. Chamber of Commerce.

The Chamber says that employers paid an average of almost $3,984 for employee benefits in 1975, and benefits average a whopping 35.4% of payroll (*BI*, Oct. 18, 1976).

* * *

A national health insurance program would raise total annual health care spending by $10 billion to $25 billion by 1980, according to an actuarial projection.

According to a study, which was prepared for the Department of Health, Education and Welfare, the actual increase would depend on which of six separate national health insurance plans were enacted (*BI*, Nov. 15, 1976).

* * *

After the Supreme Court decided that excluding pregnancy from disability coverage is not a violation of laws barring sex discrimination, some congressmen are mobilizing to change those laws.

Legislation already is being prepared to include pregnancy in the sex-discrimination laws after the Supreme Court ruled that General Electric Co. did not discriminate when it denied disability pay for some pregnant workers (*BI*, Dec. 13, 1976).

* * *

Even as they struggle under huge premium increases for group health and medical insurance during 1976, employee benefit managers say they expect more of the same next year.

As a result, the benefit managers on *Business Insurance's* Employee Benefit Board say they are giving very serious consideration to internal funding programs for employee benefits, either through tax-sheltered trusts or through other types of self-insurance (*BI*, Dec. 13, 1976). ■

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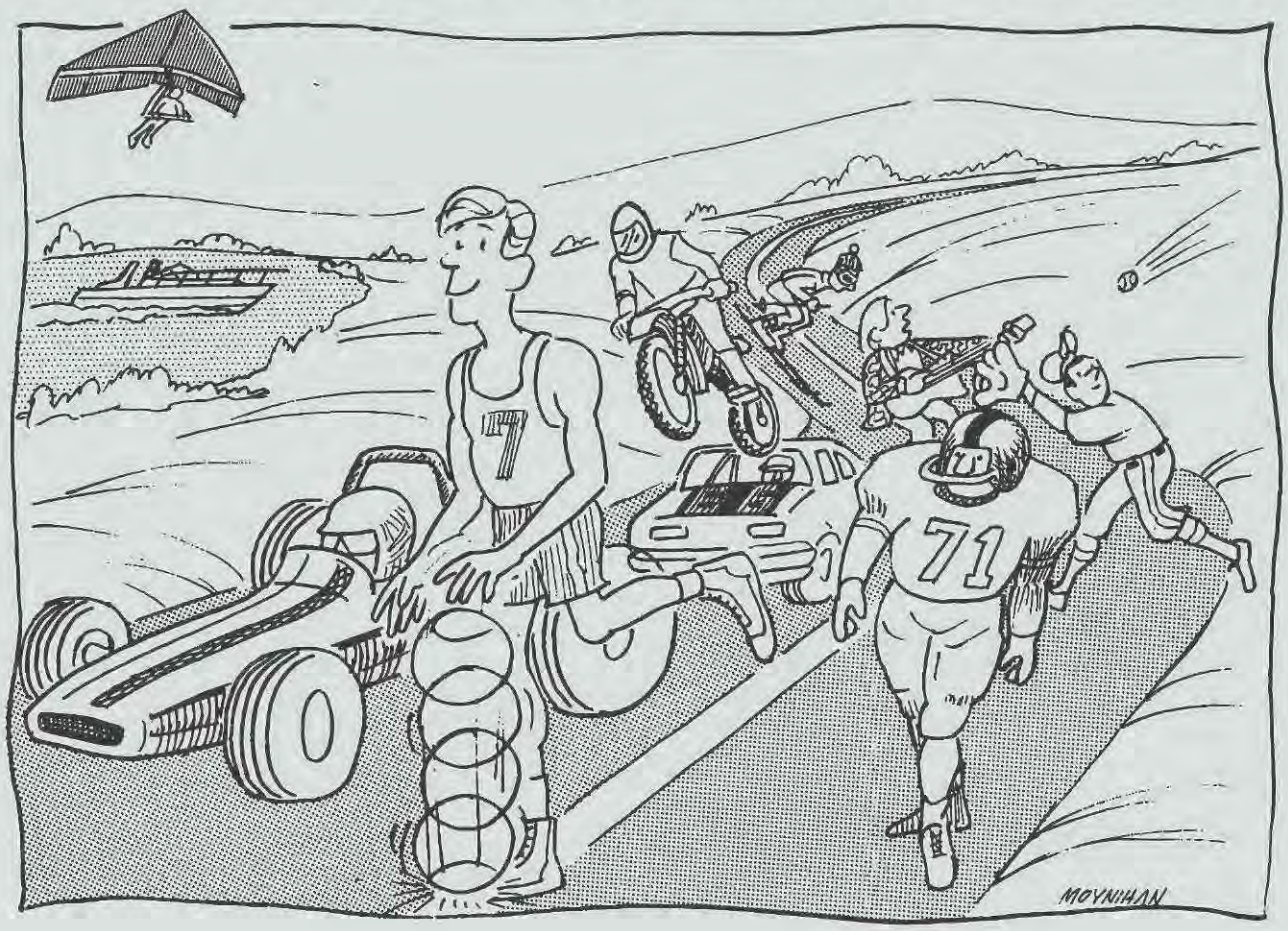
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XYZs of benefits not as simple as ABC

By DONNA DiBLASE

Does benefits jargon have your head in a whirl?

It's no wonder. The rapid rate of benefits changes over the last two decades has been matched only by the rate at which legislators and vendors have been able to turn out acronyms for laws and plans.

And, since the majority of changes have occurred mainly since the early 1970s, "in a very real sense, the changes have occurred too fast, putting employers in a position where they can't plan a long-term strategy," noted Don Hasbargen, a consultant at Hewitt Associates in Minneapolis.

However, with an ever-increasing federal budget deficit and escalating health care costs, benefit managers can expect a continuing evolution of jargon as the government and employers react.

In just the last 14 years, employers have been bombarded with federal regulations governing employee benefits, including:

- ERISA, or the Employee Retirement Income Security Act of 1974, which contained the first major federal regulations affecting employee benefits. For example, ERISA created the PBGC, or the Pension Benefit Guaranty Corp., a federal insurance program for defined benefit pension plans.
- TRA 1975, or the Tax Reduction Act of 1975 which created TRASOPs, or TRA stock ownership plans, among other things.
- MEPPA, or the Multiemployer Pension Plan Amendments of 1980, which created substantial liabilities for employers that withdraw from an underfunded multiemployer pension plan.
- ERTA, or the Economic Recovery Tax Act of 1981, which created the PAYSOP, or payroll-based employee stock ownership plan, and expanded the number of people who could set up IRAs, or individual retirement accounts.
- TEFRA, or the Tax Equity and Fiscal Responsibility Act of 1982, which established a program for encouraging HMOs, or health maintenance organizations, to participate in the federal Medicare program. TEFRA also lessened the stringency of the rules governing Keogh plans for self-employed individuals, among other things.
- DEFRA, or the Deficit Reduction Act of 1984, which extended TEFRA's freeze on COLAs, or cost of living adjustments, to employer contributions to defined contribution pension plans until 1988. DEFRA also enabled lenders to ESOPs to exclude from their taxable income 50% of the interest they receive on these loans.
- REA, or the Retirement Equity Act of 1984, which changed some of ERISA's pension plan vesting and annuity requirements.
- COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires employers to offer terminated employees the choice of continuing their health care benefits for up to 18 or 36 months.
- TRA, or the Tax Reform Act of 1986, which among other things made changes affecting contributions to tax-deferred savings plans such as 401(k)s and other defined contribution and defined benefit pension plans.

But along with regulatory changes, benefit managers have faced a seemingly endless development of vocabulary relating to pension and health benefit plans.

For example, in the 1970s, as health care costs skyrocketed, many employers decided to self-fund their health benefits plans. They found they were in need of a TPA—third-party administrator—or an ASO—administrative services only contract—so claims could be processed and paid.

Then came managed health care.

First were the different kinds of HMOs. There are IPAs, or independent practice associations, in which a group of physicians contracts with the HMO to provide care to its members while maintaining a private practice.

But there also are the GPAs, or group practice associations, in which the HMO contracts with multiple-speciality physicians' groups to provide health care to HMO members. There also are the staff models, in which health care providers are directly employed by the HMO and provide health care only to members.

Along with HMOs, came UR, or utilization review. And, with UR came a host of new terminology: Benefit managers learned of hospital admission rates per 1,000 covered employees; length of stay; pre-admission review; concurrent review; discharge planning; second surgical opinions; and catastrophic case management.

Just when they thought they were getting a grasp on these new buzzwords came the PPO, or preferred provider organization.

PPOs include UR and are similar to an HMO in some ways, benefit managers were told. Employees could still have freedom of choice of providers, but would be offered financial incentives—like waived deductibles or lower copayments—to use preferred providers.

Along with health care changes, benefit managers saw a revolutionary benefit plan design known as flexible benefits, cafeteria plans or Section 125 plans, which related to the section of the Internal Revenue Code authorizing the plans.

These plans were designed to enable employees to tailor their benefit program to their needs while taking advantage of certain tax advantages and containing benefit costs for the employer.

These plans were as much a learning experience for employees as for employers, since both needed to understand the tax advantages and cost of individual benefits.

Under the plans, employees usually are offered several different levels of health and dental insurance. In addition, they can choose an HMO and defer a portion of their pretax salary to an FSA, or flexible spending account.

Employees could defer a certain amount of pretax salary dollars to either a health care reimbursement account, a dependent care reimbursement account or a ZEBRA or zero-balance reimbursement account. However, under IRS rules governing the accounts, employees learned that they also could "use it or lose it," meaning any funds in an account unused at the end of the year would be forfeited.

In addition, they also may defer pretax salary into a 401(k) savings plan, named for the section of the tax code that created the plans.

Employers also can offer COLI, or corporate-owned life insurance, or GULP, group universal life insurance plans. ■



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Time capsule: 1977

Pension consultants say there is no large-scale movement among big corporations to replace their defined benefit pension plans with defined contribution plans as a result of the Employee Retirement Income Security Act of 1974.

Peter A. Bleyer of Alexander & Alexander Services Inc. in Chicago said only one client out of 7,500 had terminated a defined benefit plan and that was because the company went out of business (*BI*, Jan. 10, 1977).

* * *

Few second opinion programs for elective surgery have been established since a year ago when a House subcommittee concluded the programs would save millions of dollars in benefit costs, according to a *BI* survey.

Only 586 persons in New York have obtained second surgical consultations since August, said a spokesman for the national Blue Cross & Blue Shield Assn. There are more than 5 million members enrolled in Blue Cross & Blue Shield of Greater New York (*BI*, Jan. 10, 1977).

* * *

Three major national health insurance bills have been introduced in Congress, despite the Carter administration's warnings that it will not support such legislation this year.

The administration supports the concept of a gradually phased-in national health plan. But it is expected the president will be concentrating on government reorganization and economic problems in his first year in office (*BI*, Jan. 24, 1977).

* * *

State insurance officials are alarmed by the rapid growth of employee benefit trusts operating under the Employee Retirement Income Security Act of 1974.

Their fears have been intensified by the recent bankruptcy of a large self-funded trust based in California, the National Multiple Employers Foundation. And, they are afraid that more trusts will become insolvent, leaving thousands of employees with unpaid claims (*BI*, Feb. 21, 1977).

* * *

The Carter administration has proposed a strict federal limit on how much hospitals can charge patients in an effort to slash skyrocketing medical costs by billions of dollars.

The administration said it would ask Congress for authority to establish a ceiling on hospital charges. A spokesman for the Department of Health, Education and Welfare estimated the annual savings for health care payers at $2 billion (*BI*, March 7, 1977).

* * *

Congressional sources predict quick approval of a bill requiring that pregnancy be included in employers' health insurance and sick leave programs.

The measure would amend the Civil Rights Act of 1964 to require any pregnancy-related disability be treated the same as any other temporary disability in sick leave and fringe benefit programs. The bill was introduced after the Supreme Court ruled that excluding pregnancy from disability insurance plans was not discriminatory (*BI*, April 4, 1977).

* * *

It appears that profit-sharing plans are becoming less prevalent as the sole vehicle for providing employees' retirement income.

Major employers, including Sears, Roebuck & Co. and Xerox Corp., are considering establishing pension plans to replace or supplement their profit-sharing plans in an attempt to provide their workers with a predictable retirement income.

The moves by major employers are in contrast to earlier predictions that the funding requirements under the Employee Retirement Income Security Act of 1974 would discourage the formation of defined benefit pension plans (*BI*, May 2, 1977).

* * *

The United Auto Workers is setting up a group legal plan for unionized hourly employees of Chrysler Corp.

The plan, which will serve the personal legal needs of 150,000 families of active and retired Chrysler workers around the country, is the first nationwide legal plan (*BI*, July 25, 1977).

* * *

Group auto insurance may receive a big boost from a bill introduced in the Senate by Sen. Harrison Williams, D-N.J.

The bill would amend tax law to permit employers and workers to make contributions to trust funds established for group auto coverage. Currently, tax-deductible employer payments are only allowed for life, health and accident insurance as well as prepaid legal plans (*BI*, Aug. 8, 1977).

* * *

The national Blue Cross Assn. is forcing local Blue Cross plans to intensify their health care cost-control efforts.

In order to remain members of the national association, local plans will have to implement cost-control measures such as programs to find fraud, screen claims to avoid unnecessary surgery and improve coordination of benefits (*BI*, Sept. 5, 1977).

* * *

The cost of providing employee benefits has increased twice as fast as the cost of wages.

The Council on Wage and Price Stability found that the cost of employee benefits rose 133.9% between 1966 and 1974, while wages rose only 73.7%.

Although final figures for 1975 and 1976 are not available yet, the council said "more up-to-date figures would show an even higher proportion of total compensation accounted for by benefits" (*BI*, Sept. 19, 1977).

* * *

Experts say there would be little cost impact on employee benefit plans if the mandatory age for retirement is raised or eliminated.

Congress is likely to pass a measure that would raise the mandatory retirement age for private employees to 70 from 65, and would eliminate mandatory retirement for federal workers.

Benefit experts say that, although life insurance and disability coverage costs would rise if there were more older workers, pension costs would be lower because the benefit would be paid for a shorter period of time. And health insurance costs would remain for the most part unchanged, because Medicare is the principal source of coverage for people over age 65 (*BI*, Oct. 3, 1977).

* * *

A federal appeals court has ruled that states have the right to require employers or unions to provide certain benefits, if those benefits are financed by purchasing insurance. But, employers or unions that self-fund are exempt from state regulation because of the Employee Retirement Income Security Act of 1974.

The appellate court upheld a New Hampshire law that required group insurance contracts to include coverage for mental illness (*BI*, Oct. 3, 1977).

* * *

The Carter administration's new tax reform proposal would cut in half the tax-free portion of employer-paid life insurance. Under the proposal, employees would be taxed on employer-paid premiums for life insurance coverage above $25,000; the current limit is $50,000.

The tax proposal also would reduce the ceiling on pension benefits for which highly paid employees would be eligible and make employer-paid group legal services a taxable benefit (*BI*, Oct. 17, 1977).

* * *

The Pension Benefit Guaranty Corp. has officially asked Congress to raise the annual termination insurance premium to $2.25 per plan participant from $1.

The increase in needed because pension plans have been terminating at a much higher rate than had been expected, and the PBGC's deficit has already hit $61 million, said Matthew M. Lind, the PBGC's acting executive director (*BI*, Oct. 17, 1977).

* * *

The Supreme Court ruled that employers can force workers to retire before age 65 under a retirement plan that was in operation before Congress banned age discrimination.

A United Airlines plan requiring retirement at 60 had existed 26 years before Congress enacted the Age Discrimination in Employment Act of 1967.

However, the House and Senate are expected to quickly resolve differences in bills they passed prohibiting mandatory retirement before age 70 (*BI*, Dec. 26). ■

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Cartoons comment on benefit issues

An employee benefits topic under debate during Jimmy Carter's presidency, national health insurance, was the subject for the first staff-generated editorial cartoon in *Business Insurance* on Aug. 21, 1978.

There have been two *BI* editorial cartoonists in the last 20 years: Milt Priggee and Roger Schillerstrom. Mr. Priggee's tenure lasted from 1978 until 1982, when Mr. Schillerstrom took up the pen.

The editorial cartoons have commented on the shaky start-ups of HMO programs; company fitness programs; the attractiveness, and necessity, of offering complete benefits to company employees; and the constant battles with determined federal legislators to tax corporate benefit programs.

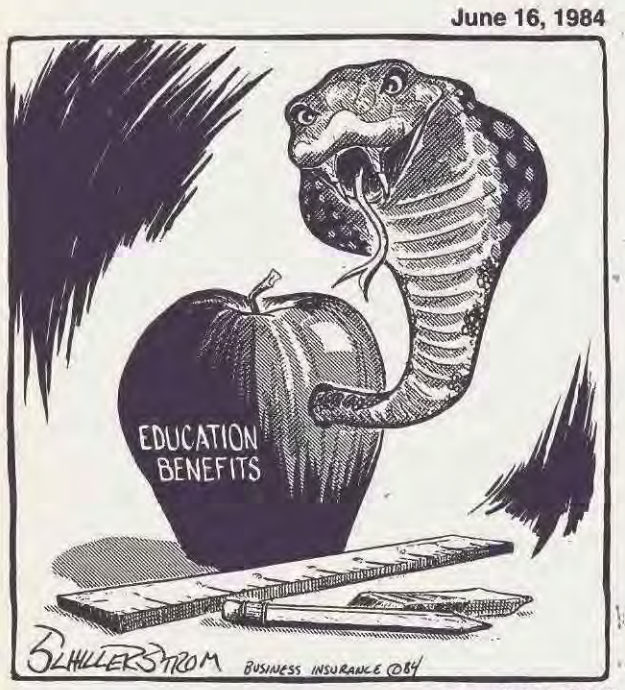
As with the collection of risk management cartoons in last week's issue, many cartoons were recalled but only a few could be chosen.

—*By Roger Schillerstrom*

March 12, 1984



June 16, 1984



Oct. 6, 1980



Jan. 23, 1984



March 24, 1980



March 21, 1983



Sept. 8, 1980



"I think you missed the point. . ."

Dec. 3, 1984



March 19, 1979



"Hey, Mr. Corporate Boss: Are you trying to tell us how to control our costs?

Time capsule: 1978

Insurers are fighting rising health care costs on two fronts: by lobbying for government action and by changing their products.

Insurers are urging state governments to review hospital budgets, extend professional standard evaluations to private patients and reorganize the distribution of health care services.

But, insurers also are working to find benefit changes that would save money and to encourage employers to take cost-saving steps (*BI*, Jan. 23, 1978).

* * *

ARA Services Inc. in Philadelphia has spent $500,000 to revamp its benefit program, but it expects to save more than that amount by stressing outpatient and preventive care.

Encouraged by its insurer, ARA instituted improved coverage for procedures that discourage costly hospitalizations, including outpatient care, extended care facilities, outpatient pre-admission testing and home health care (*BI*, Feb. 6, 1978).

* * *

Employees at American Can Co. in New York are testing a new flexible benefits plan.

The pilot program was designed by Hewitt Associates and is being underwritten by Metropolitan Life Insurance Co. The program, considered the most flexible offered by any major corporation, consists of a required core of benefits and optional benefits beyond the core (*BI*, March 6, 1978).

* * *

The Supreme Court has let stand a lower court ruling that airlines can require stewardesses to stop flying as soon as they become pregnant.

The 4th U.S. Circuit Court of Appeals ruled last summer that United Airlines' policy of forced leave was justifiable since pregnancy "could incapacitate a stewardess in ways the might threaten the safe operation of aircraft" (*BI*, April 3, 1978).

* * *

It is illegal to require women to contribute a greater percentage of their salary to a pension plan than men, the Supreme Court has ruled. However, the court said the ruling would not be retroactive because it would involve "devastating liability."

The case involved women employees of the Los Angeles Water & Power Department, who had been required to contribute 15% more than men to the retirement fund. The reason for the greater contribution, employers said, is that women on average live longer than men, and so they will receive greater pension benefits (*BI*, May 1, 1978).

* * *

Business, insurers and health care groups have given a limited OK to the Carter administration's national health insurance plan.

They approve of the administration's proposal to phase the plan in gradually and to involve private health insurers in a "significant" way (*BI*, Aug. 7, 1978).

* * *

The Carter administration has proposed a reorganization plan for the Employee Retirement Income Security Act of 1974, designed to ease administrative, compliance and reporting problems associated with the law.

The ERISA reform would clearly divide responsibility for the program between the Labor and Treasury departments. Currently, the two departments often jointly administer parts of ERISA, causing delays and other problems (*BI*, Aug. 21, 1978).

* * *

House and Senate conferees remain unable to resolve differences between measures passed by each chamber that would require employers to provide full medical and disability benefits to pregnant employees.

The key stumbling block appears to be that House members insist that employers not be required to pay benefits to an employee who has an abortion. Despite the deadlock, though, some sources are optimistic that the issues will be resolved before the end of the current session (*BI*, Sept. 18, 1978).

* * *

The Labor Department and most employers are sharply divided over how to tailor benefits for workers over age 65 following passage of a law to raise the mandatory retirement age to 70.

In its guidelines for implementing the law, the Labor Department will allow limited cuts in life insurance, medical benefits and long-term disability benefits.

Many employers, though, had planned to slash these benefits for older workers. The Labor guidelines would allow more extensive cuts in the benefits, if the company can prove that the cost of providing the benefits to their older workers would be excessive (*BI*, Oct. 2, 1978).

* * *

Congress has given final approval to a bill to require employers to treat pregnancy like any other disability, and President Carter is expected to sign the bill into law.

The measure, which was approved at the end of the session after differences were worked out by a conference committee, will cause many businesses to revamp their maternity policies (*BI*, Oct. 30, 1978).

* * *

Many employers are finding that day care is a benefit for them as well as for their employees.

Employers that have implemented the benefit often say that it helps them recruit workers and it improves morale while reducing absenteeism and turnover (*BI*, Dec. 11, 1978).

* * *

The Council on Wage and Price Stability has liberalized the treatment of benefit cost increases under the 7% wage ceiling.

The council's revised guidelines say employers will not have to charge any added costs of maintaining pension benefits against the 7% ceiling if the increases are required by law or actuarial studies. Employers also may exclude the costs of complying with any new federally mandated benefit requirements and any added health benefit costs that exceed 7% (*BI*, Dec. 25, 1978). ■

Time capsule: 1979

Despite lawsuits challenging the practice, Blue Cross/Blue Shield plans say they will expand their move to deny claims for procedures they deem medically unnecessary.

The Blues are urging member plans to curtail payments for the "admissions battery" of routine tests done before hospital admissions, which Blue Cross/Blue Shield says often are unnecessary (*BI*, Feb. 19, 1979).

* * *

Drafts of guidelines for a new law that treats pregnancy as any other disability indicate that if employers provide dependent medical coverage, they will have to cover the pregnancy-related expenses of employees' wives.

In its guidelines, the Equal Employment Opportunity Commission says that since the new law requires employers to cover their employees' pregnancy like any other disability, they must extend such coverage to dependents (*BI*, March 19, 1978).

* * *

The first phase of the Carter administration's national health insurance plan would include the establishment of minimum mandatory standards for group health insurance programs.

According to Health, Education and Welfare Secretary Joseph Califano, the standards would apply to hospital and physician services, X-rays, laboratory tests and a wide range of outpatient services (*BI*, April 2, 1979).

* * *

A provision of the bill to amend the Employee Retirement Income Security Act of 1974 would allow states to require employers to offer certain health care benefits.

The Senate Labor and Human Resources Committee has approved the ERISA overhaul bill including the controversial provision that would overturn a series of federal district court decisions that a section of ERISA pre-empts states from imposing benefit requirements on employers (*BI*, May 28, 1979).

* * *

Smaller companies are joining the move toward dental insurance coverage.

And, the decision by small companies to offer dental coverage means that the benefit is being accepted at the "grass-roots" level, according to experts. Although the original move to dental coverage was spearheaded by labor unions, providers now report a "phenomenal" growth in dental insurance at smaller employers (*BI*, June 25, 1979).

* * *

The Labor Department has announced that four more self-funded multiemployer trusts are not employee benefit plans, but merely "funding vehicles."

And, state insurance officials are using the Labor Department's position to add ammunition to their battle to regulate the trusts (*BI*, Aug. 6, 1979).

* * *

The possible bankruptcy of Chrysler Corp. could trigger a sharp increase in premiums other companies pay for federal pension termination insurance.

If Chrysler folds, the Pension Benefit Guaranty Corp. could be left holding the bag for the automaker's pension obligations. Although the PBGC also would have a preferred lien on Chrysler's huge pension assets and a right to 30% of its net worth, it could still need more funds from other employers (*BI*, Aug. 20, 1979).

* * *

The United Auto Workers has won huge benefit increases in its three-year contract with General Motors Corp.

And those changes—which include sweeping pension increases, improvements in most health care and insurance plans and a new stock ownership plan—are expected to set the stage for negotiations to begin soon with Ford Motor Co. and financially troubled Chrysler Corp. (*BI*, Oct. 1, 1979).

* * *

The nation's labor unions strongly oppose a new bill that would for the first time tax employees' health care benefits.

The bill, proposed by House Ways and Means Committee Chairman Al Ullman, D-Ore., would require employees to pay income taxes on any amount over $120 per month that his or her employer pays toward the family's health insurance, including dental, vision and prescription drug plans (*BI*, Nov. 12, 1979).

* * *

The U.S. Chamber of Commerce says that employers paid an average of $5,138 per employee for benefits in 1978, an increase of 9.6% over last year.

The Chamber also says that employee benefit costs averaged 36.9% of total compensation in 1978, up from 36.7% a year earlier (*BI*, Nov. 26, 1979).

* * *

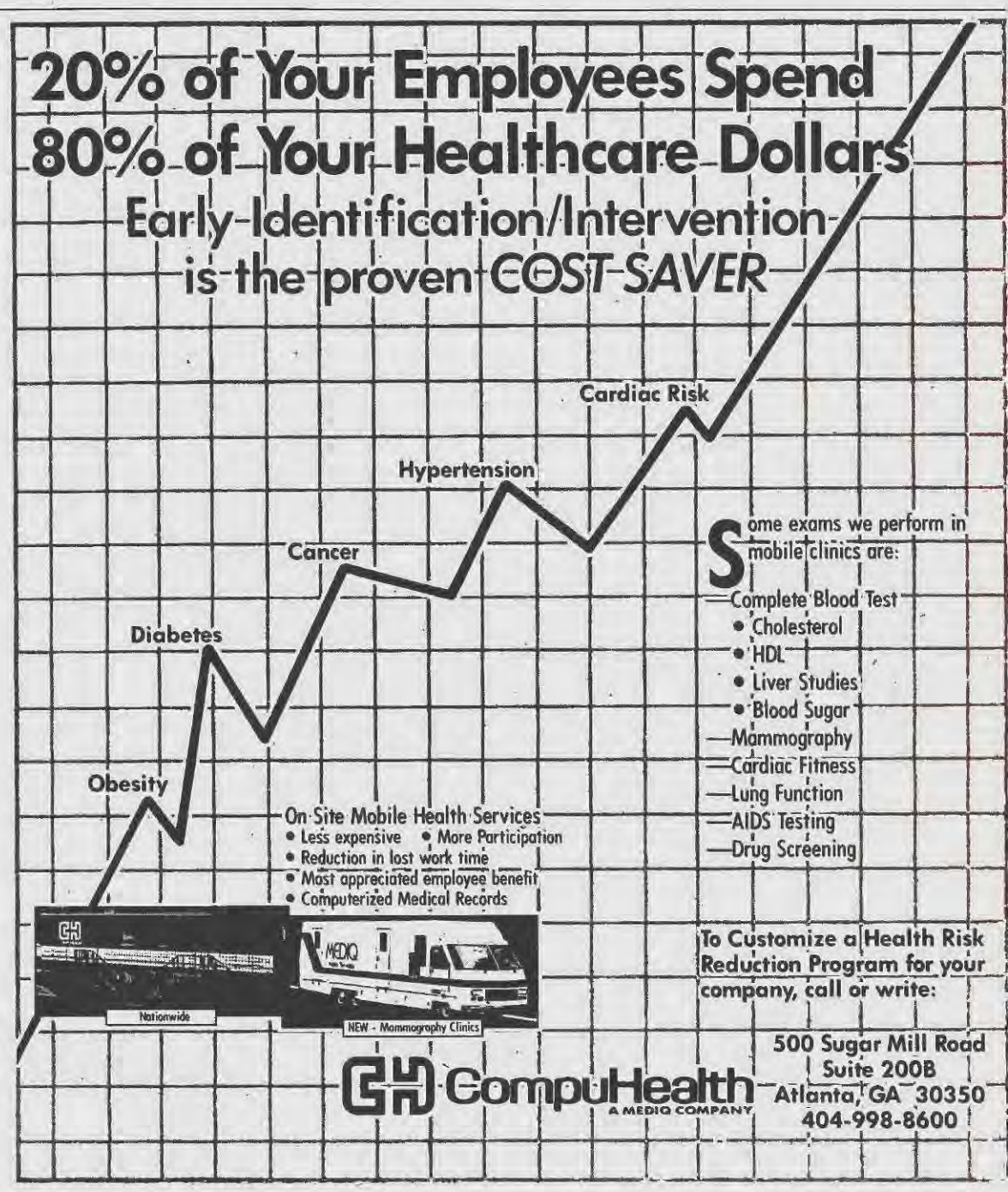
Brokers and insurers say that employers' costs for group health insurance continue to rise, with increases averaging 8% to 15%.

The only area of group coverage where prices are dropping is in group life insurance, industry experts say (*BI*, Dec. 10, 1979).

* * *

The Department of Health, Education and Welfare predicts that the number of health maintenance organizations nationwide will double during the next 10 years, to 430 from the current 216 and they will serve 15 million to 20 million people by 1989, compared with the 8 million currently enrolled.

But, HEW also predicts that even at their peak, HMOs will serve only 20% of the U.S. population, with the remaining 80% opting for fee-for-service care (*BI*, Dec. 10, 1979). ■



20 years of employee benefit innovations

Computers help solve benefit problems

By MICHAEL BRADFORD

The choice for computer-shopping employee benefit managers is not as clear as it once was.

In 1977, it was "a mainframe solution or no solution," says Thomas Garvey, president of ERISCO, a New York-based employee benefits information systems vendor.

But today, benefit managers can choose between mainframe and a variety of mini- and microcomputer systems that offer a plethora of information services.

In the relatively short history of EBIS, benefit managers have seen astounding changes. "There has been tremendous growth and it's changing every day," said Jerome Halperin, national director of the actuarial benefits and compensation consulting group of Coopers & Lybrand in Detroit.

Employee benefit information systems have evolved from their arrival as systems for administering pension plans in the 1960s to the brink of artificial intelligence today.

In the 1960s, the only employee benefits that were administered by computer were pension payments. Mr. Garvey explained that "pensions were particularly applicable to computerization" because so much of the process depended on actuarial calculations.

Pension administration did not tax the computer technology of the 1960s, and it wasn't until the middle of that decade that corporations began computerizing some of the administrative aspects of other types of benefit plans.

The principals who would later form California Interactive Computing in North Hollywood, Calif., helped blaze the computer technology trail to the benefit manager's door. In 1964, they developed a system operating on an RCA Corp. mainframe to administer group medical claims for Lockheed Corp.

Gary Smart, CIC's vp of sales, said, "it did nothing more than adjudicate claims with archaic systems." Still, the Lockheed system was an improvement over old claims handling methods.

During the late 1960s, the system was modified and redesigned to operate on International Business Machines Corp. equipment. Interest in the system continued to grow during the 1970s, and in 1977 its developers decided to form CIC.

By the late 1970s, competition among EBIS vendors was growing. It had taken more than a decade for the technology and commercial interest to develop, but corporate clients were finally learning the benefits of automation.

And the heightened popularity of self-insurance in the 1970s saw more employers taking administrative chores in-house. Systems makers saw interest from commercial clients pick up and the demand for their products increased.

Those demands grew louder when businesses became aware of the spiraling cost of health care and the words "cost containment" became a familiar part of the health care lexicon of the late 1970s and early 1980s.

Mr. Garvey of ERISCO pointed out that up until then, "The early systems were predominantly designed for corporations doing their own claims processing" and nothing more. They were "straightforward systems" that needed only to address basic claims administration tasks, he explained.

Diann Bilderback, vp-corporate services division at Advanced System Applications Inc. in Bloomingdale, Ill., said that until the late 1970s, "coordination of benefits was the only cost-containment provision the systems had. Since then, there has been a "huge array" of cost-containment measures developed that had to be addressed by EBIS, she noted.

Up until the mid- and late 1970s, "most claims administration was done manually," said Ms. Bilderback, involving a "tremendous amount of paper. When the technology came along, it relieved a lot of that paper burden."

Although the early 1980s saw more employers automating, they still weren't rushing in great numbers to computerize their employee benefit departments. In fact, companies were showing more interest in automating their risk management departments.

Business Insurance compiled a survey in December 1983 that showed only 25 of 119 benefit managers who responded, or 21%, had automation systems (*BI*, Dec. 29, 1983). That compares with 38% of the 52 risk management respondents who were surveyed a month earlier (*BI*, Nov. 21, 1983).

Eighteen of the benefit managers that responded to the 1983 survey were planning to install systems by the end of 1984. Seven others had plans to automate in 1985.

The survey showed that the most popular use for computers among benefit managers in 1982 was to show top management how benefit dollars were being spent. Apart from that, systems were used for a variety of functions including storage and summarization of claims information; judging the performance of self-insurance programs; and tracking utilization.

As the age of managed health care matured, demands for system capabilities intensified.

Employers began facing a bewildering array of preferred provider organizations, health maintenance organizations and self-insurance plans. As a result, EBIS designers began putting more emphasis on flexible microcomputer systems.

Mr. Halperin of Coopers & Lybrand said benefits systems have evolved quickly in recent years. "There have been tremendous technological changes. You can do things with micros today that you couldn't do a few years ago."

Mr. Smart of CIC agreed, saying that the EBIS technology "kind of plodded until recent years."

John Maher, benefits administrator at Ciba-Geigy Corp. in Ardsley, N.Y., pointed out that employee benefit departments have been hit with a blizzard of legislative changes in the last several years that have made an EBIS a necessity.

Benefit departments have been forced to change the way they operate to "keep up with the record keeping forced on them by government legislation," said Mr. Maher, referring to laws like the Employee Retirement Income Security Act of 1974 and the extended health care coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Some of the legislation is causing problems for companies that do not have a lot of computerized personnel information, Mr. Maher noted.

"It's a nightmare for those that didn't build data bases in the early years," Mr. Maher said, adding that Ciba-Geigy started a personnel benefits data base in 1974 that became a "good foundation" for the system that now helps the company administer its self-insured health plan.

"Companies that haven't been able to lay a good foundation are probably finding it difficult to keep up with the myriad changes in benefits record keeping," he said. In addition, a non-existent or inadequate data base makes it difficult for a company to change from an insured health plan to a self-insured program, he noted.

The computerization of employee benefits has affected more than just the in-house claims administrator. Third-party administrators have reaped the benefits of automation as well.

The computerization of the TPA has come full circle, according to Stephen F. Coady, president of Health Economics Corp. in Dallas.

"In the beginning, there were the big mainframes," Mr. Coady explained. Those systems were the property of large TPAs and were very expensive, he noted.

"Then around a decade ago there was a proliferation of personal computers. That sparked the development of the mom-and-pop TPAs," said Mr. Coady.

Mini- and microcomputers became a handier tool for most TPAs than mainframe systems, he said, because they were better suited for producing the ad hoc reports that were often requested and cost less money.

"But now, we're going back the other way," he remarked. Today, clients are demanding more "normative data" that can be used for comparison against similar national and regional information to give the company an idea of how its plan stacks up against others, according to Mr. Coady.

"Normative data bases have to be enormous," said Mr. Coady. "It's too much data for minis to handle," and TPAs are switching back to mainframe systems, he added.

Mr. Coady pointed out that many insurers are still using their mainframe systems, having never switched from those environments to administer policyholder claims because of the expense such a changeover would require.

Charles W. Esserwein, assistant vp-data processing at Associated Risk Services Co., a TPA in Atlanta, said TPAs have become so accustomed to automation that "I don't think we could stay in business if we didn't have computers."

Nearly every phase of the claims handling is automated, he explained, from the time the claim is presented until it is settled.

Both Mr. Esserwein and Mr. Coady noted that the computer is a valuable information tool, providing not only claims administration services but also serving as a repository of information that employers can use to control health care costs.

Ms. Bilderback said system developers continue to face challenges in today's health care environment.

"With the advent of managed care solutions, employers are facing a whole host of delivery options," she said, noting that EBIS designers will have to "stay abreast of technology, keeping systems user friendly and flexible."

Mr. Halperin pointed out that "things are changing so rapidly that when you get a system on-line, it is almost obsolete." EBIS makers must have the ability to continuously update their offerings, he said.

Since the first EBIS vendors came on the scene in the mid-1970s, about 10 to 15 per year have entered the competition to provide automation to corporate benefit departments.

Mr. Smart said that while he believes there are "well over 100" EBIS vendors hawking their wares today, there are maybe "20 viable contenders." Of those, he said, only eight or nine are "very strong."

In 1986, *Business Insurance* included 46 companies in its first directory of EBIS vendors. This year, the number jumped to 67 (*BI*, May 11).

EBIS vendors have taken the systems from the basic to the futuristic.

Unlike the early systems that performed simple claims processing functions, today's high-tech counterparts can even be used to inform employees about their group benefits programs.

In recent years, many companies have installed terminals that employees can easily use to learn more about their benefits. The systems can help employees design their own retirement savings programs, choose options under a flexible benefit plan or understand coverage changes.

One of the newest fads in benefits communications is the touch screen (*BI*, May 11). Unlike the more conventional keyboard terminals, these systems allow employees to ask questions and make decisions about their benefits by touching areas on the computer screen.

In the future, benefit managers will likely become increasingly familiar with systems that rely on artificial intelligence, experts predict.

Mr. Halperin explained that artificial intelligence is "essentially when the computer starts to think."

Coopers & Lybrand will soon have such a system available to benefit managers, he said, explaining that the firm already markets an artificial intelligence system that helps companies make decisions regarding tax obligations.

That system contains the knowledge of 30 "tax professionals," said Mr. Halperin. "They put all their knowledge of the tax code into the data base." A user is able to ask the computer questions concerning a tax-related problem and the machine will eventually supply a solution.

"We're trying to apply that to employee benefits," he said. "In the next year, there ought to be something available." ■

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Time capsule: 1980

The Carter administration's 1981 budget includes a proposal that would triple the federal funding to support health maintenance organization feasibility studies, planning, initial operating costs and expansion programs.

Funding for these programs would rise to $69 million in 1981 from the current ‡23 million. With this large increase in available funds, the administration estimates the number of federally qualified HMOs will increase to 139 from 105 (*BI*, Feb. 4, 1980).

* * *

Newport News Shipbuilding & Dry Dock Co. of Newport News, Va., is challenging federal guidelines requiring employers to cover the pregnancy-related expenses of employees' wives if they offer dependent health care.

In a suit filed in U.S. District Court here, the company seeks to overturn the Equal Employment Opportunity Commission guidelines issued in March 1979 (*BI*, Feb. 18, 1980).

* * *

The Financial Accounting Standards Board Statement No. 35 could hike the cost of performing actuarial valuations for pension plans as much as 15%, benefit consultants predict.

Statement No. 35 requires pension plan sponsors to issue an annual report to employees containing net assets available for benefits, the actuarial present value of accumulated benefits and changes in both (*BI*, April 7, 1980).

* * *

Most employers are defying the Equal Employment Opportunity Commission's pregnancy guideline, according to Jack Heitzer, assistant vp of operational procedures and government affairs for Metropolitan Life Insurance Co.

Mr. Heitzer predicts the courts will overturn the EEOC benefit rule that requires employers who offer dependent health care to cover the pregnancy-related expenses of an employee's spouse (*BI*, April 21, 1980).

* * *

Employers are waging war on the cost increases in the $206 billion health care system.

Those costs will reach $2.4 trillion by the year 2000 if current trends continue, so employers are scrambling to cut costs within their own companies and to form coalitions with other employers and, sometimes, health care providers to find ways to streamline the system (*BI*, June 2, 1980).

* * *

The Internal Revenue Service will not impose the tougher pension vesting standards it had planned, but it intends to stop automatically approving some plans.

The IRS is taking the action as part of its crackdown on plans that discriminate in favor of highly paid employees (*BI*, June 9, 1980).

* * *

The first publicly owned health maintenance organization in the nation will sign up its first customers this fall.

The HMO, which was developed by Contra Costa County, Calif., as an extension of its cost-cutting program, is targeting small employers (*BI*, July 7, 1980).

* * *

Although the sagging economy is forcing layoffs because there is not enough work for everyone, the benefit manager's work pace has picked up.

Benefit managers at financially troubled companies, who often find themselves with trimmed-down staffs, are struggling through a pile of paperwork created by layoffs and early retirements (*BI*, July 28, 1980).

* * *

Employers are in the midst of an epidemic of wellness programs.

Companies are using a variety of ideas, ranging from corporate spas to fitness seminars, to cut their health care costs by keeping their employees from getting sick in the first place (*BI*, Sept. 1, 1980).

* * *

Some employees are getting a new benefit: cash incentives to buy an American-made car.

Several companies have begun programs to pay workers from $100 to $250 to help them contend with inflation and help spur the sagging auto industry (*BI*, Sept. 8, 1980).

* * *

Those who provide hospice care for the terminally ill say the success of the programs depends on the support of insurers.

And that support from insurers, who do not yet cover hospice care, depends on whether they feel there is demand from buyers and if they determine that hospice care is less costly than hospital care for the terminally ill (*BI*, Sept. 29, 1980).

* * *

Flextime and flexible benefit plans are the first steps toward a more-human work society, according to Alvin Toffler, author of "Future Shock" and "The Third Wave."

Mr. Toffler says, "It's a clear example of the demassification of society and a sign that corporations are becoming more interested in their employees as individuals" (*BI*, Oct. 6, 1980).

* * *

More than 1.5 million federal workers and dependents will have dental coverage next year.

The coverage will be extended to people enrolled in the government's high-option Blue Cross/Blue Shield plan (*BI*, Oct. 20, 1980).

* * *

Curtailed benefit spending in industries hit hard by the recession resulted in the first decrease in benefit spending in a decade, according to a survey by the U.S. Chamber of Commerce.

In 1979, employers' costs for employee benefits averaged 36.6% of payroll, down from 36.9% in 1979. However, most of the drop was due to cuts in benefit spending by recession-plagued industries; those industries not hurt by the recession continued to increase benefit spending more than total compensation (*BI*, Nov. 3, 1980).

* * *

Experts agree that when President Reagan and the conservatives elected to Congress take over in January, business will have a powerful ally.

Among other things, they say, the changing of the White House guard will be the death sentence for a national health insurance plan, long pushed by liberal Democrats (*BI*, Nov. 10, 1980).

* * *

The growth of health maintenance organizations has slowed in the past year.

HMO enrollment grew to 9.1 million this year, up 11% over the 8.2 million enrolled in 1979. However, that was less than the annual growth rate of 16% that the industry has averaged since 1971 (*BI*, Dec. 15, 1980).

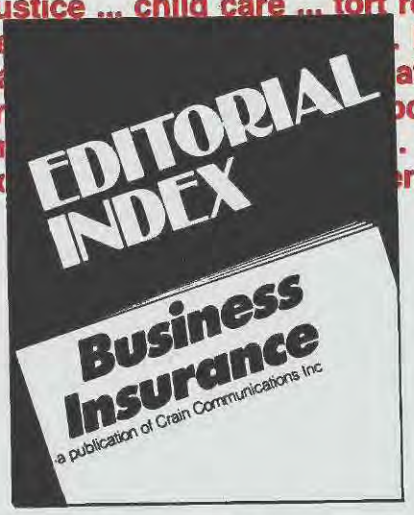
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The U.S. Department of Labor has ordered another major corporation to pull onshore its benefit program reinsured through its Bermuda-based captive.

The department has ordered American Cyanamid Co. to stop using its Bermuda captive to reinsure its group health and long-term disability plans (*BI*, Dec. 29, 1980). ■

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EI 11/2

More women leading benefit departments

By LAURA MAZZUCA

More and more women are in charge of corporate employee benefits departments than ever before, according to a survey by New York-based consultant Martin E. Segal Co.

The percentage of women in the employee benefits ranks rose to 29.5% in 1984 from 17.6% in 1982, the biennial survey of Fortune 500 non-industrial companies showed. And, although 1986 figures have not yet been tabulated, the consultant says it is safe to say the number is growing.

But it wasn't always that way.

Susan Koralik, who started out as an assistant in the benefits department of a Chicago company and now is New York region manager and a partner at Hewitt Associates, remembers a day in 1976 when a male administrator chuckled at her ambition and indulgently told her, "Girls can't be account managers, Suzie!"

While other women working their way through the employee benefit ranks may not have faced such blatant opposition, it was still an uphill climb.

Susan Weiner, assistant superintendent of the office of risk management at Dade County Public Schools in Miami, worked her way up from the statistics department to become the board's first female risk manager in 1978. She has responsibility for employee benefits and risk management.

And Jeanne F. Kardos, employee benefits director for Southern New England Telephone in New Haven, Conn., began her career in data processing 21 years ago.

"Employee benefits planning certainly can be done by women as well as men," Ms. Weiner remarked. "If you're qualified and of either sex, I'd like to think that the network is there on male as well as the female side."

"A lot of women are in it," said Ms. Kardos, who noted that at conferences, "you still see a majority of men, but there are more and more women there."

There are many reasons for the advancement of women in the employee benefits field. For Ms. Kardos, it was partially a matter of being in the right place at the right time, she said.

When Ms. Kardos entered the field in the late 1970s, many changes were taking place: the Employee Retirement Income Security Act in 1974; the advent of managed health care; an increasing move toward self-funding of health care benefits; and skyrocketing health care costs.

While Ms. Kardos had an undergraduate degree in medical technology, she had "no specific training" in the employee benefits field when she moved from data processing to the personnel department in the early '70s.

Many entry-level clerical workers start out in benefits administration, she said, eventually advancing to a supervisory position and ultimately to a level such as benefits planning.

The employee benefits field "moves much faster" now than when she first got into it, Ms. Kardos noted. "There is a need to get involved in issues directly."

The extended health care provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985; the non-discrimination rules of the Tax Reform Act of 1986; and proposed legislation mandating minimum levels of health insurance coverage "all impact the way we do business monthly."

Ms. Kardos is active in two organizations that address benefits issues: the Washington Business Group on Health and the Employee Benefits Research Institute, both based in Washington, which are "taking business's message to Congress."

Like Ms. Kardos, Ms. Koralik entered the workforce with a degree in an unrelated profession—teaching. She made the transition to personnel because there were no teaching jobs available and "because I liked to work with people—all the cliche stuff," she laughed.

Ms. Koralik started out as an assistant in the benefits department at Chicago-based Federal Sign & Signal in 1970.

"I was really lucky that the guy I worked for was tremendous," she said, referring to Personnel Director Larry Baytos. As her "mentor," he helped her advance from her "super-clerk" position to benefits administration, she said.

In 1973, Ms. Koralik was hired as a researcher at Hewitt Associates. Because of the rapidly changing benefits area, her research duties expanded and she was offered a position at Hewitt's New York office in 1974.

Her title then was "analyst" because "at that point women were not account managers," she recalled. It was feared that clients would object to dealing with women in that position.

The showdown came at a nationwide Hewitt meeting in 1976 when she confronted the group manager of account managers who told her: "Girls can't be account managers."

"We argued all afternoon and he finally agreed to try it (women as account managers)," Ms. Koralik recalled. She and another woman were named account managers, and the "experiment" was a resounding success.

Both changing attitudes and a changing field have contributed to the emergence of women in employee benefits, Ms. Koralik says. When she first entered the field, she recalled, employers were adding benefits; today, they are more concerned with how to maintain and administer existing benefits in a cost-effective manner.

The employee benefits field also is "more technical than it used to be" because of changing federal laws and spiraling health care costs, she noted. Today, benefits comprise 20% to 30% of an average employer's payroll, and employers want a close accounting of those dollars, she said.

"It's a more professional job than it was 10 years ago," she added, pointing to the Certified Employee Benefits Specialist designation as an indication of that professionalism.

Risk manager Ms. Weiner agrees that women are well-represented in the employee benefits field, although she qualified the statement by saying that in large corporations there was a layer of male employee benefits people who had worked their way up through financial positions.

Before joining the risk management department of the Dade County School Board, Ms. Weiner worked for AAA Auto Club and acquired a general lines agents license in Florida. Her insurance background was a plus in getting the job, she recalled.

The school district hired her in 1973 as a statistics supervisor, and she later advanced to insurance supervisor. She attained her current title of risk manager in 1985.

Ms. Weiner's duties include supervising the workers compensation department, the safety and asbestos programs, all property/casualty programs and employee benefits for the school board, which is Florida's second-largest employer.

When she started her career, Ms. Weiner estimated she spent 95% of her time administering risk management, with the remainder spent on employee benefits; she now says that percentage is reversed.

Ms. Weiner believes that legislative proposals concerning employee benefits are "the biggest hurdle we have to face. . .keeping up with the explosion of mandates and hoping we're doing everything correctly."

The other major issue is spiraling medical inflation, she added, which is a particularly onerous one for her department: Insurer statistics show teachers to be among the highest users of health care.

Because of these changes, the employee benefits field is exciting, she says, and advancement opportunities for women are plentiful.

"By their background and training, women are leaning more toward non-traditional educational opportunities," she observed. "They're in the limelight a little bit more. . .but there's still a long way to go." ■

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Time capsule: 1981

Major health insurers say that group medical insurance rates are up an average of 30% over last year, and some increases may be as high as 60%. The insurers attributed the hikes to inflation and increased utilization (*BI* Jan. 26, 1981).

* * *

The 52 American hostages freed from Iran are coming home to a bundle of tax-free benefits. The Hostage Relief Act of 1980 provides tax-free salaries and hazardous-duty pay, medical expenses and education benefits for dependents for up to two years for any hostages hospitalized for illness or injuries resulting from their captivity (*BI*, Jan. 26, 1981).

* * *

The major recommendation of the President's Commission on Pension Policy is that every U.S. employer should be required to offer a pension plan that immediately vests 3% of each worker's annual wage.

The panel said that unless private pensions are made mandatory, a two-tiered system will develop. Those employees covered by private plans will prosper, but those with only Social Security benefits will face poverty in old age (*BI*, Feb. 2, 1981).

* * *

An Internal Revenue Service regulation threatens 501(c)(9) trusts sponsored by trade associations. Under the IRS ruling, the tax-free trusts can be used by one company or by a trade group in which employees of members work in the same geographic area, but not by a trade group whose members are spread out around the country (*BI*, March 23, 1981).

* * *

The Equal Employment Opportunity Commission will appeal a federal court ruling that employers do not have to offer equitable pregnancy benefits to spouses of male employees.

In a landmark case, U.S. District Court Judge J. Calvitt Clarke Jr. overturned a 1979 EEOC guideline that says if an employer's health insurance plan covers the medical expenses of female employees' spouses, it must equally cover maternity expenses of male employees' wives (*BI*, April 6, 1981).

* * *

The nation's air traffic controllers, threatening a nationwide strike for June 22, are demanding a 25% increase in retirement benefits. The 15,000-member Professional Air Traffic Controllers Organization says PATCO members need higher retirement benefits because so many suffer job burnout (*BI*, June 1, 1981).

* * *

A new accounting standard proposed by the Financial Accounting Standards Board could threaten pension plan growth.

The FASB proposal would treat unfunded retirement benefits, which now are cited as a footnote in financial statements, as a liability on corporate balance sheets (*BI*, July 13, 1981).

* * *

A federal court ruling allows a self-funded multiple employer trust for employee benefits to qualify as exempt from state regulations under the Employee Retirement Income Security Act of 1974.

The decision made it clear that an association set up by employers for a specific purpose, such as self-funding health insurance benefits, can be considered an ERISA benefit plan (*BI*, Aug. 3, 1981).

* * *

The cost of providing employee benefits has risen an incredible 763% since 1951, according to the U.S. Chamber of Commerce.

The annual cost of benefits provided to the average worker rose to $5,560 in 1979 from $644 in 1951. During the same period, the Consumer Price Index rose only 190%.

And, benefit costs as a percent of payroll have nearly doubled to 36.6% in 1979 from 18.7% in 1951, according to the Chamber (*BI*, Aug. 17, 1981).

* * *

A federal judge has ruled that trustees of a multiemployer pension plan cannot unilaterally increase benefits if the action creates new unfunded liabilities for employers.

The decision, based on a suit filed by Borden Inc., granted a preliminary injunction barring the United Dairy Workers Pension Plan from increasing benefits that would create new unfunded liabilities without employers' consent. Borden is seeking a permanent injunction.

In his ruling, the U.S. District Court judge said that the Multiemployer Pension Plan Amendments Act of 1980 created potential liabilities employers never anticipated when they joined a plan. As a result, the judge said, plan trustees no longer have "unfettered authority" to set benefits (*BI*, Aug. 24, 1981).

* * *

The early returns are in, and they show that wellness plans can save money for employers.

Employers are finding that they can save millions of dollars by helping their employees stay well. For example, New York Telephone Co. says its wellness programs, by "conservative" estimate, saved the company $2.7 million in 1980 in absence and treatment costs (*BI*, Sept. 21, 1981).

* * *

Cafeteria-style benefits do not suit one small California city's taste, the city decided after an unsuccessful one-year trial.

Santa Rosa overran its benefits budget by $70,000 during fiscal 1979 because many employees opted to pocket cash rather than purchase self-insured benefits.

And, the plan wasn't very popular with employees, said William D. Kassler, city insurance and safety administrator. The biggest complaint was the difference between benefit allotments among employees. For example, a married employee with two or more dependents received double the benefits of a single worker (*BI*, Oct. 5, 1981).

* * *

Current Social Security reserves will fund only 1.5 months of benefits for the 51 million people who receive income through Social Security unless interfund borrowing and minor benefit cuts are implemented, warned John A. Svahn, commissioner of Social Security, at a conference of the Council on Employee Benefits.

The system currently is losing money at a rate of $12,300 per minute, Mr. Svahn said (*BI*, Nov. 2, 1981).

* * *

For the first time ever, the nation's average benefit cost per employee topped $6,000 in 1980.

Led by spiraling health insurance and pension expenses, benefit costs climbed to an average of $6,084 per employee in 1980, up 9.5% from $5,560 in 1979, according to a study by the U.S. Chamber of Commerce.

Benefit costs as a percentage of payroll also rose, to 37.1% in 1980 from 36.6% in 1979, according to the Chamber (*BI*, Dec. 21, 1981). ■

Time capsule: 1982

The Reagan administration plans to make employers pay most of the health care costs of older workers.

The administration is expected to unveil legislation next month that would shift most medical and hospital costs from the federal Medicare program to employer group health insurance plans for active employees over the age of 65 (*BI*, Jan. 11, 1982).

* * *

The sluggish economy and the rapidly rising cost of health care may cause the first benefit decreases in recent years, because employers no longer can pay the tab, experts say.

Recession-battered employers are asking their workers to accept benefit concessions, and experts say that such concessions are likely to be considered at negotiations involving auto, rubber, trucking and other unions during 1982 (*BI*, Jan. 18, 1982).

* * *

Employers could be faced with thousands of dollars in added benefit costs in the wake of a federal court decision mandating equitable pregnancy benefits for employees' spouses.

The federal court upheld the Equal Employment Opportunity Commission position that, since employers must provide the same benefits to their pregnant employees as they provide in any other case of disability, employers must extend the same treatment to the pregnant wives of their employees covered under their benefit plans (*BI*, Feb. 1, 1982).

* * *

A new survey says that few employers are implementing higher deductibles as a way of making their employees become wiser consumers of health care.

Fewer than 4% of the 582 major employers surveyed by Hewitt Associates require annual medical care deductibles of $150 or more under their group health plans for salaried employees (*BI*, March 22, 1982).

* * *

General Motors Corp. is implementing the first profit-sharing plan in its history.

In an attempt to regain profitability, the huge automaker is including the profit-sharing plan as part of a package of benefit and other contract improvements promised to the United Auto Workers union in exchange for wage concessions (*BI*, March 29, 1982).

* * *

A federal court judge in Pennsylvania has become the first judge to uphold a 1980 federal law that gives multiemployer pension funds the power to demand enormous payments from employers that leave the funds.

In dismissing a request for a preliminary injunction to bar a Pennsylvania multiemployer fund from demanding more than $850,000 in withdrawal liability payments from Republic Industries Inc., the judge upheld the constitutionality of the Multiemployer Pension Plan Amendments Act (*BI*, April 5, 1982).

* * *

The proposed 131% Pension Benefit Guaranty Corp. premium increase to $6 may be the shape of things to come, according to experts.

The experts say the proposed premium hike, which still must be approved by Congress, could be the first of several boosts if large corporations with huge pension liabilities collapse (*BI*, April 19, 1982).

* * *

Despite the fact that the Consumer Price Index shows that inflation is slowing, employers are not seeing any relief from high group health insurance costs.

Average increases for renewals of group medical insurance in 1982 are as high or higher than the average 30% hikes reported by major health insurers in 1981 (*BI*, May 31, 1982).

* * *

As part of a court agreement, Minnesota Mining & Manufacturing Co. has agreed to set up a $525,000 trust fund to provide back pay to as many as 1,000 female workers who were required to take unpaid maternity leave between Aug. 24, 1967, and Dec. 31, 1973.

3M announced the offer as part of a settlement of eight years of litigation between the manufacturer and the Equal Employment Opportunity Commission. The EEOC filed the suit along with some 3M female employees in 1974, alleging violation of the Civil Rights Act of 1964.

3M may also give some of the women credit for the forced leave when computing their pension benefits (*BI*, June 14, 1982).

* * *

Congress' drive to trim billions of dollars from the federal budget will cut into the pension benefits received by federal and military retirees.

Under an agreement reached between House and Senate committees, cost-of-living increase adjustments to federal and military pensions will be delayed one month during each of the next three years. In addition, pension benefits for retirees under age 62 will only be boosted to reflect one-half of the increase in the Consumer Price Index.

Currently, pension benefits for all federal and military retirees are increased annually to match the CPI (*BI*, Aug. 23, 1982).

* * *

An employer can be sued for punitive damages for alleged violations of the Employee Retirement Income Security Act of 1974, a federal judge says.

U.S. District Court Judge Cynthia Holcomb Hall ruled that "allowing punitive damages in appropriate circumstances. . .will further the express policy of ERISA to protect the interests of plan participants and beneficiaries by deterring fiduciary misconduct" (*BI*, Nov. 1, 1982).

* * *

The possibility that President Reagan will adopt a tax on employer-provided health benefits is worrying many benefit managers.

The Reagan administration has said that taxing health insurance premiums could raise billions of dollars in new revenues to ease swollen federal deficits as well as help curb soaring health care costs (*BI*, Dec. 13, 1982). ■

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Time capsule: 1983

Congress, faced with record federal deficits, is considering generating new revenue by making employer contributions to employee benefits taxable income for employees and ending some of the tax advantages of 401(k) salary deferral plans (*BI*, Jan. 10, 1983).

* * *

For the third consecutive year, insurers are predicting health coverage rate hikes of 25% to 35%.

A few employers with good claims experience may have to pay only 10% more. But others, with less favorable experience, may be hit with hikes as high as 100%, insurers say (*BI*, Jan. 10, 1983).

* * *

Associated International Insurance Co. of Los Angeles, which fully insured American Benefits Ltd. between May and July of 1982, says it will pay claims that were incurred during that period. But, coverage for the rest of the estimated 70,000 people for whom the multiemployer trust provided comprehensive health care coverage is in doubt (*BI*, Feb. 14, 1983).

* * *

More than 71% of the 287 companies surveyed by Buck Consultants said they either offer 401(k) plans or plan to implement them (*BI*, Feb. 14, 1983).

* * *

The Communications Workers of America has asked a federal court to strike a provision in the final divestiture plan of American Telephone & Telegraph Co. that calls for AT&T to divvy up some of the assets of its two giant pension plans among the seven new regional phone companies to be formed next year.

These companies would then set up their own pension plans. Most AT&T workers subsequently would not be able to carry their pension credits with them if they moved from one regional company to another (*BI*, Feb. 21, 1983).

* * *

Legislation approved last month by Congress to raise $165 billion in new revenues to bail out the Social Security system will raise employers' Social Security payroll taxes to 7% on Jan. 1, 1984, from the current 6.7%, making the hike a year earlier than anticipated (*BI*, April 4, 1983).

* * *

The Equal Employment Opportunity Commission has agreed to draft new regulations that will require employers to offer workers between the ages of 65 and 69 a choice of enrolling in a corporate group health insurance plan or choosing Medicare as their primary insurer.

In so doing, the EEOC is finally carrying out the intent of Congress when it passed the Tax Equity and Fiscal Responsibility Act last year (*BI*, April 18, 1983).

* * *

Employers would face huge cost increases if legislation is enacted barring sex-based insurance premiums.

Two bills currently are before Congress that would retroactively eliminate the use of gender as an insurance rating factor. And, insurers and employers agree that the effect of the passage of either of these bills would be higher costs (*BI*, May 18, 1983).

* * *

The Supreme Court has ruled that employers cannot offer better maternity coverage to female employees than they offer to wives of male employees covered under their group benefit plans.

The decision is expected to raise annual health care costs by 5% to 7% for employers that do not currently offer equitable benefits (*BI*, June 27, 1983).

* * *

Pension experts are studying the impact of last week's Supreme Court ruling that an employee's sex no longer can be a factor in calculating retirement benefits (*BI*, July 11, 1983).

For example, experts are trying to decide whether, under the typical defined benefit plan, women retirees' benefits should be increased to equal men's, or men's benefits should be decreased to equal women's (*BI*, July 11, 1983).

* * *

Sen. Edward M. Kennedy, D-Mass., is planning to introduce a bill under which employees would be fully vested in a pension plan after only five years of service (*BI*, Aug. 22, 1983).

* * *

The termination of two defined benefit pension plans at Mesta Machine Co. in Pittsburgh, which has filed for reorganization under Chapter 11 of the Federal Bankruptcy Act, could result in a $56.1 million claim against the Pension Benefit Guaranty Corp., the largest in the PBGC's history (*BI*, Dec. 26, 1983). ■

Time capsule: 1984

Despite opposition from employers, insurers and unions, the Reagan administration plans to ask Congress to tax employees on any employer health care contributions that exceed $175 a month for family coverage or $70 a month for individual coverage (*BI*, Feb. 6, 1984).

* * *

For the first time, U.S. employers are paying more than $7,000 a year per employee in benefit costs, according to the U.S. Chamber of Commerce.

The Chamber survey says that 1982 benefit costs averaged $7,187 per employee, up 8.5% from $6,627 in 1981. The Chamber said the increase was fueled by sharply higher health insurance and Social Security payments (*BI*, April 2, 1984).

* * *

The "use it or lose it" approach insisted upon by the Internal Revenue Service could sound the death knell for flexible spending accounts as health care cost containment tools, says Philip Alden, a vp at consultant Towers, Perrin, Forster & Crosby in New York.

The proposed rules, published May 7 in the Federal Register, explain what the IRS considers to be valid flexible benefits or cafeteria plans under Section 125 of the Internal Revenue Code.

Under the rules, employees would have to forfeit unused funds in an FSA at the end of a year.

Employers came up empty in their attempt to enlist congressional aid to save FSAs. Members of the House Ways and Means Committee were unswayed by employers' arguments against the IRS rulings (*BI*, May 14, 1984).

* * *

Facet Enterprises Inc. and the Pension Benefit Guaranty Corp. have agreed to revise an August 1982 settlement that allowed the Tulsa, Okla.-based automotive parts manufacturer to shift an underfunded pension plan to the PBGC.

Under the new agreement, which is contingent on Facet obtaining the necessary financing, Facet will pay the PBGC $11.9 million in cash and give the federal pension agency 90,000 shares of stock.

The PBGC estimated in 1982 that the Facet plan had $33 million in unfunded liabilities (*BI*, May 21, 1984).

* * *

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

Corporate giants like Time Inc., Digital Equipment Corp. and Philip Morris Cos. Inc. are sponsoring "work-and-family" seminars to help working parents cope with their dual roles (*BI*, May 28, 1984).

* * *

The Great Atlantic & Pacific Tea Co. will receive $275 million in surplus assets by terminating its 36-year-old overfunded defined benefit pension plan and setting up a new defined contribution pension plan for active workers.

A&P also has purchased annuities to pay accrued benefits to the 27,639 participants covered under the terminated plan (*BI*, May 28, 1984).

* * *

The Pension Benefit Guaranty Corp., the Labor Department and the Treasury Department have jointly issued guidelines for employers to follow when terminating overfunded pension plans.

The guidelines stipulate that: an employer may not recover any surplus assets until it has fully vested participants' accrued benefits and purchased annuities to guarantee payment of those benefits; if participants elect a lump-sum payment rather than a monthly payment, the amount of the lump sum must fairly reflect the value of the pension; and, in the case of a "spinoff" termination—which will be allowed only once every 15 years—the employer must purchase annuity contracts to cover accrued benefits of both active and retired employees (*BI*, June 5, 1984).

* * *

The new tax law—the Deficit Reduction Act of 1984—will deter employers from prefunding post-retirement health care benefits at the same time the accounting profession is encouraging employers to do so.

In addition, employers that use 501(c)(9) trusts or experience-rated plans sold by insurers to fund their employee benefit obligations will be hit with higher administrative costs and be forced to comply with a series of complex rules limiting tax-deductible reserves held by the trusts and plans (*BI*, July 16, 1984).

* * *

Employers will have less than five months to comply with a new law intended to give women a better chance of earning pension and survivors' benefits.

Final congressional approval of the Retirement Equity Act of 1984 will require employers to overhaul retirement plans to lower the minimum participation age and ease eligibility rules for survivors' benefits.

Most of these changes, which take effect Jan. 1, will lead to only slight benefit cost increases, experts say (*BI*, Aug. 20, 1984).

* * *

Congress appears ready to extend the tax-free status of educational assistance and legal benefits for employees.

Congressional sources say chances look good for passage of bills that would extend the benefits' tax-free status through 1985 (*BI*, Oct. 8, 1984).

* * *

The Treasury Department's tax simplification plan would wreak havoc on the nation's tax-preferred benefit system.

For example, the plan would eliminate 401(k) salary reduction plans, prohibit cafeteria benefit plans and tax employees on part of their employers' contributions to their health care coverage (*BI*, Dec. 3, 1984). ■



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Top events

Continued from page 3

280 points, including three first-place votes.

- The double-digit increases in health care costs during the 1980s, which forced employers to examine cost-containment options; 237 total points, including three first-place votes.
- The passage of the Tax Reform Act of 1986, which forced several significant benefit plan changes, including lower 401(k) deferral limits, faster pension vesting schedules and new restrictions on Individual Retirement Accounts; 213 total points, including one first-place vote.
- The development of 401(k) salary-reduction plans into the fastest-growing employee benefit of the 1980s; 189 total points, including one first-place vote.
- The passage of the HMO Act of 1973, which required employers with more than 25 employees to offer their workers the option to join a health maintenance organization if approached by an HMO; 132 total points.
- Congress' mandate that employers treat pregnancy like any other disability, after several courts sent down conflicting rulings on the issue; 129 total points, including one first-place vote.
- The move by American Can Co. in 1978 to offer one of the first flexible benefits programs, and the growth of such programs at other companies throughout the 1980s; 124 total points, including one first-place vote.
- The move by many employers to self-insure their group health insurance plans in the wake of rapidly rising medical costs; 104 total points.
- Extensive changes made by Congress to the Social Security system, including accelerating scheduled payroll tax increases and raising the age at which employees can receive benefits; 101 total points.

Several of the benefit managers who responded to the *Business Insurance* survey commented on the impact of rising benefit costs. For example, Richard G. Thomas, benefits director for the School Board of Broward County, Fla., said, "The role of benefits management has been heightened in most business enterprises as a result of the largely uncontrollable escalating costs and their impact on profits."

Linda Wright Manuel, corporate employee benefits director for Kurz-Kasch Inc. in Dayton, Ohio, added: "The introduction of new health care delivery systems has made us all study the various alternatives. . . .Cost is very important."

But, most of the benefit managers who responded to the *Business Insurance* survey wanted to comment on one main problem: the federal government

"There is layer upon layer of new law," complained the manager of benefits planning for a telecommunications company, who wished to remain anonymous.

"Regulations are being issued constantly," agreed the director of human resources for a textile manufacturing company with $220 million in annual sales.

Some respondents said that the constant government interference not only increases the hassles of managing benefit programs, but also decreases the quality.

"Because of government involvement, the planning and design of benefits have changed," said the corporate manager of benefits and insurance for an oil refining company with $800 million in annual sales. "We must project how things will be in the future. We have become more cost-conscious and less people-oriented."

And Ed Brady, the U.S. employee benefits manager for Digital Equipment Corp. in Concord, Mass., said: "The impact of legislation on all aspects of every benefit plan has been pervasive and ever-expanding. Creativity in benefits management has been diminished, as well as the 'fun' of the job."

In addition to the Top 10 stories, several other stories received a significant number of votes from the benefits panel. The stories that received more than 50 total points were:

- Court rulings that employers cannot unilaterally reduce promised retiree health care benefits, 98 total points.
- The strain put on the Pension Benefit Guaranty Corp. as the termination of underfunded pension plans leaves it with a multibillion-dollar deficit and a variety of proposals are made to bail out the PBGC, 73 total points.
- The ruling by the U.S. Supreme Court that sex no longer can be a factor in calculating retirement benefits, 54 total points.
- A ruling by a federal appeals court that states have the right to require employers to provide certain benefits if those benefits are financed by the purchase of insurance, 52 total points.

In addition, three stories not in the Top 10 got one first-place vote each. Those stories were:

- The move by large U.S. employers that operate across the country to establish uniform nationwide health care plans.
- The move by U.S. employers to implement wellness programs as a way of containing health care costs and improving the health of employees.
- The Deficit Reduction Act of 1984's elimination of tax incentives to prefund retiree health care benefits and restrictions on 501(c)(9) trusts. ■

Top benefit management stories of past 20 years

Story	Number of votes 1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	Total points
Enactment of ERISA	33	3	1	2	2	1	0	1	1	2	403
COBRA health care provisions	3	5	12	4	6	5	3	0	3	2	280
Health care costs soar	3	6	8	4	5	3	2	1	2	1	237
Tax Reform Act of 1986	1	10	2	5	2	4	3	4	2	2	213
401(k) salary reduction plans	1	2	8	7	3	3	2	1	1	2	189
HMO Act of 1973	0	4	3	0	2	4	4	4	4	4	132
Pregnancy benefits mandated	1	4	1	2	3	2	5	0	4	5	129
First flexible benefits plan	1	3	3	1	2	3	2	5	3	0	124
Self-insurance popularity grows	0	2	1	3	5	2	2	1	3	0	104
Social Security amendments	0	2	0	6	2	2	2	2	1	3	101

Chart: Amy Palmer, Chris Woolsey

Benefit managers learn to live with change

By ALISON KITTRELL

The dramatic changes in government regulations and in the expectations of employers and employees alike during the past 20 years have brought similarly dramatic changes to the employee benefits profession.

The overwhelming majority of the benefit managers who responded to a survey by *Business Insurance* say their field is much different now compared with when *BI* first began publishing.

"Benefits management has changed from an insurance company handling all risk benefits with the finance department handling pension and retirement plans to a full-fledged profession and department within human resources," says John D. Hill, senior international benefits specialist for Federal Express Corp. in Memphis, Tenn., and a 10-year industry veteran.

The profession has "turned proactive rather than reactive—if the manager is to be successful," remarks D.H. Kremnitz, vp-employee benefits for Carlson Cos. Inc. in Minneapolis, who has spent more than 20 years in the benefits profession.

Benefit professionals have had to develop or acquire new skills to meet these new challenges, the panel members say.

Fifteen-year industry veteran Kevin Gill, director of compensation and benefits for Springs Industries Inc. in Fort Mill., S.C., says, "It has moved from 'benefits administration'—simply making sure the employees have their benefits and letting the insurance company handle the details—to a very complex, very demanding, ever-changing profession."

"These days, the benefits professional needs to be part lawyer, part accountant, part actuary, part underwriter, part computer specialist and full-time fortune-teller, so we can forecast the future," Mr. Gill said.

And, benefit managers also are finding greater visibility in their companies as a result of the increased significance of employee benefits.

"Intrusion by government, via ERISA, et al, into the dealings and operations of private enterprises has created a great need for benefits expertise. The liability faced by companies that do not comply with the myriad of laws is staggering," says Kenneth J. Vail, benefit specialist for Certainteed Corp. in Valley Forge, Pa.

"Benefits and benefits administration have evolved into a major component of wage management in the last 20 years," says Dennis Spalding, director of human resources for Diemakers Inc. in Monroe City, Mo.

Some benefit managers are gloomy about the changes the profession has undergone during the past 20 years, especially at the hands of Congress.

Benefits management "has gone from providing basic pension and welfare programs to a complex system that is driven by the Tax Code and legal issues," says the director of benefits for a diversified services company with $1.5 billion in annual sales, who has 12 years' experience. "Matters that used to involve long-term commitments and planning are now subject to complete changes and reversals in relatively short periods of time."

And, some were quick to point out that the government should not shoulder all the blame for changes in employee benefits, because the expectations of workers also have changed.

Benefits management has changed "from flexible with many options to restrictive with fewer alternatives, due to government intervention and the attitude of the country that benefits are now a right which someone owes them," says the director of benefits/finance for a conglomerate with $14.5 billion in annual sales.

But, benefit managers also realize that the increased complexity, costs and regulation have brought them new prestige and clout within their companies.

The profession has changed "drastically from a maintenance function to one of the most significant functions in the organization. Currently it outranks labor relations as the key human resources function," says Hugh E. Becker, director of human resources for Robbins & Myers Inc. in Dayton, Ohio, and a 15-year veteran of the industry.

"The contemporary benefits manager occupies a key position in the organizational framework, which in years past was not often the case," adds Jack Hargest, director of personnel benefits for the American Gas Assn. in Arlington, Va., who has eight years' experience.

And, the corporate employee benefits manager for a manufacturing company with $300 million in annual sales, who has spent more than 12 years in the business, says, "Employers used to feel 'any dummy' could manage employee benefits. Hopefully management is becoming aware of the complexity involved."

When asked what changes they predict in their profession during the next 20 years, some employee benefits managers echo the almost-wistful comment of John J. Scott, senior vp-administration for Bradford-White Corp. in Philadelphia, who said, "Hopefully, not too many."

But most agree with 17-year veteran R.C. Regan, director of corporate benefits for Hoechst Celanese Corp. in Somerville, N.J., who predicted, "It will continue to get more and more entangled in the legal arena as regulations create more 'entitlements' to benefits."

Employee benefits will become "increasingly complex, more closely regulated, with employer plans more integrated with government-sponsored plans," agreed Thomas C. Sassman, director of compensation and benefits for Texas American Bancshare in Fort Worth and a veteran of 14 years in the industry.

The relationship between the past 20 years and the future is summed up succinctly by 17-year veteran Joseph G. Charles, group director of employee benefits for Ryder Systems Inc. in Miami, who says: "My job is bigger, more complex, more responsible, more recognized, more rewarding, and more rewarded than when I started. . . .In the next 20 years, I see much of the same."

Mr. Charles has some specific predictions: "Medical inflation has not abated. . . .Congress will meddle more in the benefits area. Just the bills they are presently discussing could have as much impact as most of what they have done to date. AIDS will have a growing impact in the benefits area. . . .So, too, will Medicare costs grow as our population lives longer. This, too, will result in more federal legislation and have an impact on post-retirement medical coverages."

The *BI* panel of employee benefit professionals seems to agree that the future, like the past, holds new challenges as they try to deal with increasing government regulation and the needs of a changing workforce. But they are ready to meet those challenges. ■

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Time capsule: 1985

Salaried workers are now likely to be able to contribute to a 401(k) salary reduction plan, according to a survey by Hewitt Associates of Lincolnshire, Ill.

The survey of 250 major U.S. employers showed that nearly three-quarters of the defined contribution plans offered to salaried employees had a 401(k) feature in 1984, up from less than half in 1983 (*BI*, Feb. 11, 1985).

* * *

Three major property/casualty insurers are using their surplus pension assets to boost their policyholder surplus.

Wausau Insurance Cos., Chubb Corp. and The Home Insurance Group plan to terminate their overfunded pension funds and realize profits of more than $264.5 million after they purchase annuities to pay benefits to participants and set up new retirement funds (*BI*, Feb. 25, 1985).

* * *

The Internal Revenue Service has changed its mind over the shifting of excess assets from defined benefit to defined contribution pension plans.

The IRS notified Buck Consultants that it is withdrawing its previous letter that sanctioned the transfer of assets if an employer received an actuarial statement that the assets in the defined benefit plan exceeded what would be required to pay accrued benefits if the plan is terminated (*BI*, March 4, 1985).

* * *

Under a recent agreement between Bethlehem Steel Corp. and its retirees, health insurance premiums paid by non-union workers who retired from the steelmaker before April 1984 are capped for life, but retirees are responsible for copayments and deductibles (*BI*, March 18, 1985).

* * *

If Wheeling-Pittsburgh Steel Corp. terminates its severely underfunded pension plans, it could slap the Pension Benefit Guaranty Corp. with the largest claim in its 10-year history.

Wheeling-Pittsburgh claims could hit $200 million to $300 million in unfunded liabilities, much higher than the PBGC's previous record claim of $63.3 million, and it could be the precursor of more big plan terminations in the nation's struggling smokestack industries (*BI*, April 29, 1985).

* * *

A government study says that flexible spending accounts should be prohibited because they actually impede health care cost-containment efforts and reduce federal tax revenues.

But, because flexible spending accounts already are so widespread, the Department of Health and Human Services report says it would be unrealistic to prohibit them, and they should be severely restricted instead (*BI*, May 27, 1985).

* * *

A federal judge has ruled that retirees have a contractual right to promised post-retirement benefits. The judge ruled that employers cannot unilaterally change those benefits after retirement.

The Reagan administration has bowed to pressure and moderated its tax simplification plan, but several benefits still would feel the sting.

The new plan eliminates the administration's proposal to tax employees on their employers' contributions to health insurance premiums above a certain level, but it includes as taxable income to the employee the first $10 an employer contributes toward individual coverage and the first $25 toward family coverage. And, although the revised plan saves 401(k) plans from total elimination, it limits tax-free contributions and restricts early withdrawals (*BI*, June 3, 1985).

* * *

The Supreme Court has ruled that states can require employers to offer certain benefits under their group health insurance plans.

The ruling is expected to raise employers' benefit costs, and to boost self-insurance, because the court said self-insured plans cannot be required to offer specific benefits (*BI*, June 10, 1985).

* * *

United Airlines plans to recover $962 million in surplus pension assets, the largest asset reversion ever.

The proposed pension asset reversion also is unique because it involves plans covering union workers in addition to salaried employees (*BI*, June 17, 1985).

* * *

A legislative package moving toward enactment would cause major benefit changes and added expense for U.S. employers.

The most significant proposal would deny employers their tax deduction for health care if they did not cover employees' spouses and dependents after an employee dies, separates from his or her spouse or divorces (*BI*, July 29, 1985).

* * *

Major league baseball team owners will double their annual contributions to the players' pension fund, following a short players' strike.

* * *

In exchange for changes in player arbitration rules, owners contributions will increase to $32.7 million from $15.5 million. The 1981 contract between the players and owners had called for the pension funds to be generated by the owners' national television contract, which has subsequently more than tripled (*BI*, Aug. 12, 1985).

* * *

Employees at the new Saturn Corp. auto plant to be opened in 1989 will have health coverage only through managed care facilities rather than traditional fee-for-service coverage.

The 6,000 United Auto Workers union members to be employed at Saturn, an offspring of General Motors Corp., will have health coverage only through health maintenance organizations or preferred provider organizations (*BI*, Aug. 19, 1985).

* * *

A hybrid pension plan, called a cash balance pension plan, is expected to grow.

The plan, introduced by BankAmerica Corp., replaces the traditional defined benefit pension plan and establishes a cash balance account for each employee when he or she becomes a member of the plan.

Then, each month thereafter, additional benefit credits are added to the account based on the employee's pay and years of service, and the account earns interest at a predetermined rate (*BI*, Aug. 26, 1985).

* * *

Employee benefits lobbying groups are headed to Capitol Hill to persuade Congress to reject the Reagan administration's renewed attempt to kill 401(k) salary reduction plans.

Leading the fight are the Assn. of Private Pension and Welfare Plans, the Employers Council on Flexible Compensation and the ERISA Industry Committee.

The administration—for the second time in 10 months—is recommending that 401(k) plans no longer be allowed (*BI*, Sept. 9, 1985).

* * *

The Supreme Court will decide the constitutionality of the 1980 federal law that allows multiemployer pension plans to demand huge payments from companies that leave underfunded plans.

The justices will review whether the Multiemployer Pension Plan Amendments Act represents an unfair seizure of a company's property (*BI*, Oct. 21, 1985).

* * *

A federal judge has ruled that retirees have a contractual right to promised post-retirement benefits.

The judge ruled that employers cannot unilaterally change those benefits after retirement, even if company benefits literature expressly states that the employer has the right to alter or terminate plans (*BI*, Oct. 28, 1985). ■

Time capsule: 1986

Congress is considering legislation that would prohibit ongoing, financially stable employers from terminating a pension plan until promised benefits are covered, and would give the Pension Benefit Guaranty Corp. a better chance to recover more assets when a financially troubled company terminates its plan (*BI*, Jan. 6, 1986).

* * *

A federal appeals court says that companies can terminate health care benefits for retirees.

In overturning a ruling against White Farm Equipment Co., the court said the Employee Retirement Income Security Act of 1974 does not give a federal judge the power to fashion common law to mandate vesting of retiree health benefits (*BI*, May 12, 1986).

* * *

The tax legislation ultimately approved by Congress is likely to include a five-year pension vesting requirement, experts predict (*BI*, May 19, 1986).

* * *

A study by Hewitt Associates of Lincolnshire, Ill., shows that defined contribution and capital accumulation plans, such as 401(k) plans, are offered by a majority of employers nationwide (*BI*, June 2, 1986).

* * *

Even though Congress has increased the annual premium employers must pay per participant to the Pension Benefit Guaranty Corp. to $8.50 from $2.60, the agency's liabilities will exceed its assets by $1.85 billion in 1990, according to a soon-to-be-released PBGC report. The current deficit is $1.5 billion (*BI*, June 16, 1986).

* * *

Employers are mounting a strong lobbying effort to urge changes in provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 that require most employers to extend group health care benefits to former employees and widowed and divorced spouses.

Employers are finding that COBRA adds substantial numbers of people to their health care plans and has a mushrooming effect on their benefit and administrative costs (*BI*, July 7, 1986).

* * *

The Equitable Life Assurance Society of the United States is shifting its entire group life and health insurance business to Equicor, a new joint venture formed by Equitable and the Hospital Corp. of America.

Equicor will allow employers to offer workers a choice between traditional indemnity coverage, health maintenance organizations and preferred provider organizations under the same group contract (*BI*, Aug. 11, 1986).

* * *

The tax reform bill approved by a congressional conference committee will raise employers' benefit costs and make some benefits less attractive for employees.

For example, the new bill limits annual 401(k) deferrals to $7,000, establishes a five-year pension plan vesting schedule, bars pretax IRA contributions by middle- and upper-income pension plan participants, and creates new and tougher non-discrimination rules for pension and welfare plans (*BI*, Aug. 25, 1986).

* * *

An "extraordinarily competitive marketplace" and $25 million in losses are forcing American Medical International Inc., an owner and operator of hospitals, to discontinue its 1½-year-old AMICARE preferred provider organization, company officials say.

AMI officials estimated they would have lost $100 million in fiscal year 1987 if AMICARE were not discontinued (*BI*, Sept. 1, 1986).

* * *

Employers may be forced to pick up the tab for millions of high-risk uninsured Americans, under a proposal that appears bound for passage in Congress.

The measure, which has been tacked onto a budget bill approved by the House Ways and Means Committee, would require states to set up pools to provide comprehensive health care coverage for the uninsured. If premiums paid by these people are not enough to cover the cost of the pools—a situation most experts predict—employers would be assessed to make up the difference (*BI*, Sept. 8, 1986).

* * *

The Pension Benefit Guaranty Corp. is taking over two massively underfunded pension plans of LTV Corp., with two more plans likely to go under.

The two plans the PBGC is taking over represent about $600 million in unfunded liabilities, and the other two plans could add an additional $1.9 billion in liabilities for the financially troubled PBGC (*BI*, Oct. 6, 1986).

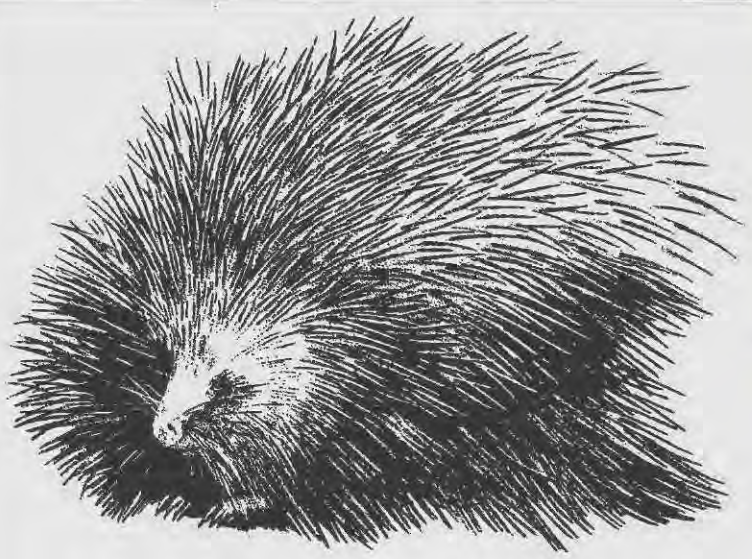
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Health and Human Services Secretary Otis Bowen is recommending that states set up a pool—subsidized by employers, insurers or individuals—to provide comprehensive health care coverage to high-risk uninsured individuals.

In addition, Mr. Bowen is urging employers be required to offer coverage to employees for catastrophic health care expenses (*BI*, Dec. 1, 1986).

* * *

In its 1988 budget proposal, the Reagan administration plans to include a risk-based formula to determine the premium an employer must pay to the Pension Benefit Guaranty Corp., after years of complaints from employers that companies with financially sound plans are subsidizing those with underfunded plans (*BI*, Dec. 29, 1986). ■



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Benefit legislation shifts course in '80s

By JERRY GEISEL

WASHINGTON—Federal legislation continues to have a powerful effect on employee benefit plans, though lawmakers now are taking a different course than they did in the 1960s and 1970s.

While the major benefit legislative initiatives between 1967 and 1980 all were fueled by the twin congressional desires of improving the financial security of benefit plans and increasing coverage for participants, the growing federal budget deficit has driven legislation since then.

For example, between 1973 and 1980, Congress passed measures to give pension plan participants new rights as well as improve the financial stability of multiemployer pension plans.

Congress also removed state barriers blocking the growth of health maintenance organizations and pumped hundreds of millions of dollars into HMOs.

Employers were required to expand health care coverage for pregnancy, while Congress amended the tax code to allow employers to offer flexible benefits, salary reduction plans and group legal benefits on a tax favored-basis to employees.

"It was a time of great enthusiasm (in Congress) and spending for benefit plans," recalled Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington-based benefits think tank.

"There was a sense if benefits were added through changes in the tax code that it was free," said Mary Nell Lehnhard, vp-government relations at the Blue Cross & Blue Shield Assn. in Washington.

In the last five years, though, benefit legislation has taken a very different course.

Legislators, burdened by the massive federal budget deficit, have forced employers to assume obligations that the government no longer can afford to provide.

"The government has run out of money to provide benefits, and Congress has turned to employer plans to make up the difference," said Ms. Lehnhard.

This shifting of benefit costs to employers has taken several forms.

Employers, for example, now are the primary payer of health care coverage for the working elderly—a responsibility once assumed by the federal Medicare program.

In addition, legislators, aware that the federal government no longer could afford to add new benefit plans, mandated that employers extend their group health care plans to former employees and their dependents.

Budget deficits also have forced Congress to trim the tax advantages of benefit plans and cut employer tax deductions for benefit contributions.

During the 1980s, Congress—among other things—slashed the maximum salary deferrals employees can make to 401(k) plans, eliminated the tax incentives for employers to prefund retiree health care benefits and rolled back tax-deductible contributions employers can make to fund pension benefits for highly paid employees.

Because of the budget deficits, "We went from a giving to a taking away. Congress said: 'We gave you 401(k). Now we are going to take some of it back. We gave you 415 limits (setting maximum pension benefits and contributions). Now we are going to cut it back,' " said Mr. Salisbury.

Aside from the change of direction, the budget deficits of the 1980s had other implications for benefit plans.

Benefit managers, once accustomed to having the time to comment on legislative proposals, found the debate moving at a speed that made it difficult to stay on top of the issues, let alone influence the outcome.

"Proposals became enacted with lightening-like speed," said Edward J. Davey, a vp with Johnson & Higgins in New York.

Not only were proposals considered more quickly, but the debate of measures often also took place behind closed doors.

That faster, more secretive approach to crafting legislation led at times to sloppy draftsmanship, forcing legislators to pass new proposals before the ink was dry on previously passed measures.

For example, just months after Congress passed the health care continuation provisions in the 1985 budget law known as the Consolidated Omnibus Budget Reconciliation Act, legislators enacted a technical corrections bill to correct a series of gaffes.

"It was appalling. More and more legislation was being passed in the dark. The mood on Capitol Hill was get it done and get it done quickly," said Lloyd Kaye, a managing director with William M. Mercer-Meidinger-Hansen Inc. in New York.

Both the speed and closed-door atmosphere combined to limit the ability of employers and benefit lobbyists to influence the outcome.

"It was frustrating to try to get people to listen," said Mr. Kaye.

"It became an intolerable situation. How much was done at the staff level behind closed doors was disturbing," said Theresa Stuchiner, a partner with Kwasha Lipton in Fort Lee, N.J.

At the same time, benefit proposals more often than not became tied to complex budget and tax bills.

That new tie also complicated lobbying because benefit lobbyists had much closer ties to the congressional labor committees, which once played the lead role in drafting benefit proposals, than the tax committees.

Even when benefit lobbyists could meet with tax committee staffers, it became difficult to influence the proposals on social policy grounds because staffers were concerned with raising revenue.

"Regardless of the social policy, revenue considerations would dominate," said J&H's Mr. Davey.

"When legislators turned to benefits, it was to come up with dollars," said Ms. Stuchiner.

But things were different in the 1970s when Congress enacted a slew of benefit proposals.

"The period 1973-'80 was a mirror image of the 1980s. There was a giving, not a taking away," said Mr. Salisbury.

And, in the 1970s, each of the major benefit laws enacted by Congress was driven by social policy, Mr. Salisbury added.

For example, to encourage the spread of prepaid health care plans, Congress enacted the Health Maintenance Act of 1973. That law pre-empted state barriers to HMO developments, including state laws that barred physicians from joining corporations.

And, the act also required employers with more than 25 employees to offer an HMO if they were properly approached by the HMO.

To further expand HMOs, the law made them eligible for what ultimately became hundreds of millions of dollars in federal grants and loans.

The Employee Retirement Income Security Act of 1974 was enacted to end years of pension plan abuses that hampered the ability of participants to collect benefits and jeopardized the financial security of the plans.

Employers were required to establish vesting schedules so that employees—no matter what—would be entitled to a benefit after a reasonable number of years.

Some plans had denied benefits if there was a short break in service, while others required as many as 20 years of service before employees were vested.

By contrast, under the most popular vesting schedule laid down by ERISA, pension benefits must be fully vested after 10 years.

To improve plan funding, employers were required to fund liabilities over a 30-year period. And, in the event that a plan wasn't fully funded when it was terminated, a federal agency, the Pension Benefit Guaranty Corp., was established to pay basic benefits through premiums paid by all employers with defined benefit plans.

Employers and plan trustees were required to act solely and exclusively on behalf of plan participants. A company, for example, no longer could routinely borrow funds from its pension plan to build warehouses.

Employers also were required to provide a description of how the plan operates as well as the plan's financial results to participants.

And, federal regulatory authorities were given the power to enforce the provisions of the new law.

On the health care side, the Pregnancy Discrimination Act of 1978 stopped companies from laying off female employees after they became pregnant or giving them smaller health care benefits than for other illnesses—once a fairly common practice.

Under the law, employers had to provide the same health care benefits for pregnancy as they offered for other illnesses and disabilities.

Recognizing that not all employees had the same need for benefits, Congress in 1978 added Section 125 to the tax code to give employees the opportunity to choose between cash and a menu of non-taxable benefits without incurring any adverse tax consequences.

The 1978 tax act also added Section 401(k), which, following the publication of Internal Revenue Service regulations in 1981, gave employees new tax incentives to save for retirement through salary reduction plans.

The Multiemployer Pension Plan Amendments Act of 1980 was a congressional move to improve the funding of multiemployer plans.

Many multiemployer plans had accumulated enormous liabilities because employers sought to keep their contributions as low as possible while unions pushed for higher benefits.

Until the mid-1970s, there was little concern about those growing liabilities; the plans were expected to remain stable because new employers would join the plans to replace companies going out of business.

But when an entire industry was dying and new companies weren't joining the plans, the burden of funding and paying benefits would fall on a smaller and smaller number of employers.

When those increasing pension costs became too great a burden on the remaining employers, they would be forced to withdraw, leaving the PBGC holding the bag for promised benefits.

The PBGC then would be forced to raise termination insurance premiums to pay for the benefits, boosting costs for other multiemployer plans.

To prevent this scenario from developing, the Multiemployer Amendments Act required employers leaving a multiemployer plan to pay a share of the plan's promised, but unfunded, liabilities. These payments became known as withdrawal liability.

Legislators believed that the specter of withdrawal liability would be an incentive for employers to stay in the plans and improve plan funding through increased contributions.

Since 1981, the year in which Congress enacted a major tax law that led to huge budget deficits, revenue considerations—not social policy—largely have been the driving force behind legislation affecting employee benefit plans.

"Looking back, 1982 was a watershed year. With the enactment of the Tax Equity and Fiscal Responsibility Act of 1982, we began to see the issue of benefit provisions being targeted as revenue raisers," said Mr. Davey.

For example, TEFRA slashed the maximum annual contribution an employer could make to a defined contribution plan to $30,000 from $45,000 per participant, while the maximum annual benefit that could be funded and provided through a defined benefit plan was cut to $90,000 per participant, down from about $136,000.

TEFRA also shifted some of the costs of the Medicare program to employers by requiring employers to extend their group health care plans to workers 65 through 69.

In the same vein, the next tax law—the Deficit Reduction Act of 1984—placed limits on the tax deductions employers could take for funding benefits, like health care and long-term disability through Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts.

DEFRA also wiped out VEBAs as a tax-effective way to fund retirees' health care benefits, as well as freezing until 1988 the maximum tax-deductible contributions employers could make to provide pension benefits for highly compensated employees.

Revenue considerations also were the reason for many—though not all—of the benefit provisions in the Tax Reform Act of 1986.

"With tax reform aimed at lowering basic tax rates, obtaining revenue through benefits became one way of achieving this goal," said EBRI's Mr. Salisbury.

For example, to help pay for those lower tax rates, tax-deductible contributions to Individual Retirement Accounts were eliminated or cut back for middle and upper-income pension plan participants, while employers terminating overfunded pension plans were hit with a 10% excise tax on the reversion.

In addition, the maximum annual salary deferral an individual could make to a 401(k) plan was cut to $7,000 from $30,000, while the plans themselves were made less attractive to employees by making it tougher and more expensive to collect benefits before retirement.

But other provisions in the new tax law were a throwback to the congressional goal of increasing benefits to participants.

The law, for example, established a new five-year vesting schedule to replace ERISA's 10-year standard and decreased the ability of employers to integrate or reduce pension benefits by the Social Security benefits received by retirees.

But budget considerations very much were a consideration in the 1986 enactment of COBRA's health care continuation provisions.

This provision had its origins during the recession of the early 1980s when legislators became concerned about the large numbers of people who lost health insurance coverage when they were laid-off and found it prohibitive to buy coverage in the individual market, said Mercer's Mr. Kaye.

Since there was no federal money to provide coverage to people who lost coverage, Congress turned to employer plans.

"The government is out of money and how can we do social good? Congress has turned to employer plans. COBRA is the most dramatic example of this trend," said Ms. Lehnhard of BC/BS.

Continued on next page

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Continued from previous page

Under COBRA, former employees can buy group health care coverage for up to 18 months. Employers also have to extend coverage for up to 36 months to employees' widowed, separated or divorced spouses.

Employers can charge COBRA beneficiaries a premium equal to 102% of their cost.

The effects of this welter of benefits legislation are varied and not always in ways envisioned when the laws were enacted.

For example, some critics charged that ERISA would be the death of the private pension plan system because employers would terminate plans rather than meet the new federal funding, reporting and participation standards.

While thousands of plans did terminate in the wake of ERISA's enactment, they often were replaced by new plans that met ERISA's standards.

In fact, between 1976, the first year that many of ERISA's rules went into effect, and June 1986, the number of defined benefit plans has increased to 249,000 from 132,000, according to EBRI.

Today, defined benefit plans comprise about 30% of the pension plan universe—the same percentage as in 1976.

Unquestionably, though, ERISA did force employers to turn to outside consultants for help, marking the start of the great boom of the benefit consulting industry.

"Employers needed unbiased, high-quality objective skills. There was a need for expertise," said Kevin Meehan, an attorney with The Wyatt Co. in Washington.

But ERISA also led to a big increase in the number of congressional and agency staffers regulating and evaluating benefit plans on a day-to-day basis and ultimately coming up with new proposals.

"Prior to ERISA, the number of people in government generating proposals probably was 1% of what it is today," said Mr. Salisbury.

The enactment of the HMO Act is given credit for triggering the start of what has to become a boom in HMO growth during the late 1970s and '80s.

"It gave a highly, public visible boost to HMOs," said Ms. Lehnhard.

"The HMO act opened up HMOs to new markets. And the loans and grants were crucial to HMO development," said James Doherty, president of the Group Health Assn. of America, a Washington-based HMO trade group.

And, the Multiemployer Amendments Act, while initially triggering outrage from employers angered that they now faced liabilities they never counted on when they joined the plans, has led to improved funding, experts say.

For example, this year the average multiemployer plan was 96% funded for vested benefits, up from 90% in 1983, according to surveys conducted by Martin E. Segal Co. in New York.

More recently, the enactment of COBRA has led to big administrative hassles for employers trying to keep track of benefits and premium payments for thousands of people lacking a direct employment relationship.

"We have one person in our benefits department dealing with COBRA claims, and one is not proving to be enough," said Art Young, benefits manager at Hewlett-Packard Co. in Palo Alto, Calif.

Benefit proposals coming out of Congress in the future are likely to increase rather than diminish, many say.

"Benefit plans are viewed as a big fat bubble by some in Washington. Legislators will go after benefits even more aggressively than in the past," said Mercer's Mr. Kaye. ■

Court decisions on benefits increase employers' costs

By STEPHEN TARNOFF

Court decisions affecting employee benefit plans over the last 20 years have placed greater financial and administrative burdens on employers.

In some cases, the courts have expanded benefits for employees—especially women—restricted employers' ability to modify benefit plans and empowered states to require insured plans to offer certain benefits.

Other decisions, however, have helped employers, such as a decision preventing returning military veterans from accruing payments under a profit-sharing plan for time they were in the service.

However, federal legislation has supplanted at least one court ruling that favored employers: the 1976 U.S. Supreme Court decision that allowed employers to exclude pregnancy from disability plans.

The following are some of the most significant court decisions involving employee benefits during the last two decades.

● *General Electric Co. vs. Gilbert.* In a historic decision, the U.S. Supreme Court in late 1976 ruled that excluding pregnancy from disability coverage is not discriminatory (*BI*, Dec. 13, 1976).

The case involved a class-action suit filed in 1972 by 43 female employees of General Electric Co. that charged GE discriminated against them on the basis of sex by excluding pregnant employees from the firm's disability plan.

GE forced its female employees to take unpaid maternity leave at the end of their sixth month of pregnancy. At the same time, the GE plan paid benefits to men who took time off to have hair transplants.

A lower court agreed with the plaintiffs that the GE plan was discriminatory against women.

However, the Supreme Court disagreed. "Gender-based discrimination does not result simply because an employer's disability benefits plan is less than all-inclusive," the high court said.

The GE plan "is nothing more than an insurance program which covers some risks but excludes others."

However, the decision was subsequently overturned by federal legislation.

In October 1978, Congress gave final approval to the Pregnancy Discrimination Act, landmark legislation that outlawed sex discrimination on the basis of pregnancy by requiring employers' disability plans to treat pregnancy as any other disability.

However, the act does not require employers to provide disability plans.

"It (the decision) was extremely significant," said Susan Ross, a law professor at Georgetown University Law School who at the time was an attorney for the American Civil Liberties Union, which filed an amicus brief in the case. "It had terrible ramifications for women workers."

However, she stressed that the decision did prompt the 1978 act, which forced employers to offer disability benefits for maternity leave if they provide disability coverage to their employees.

● *Newport News Shipbuilding & Dry Dock Co. vs. Equal Employment Opportunity Commission.* In another important decision involving pregnancy benefits, the U.S. Supreme Court ruled in 1983 that employers must provide equitable pregnancy benefits to spouses of male employees.

In a 7-2 decision, the high court ruled that Newport News Shipbuilding & Dry Dock Co. of Newport News, Va., violated the Pregnancy Discrimination Act of 1978 because it placed a $500 cap on pregnancy hospitalization benefits for spouses of male employees while providing full health care coverage for husbands of female employees (*BI*, June 27, 1983).

Newport News Shipbuilding had challenged 1979 regulations published by the Equal Employment Opportunity Commission to aid employers in complying with the pregnancy discrimination act.

Under the EEOC regulations, an employer's health insurance plan must cover maternity expenses of male employees' spouses if the plan covers the medical expenses of female employees' spouses.

A U.S. District Court judge in 1981 agreed with Newport News Shipbuilding's argument that the Pregnancy Discrimination Act only applies to employees.

However, the 4th U.S. Circuit Court of Appeals disagreed, finding that the act applies to spouses' pregnancy benefits because those benefits are employment-related.

The Supreme Court upheld the 4th Circuit.

It is unlawful to give the husbands of female employees a specified level of hospitalization coverage for all conditions while "the wives of male employees receive such coverage, except for pregnancy-related conditions," the majority of the court said in an opinion written by Justice John Paul Stevens. To do so "gives married male employees a benefit package for their dependents that is less inclusive than the dependency coverage provided to female employees."

Andrew M. Kramer, the attorney for Newport News Shipbuilding, said it was difficult to assess the financial impact of the decision on employers. He noted, however, that some had complied with the effect of the decision prior to it being handed down, while some adopted a "wait and see" attitude.

"It's obvious for those who didn't, it brought in a new pool of claimants under the insurance program," said Mr. Kramer with the Washington office of the Cleveland-based firm of Jones, Day, Reavis & Pogue.

● *City of Los Angeles Department of Water and Power vs. Manhart.* In April 1978, the U.S. Supreme Court made it unlawful for pension plans to require women to contribute more than men.

The high court ruled that the Los Angeles Department of Water and Power violated the federal Civil Rights Act of 1964 by requiring female employees to contribute more than male employees to a mandatory pension plan (*BI*, May 15, 1978).

The water department contended that since women on the average outlive men, women receive more benefits and should be required to contribute more to the plan.

The court rejected that argument, however, ruling that the Civil Rights Act prohibits discriminating against individuals as members of a racial, religious, sexual or national class.

The statute's focus on the individual is "unambiguous," wrote Justice Stevens. "Even a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply."

Georgetown Professor Ross, who also worked on the case as an attorney for the ACLU, said the decision "was extremely significant as far as forcing employee-retirement plans to be sex-neutral."

● *Norris vs. Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plan.* Although five years after Manhart, some describe this as a companion case. In *Norris*, the U.S. Supreme Court ruled that an employee's sex could no longer be a factor in calculating a retirement benefit (*BI*, July 11, 1983).

By a 5-4 vote, the U.S. Supreme Court ruled: When men and women make equal contributions to a pension plan, women cannot receive a smaller monthly benefit than men, whether directly from the plan or under an annuity purchased from an insurer selected by the employer; and benefits do not have to be equalized for employees retroactively. Equal benefits were required only on contributions made after Aug. 1, 1983.

Five justices agreed that if contributions from both are equal the practice of paying women smaller monthly retirement benefits than men is discriminatory on the basis of sex, which violates Title VII of the Civil Rights Act.

"We have no hesitation in holding. . . that the classification of employees on the basis of sex is no more permissible at the pay-out stage of a retirement plan that at the pay-in stage," the court added.

● *Raypole vs. Chemi-Trol Chemical Co. Inc.* In this decision, the 6th U.S. Circuit Court of Appeals ruled that employers are not required to make retroactive profit-sharing contributions to veterans for the time they spent in the military when they return to their former jobs (*BI*, March 4, 1985).

The decision overturned a ruling by the U.S. District Court for the Northern District of Ohio that granted two veterans employed by Chemi-Trol Chemical Co. Inc. retroactive contributions for the time they spent in the military.

The lower court found that profit-sharing contributions are perquisites of seniority, which are protected by federal laws requiring that veterans be re-employed with the same status and benefits they would have enjoyed had they not left their jobs to join the armed forces.

However, the appellate court ruled that Chemi-Trol's profit-sharing plan represented short-term compensation for work performed and not a reward for length of service. And, the plaintiffs' right to contributions under the plan were subject to "a significant contingency" when they entered the military.

Therefore, the benefits could not be considered "perquisites of seniority," the appeals court held.

"If the decision had stood, there would have been significant ramifications," said David Wray, president of the Chicago-based Profit Sharing Council of America, which filed an amicus brief with the 6th Circuit.

"An untold amount of money would have been involved in making retroactive contributions on behalf of returning veterans," he said.

It also would have been unclear where the money would have had to come from—possibly other participating employees—which would have caused significant difficulty, Mr. Wray added.

● *Metropolitan Life Insurance Co. vs. Commonwealth of Massachusetts.* In this case, the U.S. Supreme Court ruled that states may require group health insurance policies to offer certain benefits (*BI*,

Continued on next page

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Court rulings

Continued from previous page
June 10, 1985).

The decision involved a Massachusetts law that requires insured employee benefits plans to offer at least $500 of coverage annually for outpatient mental health care. In addition, the law required plans to provide coverage for at least 60 days of inpatient mental health care per year.

In the case, Travelers Insurance Co. and Metropolitan Life Insurance Co. petitioned the high court to overturn the 1976 law.

The insurers argued that a "pre-emption" provision of the Employee Retirement Income Security Act of 1974 bars states from regulating benefit plans covered by ERISA.

But by an 8-0 decision, the court said the scope of the pre-emption provision was explicitly limited by another provision in ERISA known as the "savings clause," which preserves any state law regulating insurance.

According to the court, the Massachusetts law dictates the terms of certain insurance contracts and "seems to be saved from pre-emption by the savings clause as a law 'which regulates insurance.' "

"The plain language of the savings clause, its relationship to the other ERISA pre-emption provisions and the traditional understanding of insurance regulation all lead us to the conclusion that mandated-benefit laws. . . are saved on pre-emption by the operation of the savings clause," Justice Harry Blackmun wrote.

The court also ruled that federal labor laws do not pre-empt the Massachusetts law and that the state law does not interfere with collective bargaining processes.

The decision was a blow to group health insurers and their policyholders, which had hoped to escape the costly administrative burden of tailoring policies to meet the varying requirements of different states.

"I think it's an important case in that it had a significant impact on the shift of business from insured mechanisms to self-insurance," said Jack Helitzer, vp-group staff operations for Metropolitan Life. "It's not the sole reason, but is certainly a major reason," for the shift.

● *Eardman vs. Bethlehem Steel Corp.* In September 1984, a U.S. District Court judge in Buffalo, N.Y., ruled that Bethlehem Steel Corp. did not have the right to reduce medical benefits for its retired white-collar workers (*BI*, Sept. 24, 1984; Oct. 1, 1984).

Judge John T. Elfvin ordered Bethlehem to restore first-dollar medical coverage to its non-union retirees and to reimburse them for any additional expenses that a new plan —which provided less-generous medical benefits—had cost them.

Bethlehem had altered the retirees' medical plan April 1, 1984. Under the new plan, retirees and their dependent spouses were each required to pay $7 monthly for retiree health coverage if they were eligible for Medicare and $12 a month if they were not eligible. Also, they were required to pay $7 monthly for coverage for dependent children.

Under the previous plan, retirees did not have to make premium contributions.

The new plan also introduced several deductibles for the first time, including a $356 per-admission deductible for inpatient care. It also included a 20% coinsurance provision, though retirees' out-of-pocket medical expenses were capped at $800 annually.

Judge Elfvin ruled that because of ambiguous plan language and "extrinsic" evidence —including promises made to retirees— Bethlehem did not have the right to reduce the amount of retirees' health benefits.

Bethlehem subsequently appealed the decision to the 2nd U.S. Circuit Court of Appeals; however, the parties ultimately settled the case in early 1985 before a decision came down (*BI*, March 18, 1985).

"The significance of this case was that health care and insurance benefits of non-union employees were protected under ERISA even though they were not vested pension benefits," said Richard Moot, the attorney for the retirees in the case.

Among Bethlehem's arguments were that if they were not vested, they could be canceled. But the court rejected that argument, said Mr. Moot of the Buffalo law firm of Moot & Sprague.

Mr. Moot said the decision was one of the first to rule on the issue and that there have been a number of decisions since, most of which have agreed with Judge Elfvin.

● *Pension Benefit Guaranty Corp. vs. R.A. Gray & Co.* The U.S. Supreme Court unanimously upheld a retroactive provision in the Multiemployer Pension Plan Amendments Act of 1980 that says employers that left the plans before President Carter signed the law —but after its effective date—can be slapped with withdrawal liability charges (*BI*, June 25, 1984).

As a result, employers that left underfunded multiemployer pension plans during the five-month period in 1980 between the law's effective date and when the president signed the law, were on the line for tens of millions of dollars in withdrawal liability payments to the plans.

Congress can make a law's effective date retroactive as long as it has a rational legislative purpose in doing so, said the decision, written by Justice William Brennan.

"We believe it was eminently rational for Congress to conclude that the purposes of the MPPAA could be more fully effectuated if its withdrawal liability provisions were applied retroactively," the high court said.

The 1980 law plugged a loophole in ERISA that, according to a 1978 PBGC report, actually encouraged employers to withdraw

Continued on next page

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Financial:	
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Secretaries, Treasurers, controllers and other Financial Personnel	5,600
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	9,701
Sub-total	**23,868**
Associations	500
Government, Unions and Educational Institutions	914
Commercial Consumers Sub-total	**25,282**
Insurance Agents and Brokers	10,858
Insurance Companies	7,140
Financial Institutions	989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants	4,617
Others Allied to the Field	1,792
TOTAL	**49,689**

* Source Business/Occupational breakdown of qualified circulation, May 25, 1987 issue, as submitted to BPA for June 1986 BPA Publisher's Statement.

Continued from previous page
from multiemployer plans.

To discourage employers from leaving underfunded plans, and thus dumping the plans' liabilities on remaining employers, the MPPAA says companies withdrawing from multiemployer plans would have to pay a share of the plan's unfunded vested benefits.

And, because Congress feared that employers enrolled in underfunded multiemployer plans might flee the plans while it was considering imposing severe withdrawal liability penalties, Congress made the effective date of the act retroactive.

The Supreme Court decision involved the challenge of R.A. Gray & Co., a Tigard, Ore., general and commercial contractor that left the Oregon-Washington Carpenters Employers Trust Fund in June 1980.

The privately owned small construction company was later told by the carpenters' plan that its share of the plan's $27 million unfunded vested benefit came to $201,359.

The company subsequently filed suit against the plan, questioning the right of Congress to impose withdrawal liability retroactively.

On May 20, 1983, the 9th U.S. Circuit Court of Appeals agreed with Gray's arguments, finding that employers that withdrew from the plan were required "to pay a sum that seriously threatens their solvency without a specific showing of the proportionate need on the part of the pension trust funds."

However, the U.S. Supreme Court reversed, holding that Congress had a rational legislative purpose in making withdrawal liability charges retroactive.

"Congress was properly concerned that employers would have an even greater incentive to withdraw if they knew that legislation to impose more burdensome liability on withdrawing employers was being considered," the court said.

"Withdrawals occurring during the legislative process not only would have required that remaining employers increase their contributions to existing pension plans, but also could have affected the stability of the plans themselves."

● *Bowen vs. Public Agencies Opposed to Social Security Entrapment.* In a unanimous decision, the U.S. Supreme Court ruled last year that public employers cannot withdraw from the Social Security program (*BI*, June 30, 1986).

The decision upheld the Social Security Amendments Act of 1983 that bars state and local governments from withdrawing from the program on or after April 20, 1983.

The Social Security withdrawal ban, designed to curb a growing loss of Social Security payroll tax revenues, was challenged by the state of California and a group of California public entities known as Public Agencies Opposed to Social Security Entrapment.

They argued that the ban violated a "contract" they and other state and local governments had with the federal government. Under Section 418 of the 1950 amendments to the Social Security Act, state and local governments could opt out of Social Security two years after giving notice.

A U.S. District Court in California ruled in favor of the public entities, saying the 1983 amendments infringed on their contractual right to withdraw from the program.

But the Supreme Court disagreed. The justices noted that Congress had explicitly given itself the right to make future changes in the law when it passed the Social Security Act in 1935.

"Congress anticipated that it would be necessary to respond" to changes and therefore included a clause in the Social Security Act giving it the right to amend or alter any provision of the act, the justices said.

"As appellees must concede, the act itself, including the original version of (Section) 418, created no contractual rights. Therefore, there is no doubt that Congress had the power to amend the section," the justices added.

● *Hansen vs. White Motor Corp.* Disagreeing with a U.S. District Court in Buffalo, N.Y., a three-judge panel of the 6th U.S. Circuit Court of Appeals in Cincinnati ruled in a decision involving White Farm Equipment Co. that employers can terminate health care benefits for retirees without violating any federal common law.

ERISA does not allow a federal judge to fashion common law providing for the mandatory vesting of retiree health benefits, the court ruled on April 21, 1986 (*BI*, May 12, 1986). Congress, not the courts, should decide whether there is mandatory vesting of retiree health benefits, the appeals court ruled.

● *Alessi vs. Raybestos-Manhattan Inc.* Pension benefits can be offset by workers compensation benefits to retirees, the U.S. Supreme Court ruled in 1981.

In a unanimous decision, the high court upheld an appellate court ruling that ERISA did not bar General Motors Corp. and Raybestos-Manhattan Inc. from subtracting a workers compensation payment from the pension benefit received by an injured retired worker (*BI*, May 25, 1981).

● *Henn vs. National Geographic Society.* The 7th U.S. Circuit Court of Appeals strongly upheld the validity of early retirement window plans, saying they are a benefit to employees and are not presumptively discriminatory (*BI*, June 29).

● *Alabama Power Co. vs. Davis.* The U.S. Supreme Court in June 1977 ruled that under Section 9 of the Selective Service Act an employer must credit a returning employee's pension plan for his period of military service.

● *Murphy vs. Heppenstall.* The U.S. 3rd Circuit Court of Appeals in December 1980 ruled that Heppenstall Co. was liable for the difference between pension payments guaranteed by the Pension Benefit Guaranty Corp. and the benefits promised under provisions of an employer-union pension agreement.

The case involved 16 retired employees who sued their employer for the additional benefits when the pension plan was terminated by the court.

● *International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America vs. Daniel.* The U.S. Supreme Court in January 1979 ruled that non-contributory pension plans are not subject to the anti-fraud provisions of the federal securities laws.

● *Connolly vs. Pension Benefit Guaranty Corp.* The U.S. Supreme Court in February 1986 again upheld the constitutionality of the withdrawal liability provisions of the Multiemployer Pension Plan Amendments Act.

The court ruled that the law did not violate the "taking clause" of the Fifth Amendment of the U.S. Constitution. ■

Innovative prescription plans stem rising costs of benefit

By KARI BERMAN

Innovative prescription drug programs are growing in popularity as employers attempt to control the cost of prescription drug coverage.

Independent credit card and mail order drug plans are becoming more popular among employers trying to stem the rising cost of the benefit, which employers first began offering under major medical insurance plans in the early 1970s.

According to the William M. Mercer-Meidinger-Hansen Inc. 1987 survey on "Miscellaneous Group Benefits and Total Benefit Costs," 61% of the 818 companies polled provided some type of prescription drug coverage in their overall medical benefit packages.

"Prescription drug coverage began being included in (major medical) plans about 15 years ago and has remained an important part ever since," said Jennings Hart, senior vp in the benefits division at McDonough Caperton Insurance Group in Charleston, W.Va.

Benefits experts say that typically, prescription drug benefits cover 80% of the cost of drugs and include a deductible ranging from $100 to $200.

But as the cost of prescription drugs soared along with other health care costs during the 1970s and 1980s, benefit managers began looking for ways to contain those costs without completely shifting the responsibility to employees, benefit consultants explained.

Under both the credit card and the mail order plans, employers contract out the prescription drug dispensing service for a negotiated fee, allowing employees to purchase generic drugs for minimal copayments, Mr. Hart explained.

"Employees tend to like the convenience of the credit card system, where they go to the designated pharmacy, show their card, pay a $2 copayment and leave with their prescription," he said.

Employees on long-term maintenance medication, however, often opt for the mail order method, through which they are usually provided a three-month supply of their prescription for a $5 copayment.

"We have been very successful with both our credit card and mail order programs," said Jim Manning, executive vp of finance and administration at Medco Containment Services Inc., a Fairlorne, N.J., drug distributor.

"Companies are offering this program more and more because it is cost effective," agrees John Staelin, national marketing director of New York-based Sanus Corp. Health Systems, a health maintenance organization. "There is more access to generic drugs, less inventory cost and no labor costs for pharmacy employees. It is a winner."

The mail order drug method has worked well for New York-based Travel Related Services, a unit of American Express Co., for the last three years, according to Karen Manning, employee benefits director.

Ms. Manning said that while the company does not yet have any figures on how much the program has saved the company, employees have expressed satisfaction with the program.

"Our mail order program is bundled with the major medical plan, and the employee simply sends $5 to the distributor, receiving a 90-day supply in return," she explained.

Pacific Gas & Electric Co. in San Francisco also offers a prescription drug credit card plan.

"We began a prescription credit card program this year in response to employee requests, and so far, 2,500 of our 8,000 employees are taking advantage of it," reported Sally Gottlieb, supervisor of benefit administration.

PG&E employee cardholders pay a only a $3 copayment for prescription drugs when the drugs are purchased at designated pharmacies.

Although the mail order and credit card systems are promising cost containment measures, they are not problem free, experts agree.

"The main problem we see with the mail order plan is over ordering of prescriptions," pointed out John Wickens, vp-group underwriting at Prudential Life Insurance Co. of America in Roseland, N.Y.

Sometimes employees or their dependents will order a long-term supply of prescription drug and then the prescription changes.

The unused drugs must be discarded, rendering the cost-containment features of the program ineffective, Mr. Wickens pointed out.

But Luann Rhodes, a special projects coordinator at Capital Blue Cross in Harrisburg, Pa., disagrees.

If employees are limited to a three-month supply of their prescription drugs and if employers audit the programs to ensure that employees are not abusing the program by, for example, lending their credit cards to ineligible relatives or friends, employers can maintain the cost efficiencies of the program.

Capital began offering a mail order prescription drug program within the past few months that already services approximately 130,000 people. Under the program, businesses pay wholesale prices for the drugs rather than retail prices, Ms. Rhodes explained.

Employees or their dependents that opt for the plan are not required to make copayments. Employees whose prescription drug costs are covered under a major medical program are required to make a $5 copayment if they participate in the mail order benefit.

Employers that offer the credit card system are mostly concerned with controlling who uses the cards.

"The problem arises when a cardholder starts using the card to get prescriptions for individuals not covered by the benefit," pointed out Pat Wiley, an assistant vp at Johnson & Higgins in New York.

Although supporters of the program admit that card abuse is a kink in the system, they maintain that proper auditing by the distributor can reduce the problem.

"Prescription drug plans are good cost-containment measures for companies and they are here to stay," predicted Ted Wood, vp at Fred S. James & Co. in Portland, Ore. ■

State laws mandate parental leave plans

By KARI BERMAN

As baby boomers begin having children of their own and both parents in many families immediately resume their careers, state and federal legislators are turning to employers to offer a new benefit—parental leave.

A growing number of employers nationwide already are feeling the pressure to implement parental leave plans. Six more states have passed laws this year mandating that employers provide unpaid maternity and parental leave to both female and male employees, bringing to 17 the total number of states with such laws.

Typically, those laws require employers to grant a certain number of weeks of unpaid leave each year and guarantee employees their same or comparable positions when they return after caring for a newborn, adopted or ill child.

The congressional measures under consideration would force employers to offer family leave plans that would allow employees to take unpaid leaves of absence to care for not only newborn, adopted or ill children, but also ailing parents.

"Parental leave is becoming an important issue, in response to the combination of the rising number of women in the workforce and two-income families. Employees need help taking care of their children," said Patricia Wiley, assistant vp in the benefits department of Johnson & Higgins in New York.

According to the U.S. Bureau of Labor Statistics, there were 50.4 million working mothers as of September, nearly double the 29.7 million working mothers in 1970.

And, as of March, an estimated 3.2 million, or 52.6%, of married women with children less than 1 year old were employed, according to the bureau. In contrast, 43.3% of married women with children less than 1 year old held jobs in 1970. And, more than 60% of these working mothers have never received paid maternity leave, the bureau says.

Some benefits experts, though, feel that neither states nor the federal government have the authority to mandate that employers provide specific types of benefits.

"I think that it should be left to the individual company, and I don't believe that legislation should be involved," said Jennings L. Hart, senior vp in the benefits division of McDonough Caperton Insurance Group in Charleston, W.Va. "Employers should not be responsible for problems that are the result of social issues," he said.

Oregon's parental leave law, passed earlier this year, exempts employers that offer equivalent options in flexible benefit packages.

Meanwhile, some employers are unilaterally implementing parental leave policies for their employees.

For example, since last July, employees of New York-based American Express Co. have up to 12 weeks unpaid leave per year to attend to family-related matters, including maternity, paternity, adoption or care for seriously ill immediate family members. Although the time off is unpaid, employees are guarantied their jobs upon return, according to Jean Fraser, vp-employee relations.

Employees can take a single 12-week leave or the leave can be broken into several shorter leaves that total 12 weeks for the year.

"Providing for parental leave and dependent care will grow in importance in the future," Ms. Wiley said. "I predict that it will become a significant employment issue in the years to come and (legislative) answers will have to be found," she added.

Florida exchange

Continued from page 1

Unless the exchange reopens soon and collects premium assessments from member syndicates, the IEA's bank balance will continue to dwindle. Mr. Cross said the exchange has around $500,000 to pay operating expenses—enough to keep the IEA afloat at least until year-end.

But, beyond that, "it is difficult to say" how long the exchange could survive on only premiums that are still due on past business written by IEA syndicates, Mr. Cross noted.

Seven of the IEA's 15 formerly active syndicates remain in rehabilitation as a result of heavy losses attributable to reinsurance, and syndicates are still attempting to rescind or commute several of the problem treaties. It is not known how many—if any—of the eight syndicates not in rehabilitation plan to resume underwriting when the exchange reopens.

In addition, the Insurance Department has expressed concern that the IEA is named in almost two dozen lawsuits concerning policies written by exchange syndicates.

Mr. Cross would not say whether he thought the meeting with Mr. Gunter would signal the end of the exchange, but he did acknowledge that the Insurance Department is not voicing the optimism for the marketplace it has in the past.

When the IEA's problems began mounting earlier this year, Mr. Gunter publicly backed the marketplace. Recently, however, his tone has become much less supportive.

In a statement, Mr. Gunter called the IEA "an example of a self-regulating industry which is floundering due to a lack of internal controls. It is difficult to speculate about the exchange's future because of its unsound financial history" and because it is the first market of its kind to operate in Florida.

The IEA, although under the ultimate supervision of the Florida Insurance Department, was allowed to operate on a self-regulatory basis when it was created by a special act of the Florida Legislature in 1979.

Mr. Gunter said there are questions that must be answered "in the exchange's favor" before the IEA can attempt to reopen. Those questions are:

- Is the exchange financially viable in light of the almost two dozen lawsuits it faces?
- Are syndicates financially viable when yet unreported losses are taken into account?
- Can the exchange succeed in any case, considering its troubled history?
- Have internal controls been established to prevent history from repeating itself?

"Until these questions are answered, it would be irresponsible to allow the exchange to assume any additional liabilities," Mr. Gunter said.

Bill Godwin, assistant director of insurance company regulation at the Florida Insurance Department, said it will be "pretty tough" for the exchange to answer those questions to the department's satisfaction.

"We don't have any timetable in mind for a reopening," Mr. Godwin said. "Our concern is that they demonstrate to us that the problems that led up to last February have been corrected."

Mr. Godwin pointed out that one of the department's major concerns is the level of unreported claims facing IEA underwriting members. A few weeks ago, "a $3 million to $4 million claim came in that we didn't know anything about," he said. Underwriters had set up only a $1 million reserve for the coverage.

"We just don't know" whether the amount of unreported claims will be significant, he said.

The IEA's task of estimating unreported and future claims is "a tough one," Mr. Godwin said. "I can appreciate their plight. How can you know what's not reported?"

The IEA is 'an example of a self-regulating industry which is floundering due to a lack of internal controls,' says Florida Insurance Commissioner Bill Gunter.

In an effort to better estimate outstanding liabilities, the Insurance Department issued an emergency order asking all IEA brokers to immediately report any outstanding claims and premiums withheld.

Mr. Vaisman, the broker association's president, called the order "absurd." He said that only about 18 of the 78 current and former IEA brokers have not supplied claims information and that the Insurance Department could have collected the information more quickly and easily by contacting those producers directly.

In addition to unreported claims, Mr. Godwin said the department also is concerned about future litigation that could end in recoveries against the exchange.

Although the exchange exists to provide an operating environment for its underwriting members and assumes no risks, plaintiffs have named the IEA in approximately 23 lawsuits concerning coverage written by syndicates.

Mr. Cross maintains that policy wording "clearly indicates that the insurers are the syndicates and not the exchange." He also said that attorneys for the IEA believe the exchange has no liability in the disputes.

When such suits were filed in the past, the IEA "contacted counsel for the plaintiffs and pointed out that the exchange is not an insurer," Mr. Cross said. "In the past, that has been sufficient to get the plaintiffs to drop the charges" against the IEA, he said.

But recently, plaintiffs worried about collecting from financially strapped syndicates have taken a "shotgun approach" to filing suits and have named "everybody and their brother" related to the exchange, according to Mr. Cross.

While the IEA feels it is not liable for damages that stem from coverage disputes involving exchange syndicates, the Insurance Department is not so confident.

"The legal advice that we are getting is that there may be some recovery against the exchange," Mr. Godwin said.

The suits in which the IEA is named range from complaints seeking small unpaid claims from automobile accidents to litigation seeking tens of millions of dollars.

The potentially most damaging litigation that the IEA faces is the ongoing dispute involving Omaha Indemnity Co. The Mutual of Omaha unit filed suit in 1986, charging that two syndicates accepted reinsurance business they were financially unable to handle. Both syndicates stopped writing business in February 1986 when losses attributable to the reinsurance were uncovered.

Omaha Indemnity says it has suffered losses of about $169 million on business generating premiums of $118 million, of which $67 million was not reported.

The Omaha Indemnity litigation is particularly important because it could result in a large claim against the IEA's $14 million guaranty fund if the syndicates are unable to pay claims to the ceding company.

Another suit, filed by Colony Insurance Co. of Warwick, R.I., earlier this year, charges among other things that the exchange and its officials did not properly police its underwriting members, and the insurer seeks to recover at least $3 million related to losses on financial guarantee insurance business ceded to IEA syndicates (*BI*, Aug. 10).

The IEA also is involved in a dispute concerning business ceded by Forum Insurance Co. of Schaumburg, Ill. While the exchange reached a partial agreement concerning some syndicates that reinsured Forum's long-haul trucking business, it still must agree to terms concerning other syndicates.

Other disputes involve separate wranglings concerning business ceded to syndicates by International Bankers Insurance Co. of Coral Gables, Fla.; Dependable Insurance Co. of Jacksonville, Fla.; Protective Casualty Insurance Co. of Baton Rouge, La.; and Angelina Casualty Co. of Lufkin, Texas (*BI*, Aug. 31).

Mr. Gunter's apparent change of heart toward the exchange has caused some IEA members to express concern that the Miami marketplace may be heading for a final shutdown.

"I'm a little less optimistic than I was two months ago," Mr. Vaisman said.

The exchange's downtown headquarters has seen an exodus of brokers from its offices, but some producers who have moved out still retain their IEA memberships in case the market does reopen, Mr. Vaisman pointed out.

Still, the number of member brokers has shrunk to about 38 from 72 in 1986, and Mr. Vaisman admits that the IEA's problems have pared the brokerage ranks. Only a few truly support the facility, he conceded.

Mr. Vaisman said he and most brokers that placed business with the IEA are in the same position. By now, they have already found other markets to write coverage that had been written by exchange syndicates before the marketplace was shuttered, he explained.

"What I have left is 10 or 15 policies" that were written by IEA syndicates and could possibly be placed on the exchange if it reopened, Mr. Vaisman said. But if the marketplace does not reopen by January, "I will have replaced all my business."

Although Mr. Vaisman's faith in the marketplace has faded, he said it would be possible for the commissioner to breathe life into the IEA by throwing his support behind it.

And, a large, healthy syndicate could be the foundation for re-establishing the marketplace.

"If we could get a good booming syndicate in here with some business, then it might roll again."

"We've all got our fingers crossed," Mr. Vaisman said.

However, the syndicate investor who asked not to be named pointed to the lack of support from Mr. Gunter as the likely death knell for the IEA. "I can't fault the commissioner, but somewhere along the way he just really started to get the sense that (the exchange) would be a bigger liability existing than not existing.

"I think he gets certain feedback from people in the department. It has turned him off so much that he is beyond the point of being able to reason about keeping the exchange going," the investor said. "The minute we lost his support, it made an impossible job even more impossible. Whoever was left that wanted to keep it going felt they had a battle going that they could not win."

Mr. Godwin pointed out that if the exchange does reopen, any syndicates that decide to underwrite probably would face capacity problems.

The seven syndicates in rehabilitation would not be able to accept business if the exchange reopens soon, he noted, and the department anticipates "that the remaining syndicates would not be able to write at all or very much."

He explained that premiums continue to be paid on reinsurance treaties booked previously and, as a result, the syndicates not in rehabilitation likely would report a high net premium-to-surplus ratio unless they receive new capital.

Florida law allows IEA syndicates to underwrite business at a maximum 4-to-1 ratio. ■

Regulation

Continued from page 2

In addition to government's frustration with the property/casualty industry, consumers also may be losing faith in insurers, he said.

"It is estimated that 25% of the property/casualty risks are being covered outside traditional insurance. They're being covered through risk retention groups or captives and other means. As customers withdraw their risks, they withdraw their trust," he said.



Mr. McCormick

Insurers must take three main steps to improve both the government's and consumers' trust in the industry, according to Mr. McCormick. The industry must upgrade its accounting rules, improve state regulators' ability to monitor solvency and encourage regulators to use their knowledge to take tough action on insolvencies.

"Our balance sheets are supposed to report our financial health and are scorecards for us as companies and for regulators," he said. However, because of inadequate loss reserving by insurers and overstatement of surplus, balance sheets often are unreliable, he added.

"We need to look very closely at loss reserves and the accounts in which our reserves and assets are invested. All investments should be properly marked to market value, instead of to their amortized value" so that an insurer's holdings are more accurately reflected, he said.

"Such a change would prove to be a very stabling force. The property/casualty industry has had an abysmal record of setting loss reserves and until the industry learns to do this, the idea of discounting loss reserves should be avoided," he said.

"Achieving adequate loss reserves is very difficult, but if it turns out that reserves are inadequate, regulators should step in and companies should be fined," he asserted.

'Achieving adequate loss reserves is very difficult, but if it turns out that reserves are inadequate, regulators should step in and companies should be fined,' William M. McCormick says.

An additional effort to upgrade accounting standards would force insurers to examine and improve the way in which they account for uncollectable reinsurance, he said.

"There is no statutory provision relating to uncollectible reinsurance, but careful reserving for this would help. We should require some minimum reserve—say 2%—of our total receivables," he suggested.

If insurers adopted these more disciplined procedures to account for loss reserves and surplus, "we'll be introducing checks and balances into the system and will be able to see cycles quicker," Mr. McCormick said.

But, along with adopting stricter accounting rules, insurers "need to strengthen regulators' ability to monitor solvency and financial strength. Insurance is a commodity that is a necessity and not a choice. For that reason, it deserves public attention. The regulators often do too little too late," he said.

Some of the problems in regulating the industry are that the industry is very fragmented with many competitors, cost feedback is often slow and insurers' financial reports filed with states are not required to be audited, but should be, Mr. McCormick explained.

"We need to help our regulators get the facts they need so they can monitor solvency properly. I'm afraid our regulators have quite simply lost the big picture. They ignore the big things and concentrate on the minute details of each insurer," he said.

And, insurers need to encourage better solvency enforcement by government regulators because "giving them the proper information won't matter if they don't enforce solvency requirements. In the insurance industry, we need to reinstate capital punishment for these violations," Mr. McCormick asserted.

"I don't know why, but regulators do not have the courage to shut down the fly-by-night insurers. Instead of focusing on the bad accounting practices of the industry, they look at Band-Aid solutions like price-fixing," he said.

"Years ago, in California, we all knew of one insurer that was in bad shape and many of us warned the regulators in 1983. But, in 1986, the insurer finally went under. When this happens and there are all of these obligations and no assets, the guaranty fund pays, which means all of us pay," he explained.

Mr. McCormick obviously was referring to Mission Insurance Co.

But, along with forcing regulators to more actively enforce solvency requirements, "let's make the commercial insured take more responsibility for the insurer they do business with," encouraging them to examine the insurance company's solvency and claims history more closely, he suggested.

"We also must give regulators support when they root out low-ball loss reservers and high-ball surplus staters," he urged industry executives.

"Our industry is really in trouble and if we continue along the way we are, our allies will become our enemies. I realize we have a long way to go. But, just as the forces creating the cycle are greater than any one company, so too are the solutions to our problems," Mr. McCormick said.

Cal/OSHA

Continued from page 1

managements and some of his fellow Republicans in the state legislature, Mr. Abascal said.

"There's no constituency on this issue, except George Deukmejian," he said.

Cal/OSHA was widely known as an effective worker safety program, its defenders say. Its standards were more stringent than federal rules in several areas and California's rate of industrial accidents was among the lowest in the country, according to a study by the state controller's office.

"The governor was a damn fool to end that program," said state Assemblyman Richard Floyd, a Democrat from Hawthorne.

Mr. Floyd and others predict the withdrawal of the state from private business safety programs will lead to more accidents and higher costs to employers for workers compensation insurance.

"There's no way workers comp rates won't go through the ceiling," Mr. Floyd said.

Costs for serious injuries and deaths will more than exceed the $7 million the state spent as its share of the program, he said.

The court ruling was the latest move in a battle between Gov. Deukmejian and Cal/OSHA supporters that began in January, when the governor announced plans to limit the agency's role.

The Legislature, however, included enough money in the Department of Industrial Relation's budget to continue the work through the 1987-88 fiscal year. In an effort to protect Cal/OSHA, the money was melded into the department's lump-sum appropriation.

Gov. Deukmejian, in turn, singled out $7 million that he attributed to Cal/OSHA work and vetoed the expenditure.

The court ruled that state law does not allow the governor to veto parts of a budget that are not specifically listed in the legislation. Also, the justices found that the budget veto means the cut should be made in the department's overall budget.

"The (Department of Industrial Relations) director must allocate such moneys for the administration and enforcement of Cal/OSHA in the private sector as are necessary to carry out these duties," Justice Coleman Blease wrote.

The court did not order the $7 million returned to the budget; however, it did order the department to fulfill its Cal/OSHA duties with existing funds.

The legal assistance group also raised the issue of whether the governor has the power to rescind legislated programs such as worker safety through budget vetoes, an issue that Gov. Deukmejian addressed in statements last week.

"The issues raised in this decision go far beyond the question of whether California's worker safety program will be administered by the federal or state government. . .the case involved a fundamental question of separation of powers," Gov. Deukmejian said.

But Claudia Smith, counsel for the legal aid group's migrant farm worker project, said the governor was using constitutional issues to mask his real intent.

"The appeal will put the health of 9 million workers. . .in jeopardy for that much longer. I think that's irresponsible," she said.

Meanwhile, State Controller Gray Davis released a report Oct. 15 criticizing the transfer from state to federal authority and reported that Cal/OSHA's performance slipped in its final months.

The audit conducted by his department found Cal/OSHA inspections dropped 21%, citations for workplace problems fell 29% and penalties for safety violations decreased 45% in the last six months of the state program.

"Under the mismanagement of the department, the state virtually stopped enforcing the laws protecting California workers even though they had the resources," Mr. Davis said in a statement.

He singled out the large drop in penalties for violations as a major problem. "Penalties are clearly a deterrent to unsafe workplace conditions. The presumption is the more enforcement—the more worker safety," Mr. Davis said.

Mr. Davis, a Democrat, said the $7 million savings figure projected by the Deukmejian administration was misleading because the state also will lose revenue from penalties.

"The transfer is a bad deal for everyone," he said. "The administration has eliminated the finest workers' safety program in the nation at half the savings they projected."

But Ron Rinaldi, director of the Department of Industrial Relations, defended moving the state's safety program to federal hands.

The controller's audit was "terribly contrived," he said. For example, the report states the department has failed to collect $280,000 annually in federal grants for worker safety consulting work, while Mr. Rinaldi said the department has received, and continues to receive, the federal money.

He also challenged any contention that workers are in more peril because the safety program moved from state to federal authority.

"Mr. Davis would have you believe the employer would completely change his practices" after the transfer, Mr. Rinaldi said. ■

Maine work comp

Continued from page 2

assignments through year-end and continue coverage under those policies until they expire.

"Some bill will have to pass," Mr. Edwards said. "I can't believe the state will allow a situation where commercial insurance is not available."

However, the situation could become critical sooner than expected if a court approves Liberty Mutual's request to immediately prohibit Mr. Edwards from assigning any more employers to the insurer through the assigned risk plan. In addition, Liberty Mutual wants permission to cancel existing ARP policies before year-end after giving the necessary notice, said Kevin Gillis, a Portland attorney representing the insurer.

Liberty Mutual is using as support for its request Mr. Edwards' finding that the insurer could expect a 2% to 4% annual rate of return on pool business.

State Superior Court Judge Donald Alexander in Augusta, who is expected to hear Liberty Mutual's request today and rule on it by mid-November, previously ruled that an 11% to 14% return was fair, said Mr. Gillis, who is a partner with the firm of Richardson & Troubh.

In an Oct. 21 address to the Legislature, Gov. McKernan said a recent actuarial study found that "Maine's workers compensation rates were about average but that the costs of the benefits in our system were substantially higher" than in other states.

Insurers' losses, expenses and dividends exceeded direct premiums by 118.9% in 1986, says the National Council on Compensation Insurance. But some insurers say costs have exceeded premiums by 200% or 300%.

Unless the costs of the work comp system are reduced, insurers would need 75% to 100% rate increases, the governor said.

Workers with permanent partial disabilities receive about 70% of the system's compensation, although their injuries comprise only 4% of all cases, Gov. McKernan said.

"Maine is one of the few states that provides permanent impairment benefits, plus wage-loss benefits for life, with an escalator for cost of living capped at 5%" annually, he noted.

For example, a 25-year-old worker earning $310 per week who suffers a permanent partial impairment that results in a 50% wage reduction could receive $912,000 in wage-loss and impairment benefits if he reaches his life expectancy and the case were not settled with a lump-sum payment. This compares with a total of $38,000 in New Hampshire and $41,000 in Vermont.

One of the bills proposed by Gov. McKernan, H.B. 1918, would amend the system by limiting the duration of permanent partial benefits according to the percentage of a worker's impairment; eliminating the cost-of-living escalator for permanent partial benefits; and offsetting the impairment payment against the wage-loss payment so a claimant with a permanent partial injury could receive only one type of benefit.

The bill also requires that to be considered totally disabled, workers must be more than 75% physically impaired or meet a standard definition of disability. In addition, a totally disabled worker would not be eligible for cost-of-living benefit increases until two years after the date of injury.

The bill also would require that recognized impairment schedules, like American Medical Assn. guidelines, be used to determine an injured worker's degree of impairment and would replace the use of adversarial medical experts with independent medical examiners. It also would place responsibility for determining a claimant's suitability for rehabilitation with the state's Office of Employment Rehabilitation, rather than allowing service providers to decide.

The bill also prohibits attorneys' contingent fees and allows non-lawyers to appear at hearings before the state Workers' Compensation Commission. It also would increase to 1% of paid claims from the current 0.25% the maximum amount insurers could be assessed to finance the Commission on Safety in the Maine Workplace.

In addition, the bill would prohibit the payment of lump sum medical expenses and discourage other lump-sum payments.

The governor's other bill, H.B. 1917, would repeal the state's competitive rating law—which was already blunted by the cap on rates contained in the 1985 law—and replace it with a prior approval system.

Workers compensation rate-making, which has been the superintendent's responsibility, would be the responsibility of a three-person rating board.

This board also could set standards for a new medical fee schedule and periodically review benefits.

The bill also would make deductibles mandatory for employers with poor loss experience without retrospectively rated policies. And, it would strengthen reporting requirements for insurers with more than a 1% share of the Maine work comp market and require comprehensive claims data collection.

The AIA's Mr. DiGiovanni said insurers have "real problems" with the reporting requirements in the bill, which he calls costly and "unworkable."

Labor also opposes provisions in the legislative package. Charles O'Leary, president of the Maine AFL-CIO in Bangor, said the union is "adamantly opposed to benefit reductions for permanent partial" injuries.

Most observers predict that legislators will hammer out a compromise bill before year-end, perhaps as early as Thanksgiving. ■

Update

Jury rules against R.I. Blues

Continued from page 2

were unfair and illegal," said Blair R. Suellentrop, chief executive officer of Warwick, R.I.-based Ocean State.

Court finds for tobacco makers

NEWARK, N.J.—In a victory for the tobacco industry, a New Jersey federal court has rejected the use of a legal theory in a product liability suit brought by a plaintiff seeking unspecified damages.

U.S. District Court Judge H. Lee Sarokin ruled Oct. 27 that New Jersey law precludes the plaintiff from recovering against three tobacco manufacturers under the "risk/utility" theory of strict liability, under which the companies would be liable for manufacturing a defective product because the risk to users of the product significantly outweighs its benefits.

A New Jersey product liability law signed last July intended to bar the risk/utility theory in pending cases, Judge Sarokin said. The law also provides that a manufacturer cannot be held liable if harm is caused by an unsafe, inherent aspect of the product that should be recognized by a consumer, a test that is more favorable to the tobacco industry than to plaintiffs.

The suit has been brought by Antonio Cippolone on behalf of his wife, who died after smoking for 40 years. The three defendants in the ongoing litigation are Philip Morris Inc., Liggett Group Inc. and Loew's Theatres Inc., owner of Lorillard Inc.

An attorney for Mr. Cippolone said a motion will be filed asking Judge Sarokin to reconsider the decision.

Warehouse fire losses covered

PARIS—Stockholm-based Electrolux AB has insurance to cover the loss of 200 million French francs ($34.2 million) worth of household appliances destroyed in an Oct. 25 warehouse fire in Merly La Ville, France, according to Leif Lindgren, senior vp of Electrolux.

The loss, after a 5 million French franc ($854,500) deductible, is insured by Paris-based Assurances du Groupe de Paris SA, which is reinsured by Electrolux Reinsurance Luxembourg SA, Electrolux's Luxembourg-based captive insurer. The captive is reinsured by "various reinsurers," said Mr. Lindgren.

The warehouse is owned by a subsidiary of French insurer L'Union des Assurances de Paris, Mr. Lindgren said.

BM&F, Italian broker join forces

FORT WORTH, Texas—An agreement reached between Bayly, Martin & Fay, the 10th-largest U.S. insurance brokerage, and Nikols Group, Italy's largest brokerage, will create international marketing capabilities for both operations.

And, through a new stock issue involving an undisclosed sum, Milan, Italy-based Nikols, which projects 1987 revenues at $28 million, will become a 30% shareholder in BM&F of Fort Worth, pending U.S. regulatory approval.

"Bayly, Martin & Fay will operate in the U.S., they will operate as Nikols in Italy, and we will operate together, 50-50, elsewhere in the world," explained BM&F Chairman and Chief Executive Officer Greg B. Kent. The new international entity will be known as BMF-Internike Overseas Holding.

BM&F's London office and Internike, Nikols' London-based subsidiary that brokers insurance outside of Italy, will continue to operate separately.

Funds from the shares purchased by Nikols will "give us a strong financial position that will allow us to grow. Expansion is the way I plan to do the majority of that growth. I will be investing some of the money back into our existing locations," said Mr. Kent.

Briefly noted

Wilson H. Taylor has been named chairman and chief executive officer of **CIGNA Corp.**'s property/casualty division. Mr. Taylor, currently president of the division, will succeed Robert D. Kilpatrick when he retires in March 1989. . . .Directors of New York-based **Alexander & Alexander Services Inc.**, the second-largest U.S. brokerage, last week authorized the purchase of up to 1 million shares of the company's common stock, depending on market prices and conditions. A&A currently has 42.7 million shares outstanding, which last week were trading at approximately $17.75 per share. Meanwhile, **Corroon & Black Corp.**, the sixth-largest brokerage, has authorized the repurchase of up to 2 million shares of its stock, which last week was trading at approximately $24.63 per share. . . .The Property Claim Services division of American Insurance Services Group Inc. estimates that **insured losses resulting from the Oct. 1 earthquake** in Southern California will total $30 million. . . .**Keith Gillies,** chairman of Lloyd's of London reinsurance broker Golding Stewart Wrightson Ltd., has resigned following the merger of Golding Stewart Wrightson with the reinsurance division of Willis Faber P.L.C. He is the fifth executive to leave since the merger was finalized (*BI*, Sept. 21). . . .The Senate last week passed **Medicare expansion legislation** that would limit a beneficiary's annual out-of-pocket acute care expenses to about $1,850 and phase in a new prescription drug benefit covering 80% of expenses over a $600 deductible. . . .The General Accounting Office last week reported that proposed **parental leave legislation** would cost employers about $500 million annually. Business groups have contended such legislation would cost employers billions of dollars. . . .Four-term **Louisiana Insurance Commissioner Sherman Bernard** was defeated on Oct. 24 by Doug Green, a 38-year-old Baton Rouge computer consultant. . . .Crum & Forster Inc. subsidiary **J.H. Blades & Co. Inc.** has been sold to Lloyd's broker Jenner Fenton Slade Ltd., a unit of CJP Insurance Brokerage Holdings Ltd. for an undisclosed sum. Blades is a Houston managing general agent, wholesale broker and Lloyd's correspondent, reporting 1986 gross revenues of $11.3 million.

COBRA fines

Continued from page 1

ensure that employers have incentives to monitor their own compliance with the health care continuation rules and to retroactively correct any violation."

The new COBRA penalties, contained in budget reconciliation legislation that is expected to win congressional approval, are being welcomed by experts as a vast improvement over the current penalties.

"The switch to an excise tax, especially for large employers, is a welcome change from the prior draconian penalties," said Andy Anderson, a consultant with Hewitt Associates in Lincolnshire, Ill.

"It is an advance. It is a step in the right direction. The current rules are unlivable," observed Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

"The new proposed sanctions fit the violations more closely," said Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers.

John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J., agreed with that assessment. "The legislation is an attempt to fit the penalty more closely to the crime," he said.

In fact, the current penalties could prove counterproductive to the congressional desire of ensuring that employers comply with COBRA, said Edward J. Davey, a vp with Johnson & Higgins in New York.

If an employer automatically loses its tax deduction for a COBRA violation involving one beneficiary—even if the problem is immediately corrected—the employer would lack an incentive to retroactively extend coverage, he explained.

The proposed new rules, however, would offer an incentive for compliance because the $100 per day excise tax is waived if the violation is inadvertent and is corrected within 30 days by offering a beneficiary retroactive coverage.

Experts, however, still are concerned about provisions in the House legislation that call for a special minimum tax of $18,000, which would apply in certain situations.

This tax would apply if during a plan audit the IRS found a COBRA violation that was not corrected before the employer received notice that the IRS would be auditing its plan.

In such a situation, the period of non-compliance will automatically be considered the greater of 180 days—thus making the employer liable for an $18,000 fine per affected beneficiary—or the actual period of non-compliance if longer than 180 days.

According to the Ways and Means Committee report, the purpose of this special audit rule and the steep $18,000 tax is to give employers an incentive to monitor themselves for compliance with the health care continuation rules.

But consultants describe the penalty as overkill.

"If you don't catch the problem in time and you are audited, you are going to have to pay a lot of money," said Seth Tievsky, an attorney in The Wyatt Co.'s Research and Information Center in Washington.

Plan audits, up until now, have been rare. But, consultants say they have heard that the IRS plans to step up audit activity.

The $18,000 minimum penalty also would apply in situations where a violation had occurred and it was no longer possible for an employer to correct the violation.

This could occur in a situation in which an employer failed to extend COBRA coverage and then the beneficiary later lost eligibility for coverage. That could happen because the right to COBRA coverage ceases when a former employee joins another company and is covered under the new employer's health care plan.

The legislation, though, will be especially welcomed by employers that participate in collectively bargained multiemployer welfare plans.

In what some say is perhaps the most unfair aspect of the current COBRA rules, an employer in a multiemployer plan would lose its tax deduction if another unrelated employer or the plan administrator violated COBRA.

Under the proposed legislation, an employer would not be liable for violations caused by another employer in the plan.

And, while the current rules would cause an employer to lose its tax deduction for health care expenses even if the plan administrator were at fault, the proposed legislation would make the administrator and employer jointly and severally liable for the excise tax.

The new penalty provisions would not go into effect until Jan. 1, so employers that violated COBRA before Jan. 1 still could face the penalties under the current law.

However, for violations before Jan. 1, the secretary of the Treasury should "exercise administrative restraint" in applying sanctions, taking into account whether the employer made a reasonable effort to prevent and correct violations, according to the committee report.

The legislation does, however, expand COBRA coverage in one situation to give beneficiaries greater protection from uncovered expenses.

Currently, COBRA coverage ceases when a beneficiary receives coverage under another employer's health care plan.

But that provision hurts beneficiaries with illnesses that are not covered under a new health care plan's exclusion for pre-existing conditions.

The legislation would allow a beneficiary to keep COBRA coverage if the new plan does not extend benefits for the pre-existing condition.

"From the perspective of a beneficiary, it is a very good change," said Hewitt's Mr. Anderson.

The proposed changes to COBRA are the direct result of a massive lobbying campaign by employers, observers say.

The Internal Revenue Service received more than 1,300 letters, nearly all denouncing the loss of tax deduction for health care expenses penalty.

After those letters were received, administration officials began to send signals to Congress that changes to COBRA's penalty provisions were in order but that only legislators could make the changes (*BI*, Oct. 12).

"This goes to show that when employers focus in on a particular issue, their comments can have an impact," said J&H's Mr. Davey.

Ironically, if legislators do approve the changes, they will be part of a budget reconciliation bill that now is winding its way through Congress. The current health care continuation provisions were included in a budget reconciliation bill passed by Congress last year, illustrating how benefit issues now often become part of budget legislation. ■

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Learning lessons

Continued from page 100

reflect a more intelligent use of capital relative to the returns that might be available in the business. In any event, prospects for about average surplus growth appear muted. We believe that this should lessen the likelihood of excessive competition in 1988 and beyond. In fact, management should stop playing chicken and should be raising prices where needed.

Traditionally, it was perceived that the property/casualty business was a self-correcting business. Good earnings brought about bad earnings and cycles would reverse. The past two underwriting cycles did not quite work that way, and managements basically engaged in crisis management going from one precipice to another. The world has changed and managements must adapt. Integrity of balance sheets is critical. Likewise, management must have the intestinal fortitude to walk away from poorly priced business. If you do not expose capital you cannot lose it. Smaller is not necessarily bad at appropriate times. If the industry cannot do a better job of controlling its propensity to shoot itself in both feet, it may find that federal regulation, perhaps in tandem with state regulation, to be more a possibility than a fear.

Consolidation within the industry also seems to be a probability. Critical mass involving more efficient distribution of the product, enhancement of management information systems, a better matching of assets and liabilities and an upgrading of the sophistication and caliber of management is a must if companies are to survive and prosper in the 1990s.

The sharp decline in the stock market prices of many of these entities clearly makes several companies potential acquisition candidates. Some argue that an unfriendly deal cannot be done in the property/casualty business. We are not so sure that this is so.

To insurance buyers who are seeking out cheap prices, the term "caveat emptor" clearly applies. To the managers of those purveyors that who accommodate the aforementioned demand, we suggest they secure portable pensions and/or retire from the business before the due bills arrive. ■

New York exchange

Continued from page 1

Perrin Forster & Crosby showing that six of the exchange's eight insolvent syndicates may be broke by $170 million (*BI*, Oct. 12).

Roy Pomerantz, a lawyer with the New York firm of Kroll & Tract, confirmed that Syndicate of Wall Street Investors N.V. was among those requesting the filing extension.

Noting that the exchange had information from the Tillinghast report as early as mid-August, Mr. Pomerantz said that if the exchange had "gone public" with the report, syndicates would have "been able to make decisions on the basis of greater information than was available to them" before the Sept. 1 filing deadline for withdrawal notices.

Mr. Pomerantz is representing Wall Street Investors and two other syndicates in lawsuits against the exchange and its security fund to block the draw down of their security fund contributions (*BI*, Sept. 28).

Other syndicates are now expected to take advantage of the extended deadline to reconsider their participation on the exchange.

American International Group Inc., one of the exchange's earliest and biggest supporters, is "reviewing and reassessing" its position on the exchange, said Thomas A. Tizzio, president of AIG's brokerage division and a former exchange governor.

AIG, which owns one exchange syndicate and manages three others, has not decided what it will do, Mr. Tizzio said.

Some exchange members expressed bitter disappointment with the board's decision, seeing it as an invitation to those remaining on the exchange to leave.

However, others saw it as a reasonable response to the wishes of some of the exchange's syndicates.

"I think it's a reasonable decision under the circumstances. I don't think they should force syndicates to remain if they want to come off the exchange," said Betsy Brougher-Ayers, president of North Atlantic Treaty Managers Inc., an underwriting manager that provides services to Wall Street Investors, among other syndicates.

Joseph Fahys, the exchange's president, said: "The action of the exchange board of governors in extending the timing requirement for member withdrawals is entirely appropriate. Syndicates, brokers and the exchange now have additional time to consider their positions and their future plans."

A report on exchange operations by New York-based Stewart Economics Inc. recommended that the exchange go forward with fewer, larger syndicates, a condition that could be hastened if several syndicates take advantage of the extended filing period.

A membership meeting to discuss the exchange's future, including the Stewart report, has been scheduled for Nov. 23.

In his letter to members, Mr. Urquhart noted that withdrawal petitions must include plans for the run-off or reinsurance of withdrawing syndicates' obligations.

All withdrawal plans must be reviewed by other exchange syndicates and approved by the board of governors.

Eleven of the exchange's 45 syndicates filed withdrawal plans by Oct. 3. A 12th, Wall Street Investors, filed a plan despite being told it had missed the Sept. 1 deadline for filing a notice of intent to withdraw.

Excluding these syndicates and the eight insolvent underwriting members, the exchange was expected to enter 1988 with 25 syndicates.

However, this number may be in doubt following the filing extension, which was announced near the end of a meeting of exchange members that followed the board meeting Oct. 23.

"It was like almost an aside at the end of the meeting," said an exchange observer who was present at the meeting. "All the chins in the room hit the floor."

"It's unfortunate the board chose to take that action. I personally felt it was not that necessary," said Howard J. Fleming, president of Raven Re Management Inc., which is managing the run-off of Sentry Syndicate Inc.

"You get to the point where you just want to shake your head and walk away."

Mr. Fleming said he had lined up investors to contribute between $5 million and $10 million to capitalize a new syndicate but that he told the investors last month to "forget it."

The decision to abandon the new syndicate was not precipitated by the extended withdrawal deadline, he acknowledged. But he added, "You have to be blind not to see what's going on now."

Each syndicate will have to decide whether it can expect to attract the kind of business it wants on the exchange, he noted.

"If they are not going to get the business they want and the board says go ahead and pull out, they are going to do it," he observed, adding that he also expects some syndicates to remain on the exchange, convinced that it remains a viable marketplace.

"I suspect after this letter goes out there will be some additional syndicates deciding to withdraw, even though they had not previously considered it," Mr. Pomerantz said, referring to Mr. Urquhart's letter.

"It's obvious that the reason they did it is that there are more syndicates that want to withdraw," added Walter Groden, president of the David C. White Agency Inc. of Rockville Centre, N.Y., a long-time exchange broker. "The effect of that is not good. It can't possibly be good."

White Agency has organized a new syndicate—Lion Syndicate Inc.—with $5 million to $10 million in capital to write direct automobile risks, Mr. Groden noted.

Whether the syndicate joins the exchange, though, will depend on the exchange's ability to maintain its status as an approved non-admitted market in 39 states and on whether the syndicate can negotiate a cap on expenses related to operating on the exchange.

These expenses—particularly those related to the purchase of the exchange's headquarters building and its back office systems—are a major concern of the exchange and its remaining syndicates.

Lion Syndicate was ready to join July 1, but the exchange suggested postponing the application until the exchange could sort out problems related to the insolvent syndicates, Mr. Groden said.

The syndicate's application date was first put off until Oct. 1 and has since been postponed until Jan. 1, though Mr. Groden said he is not counting on a Jan. 1 application date either.

Meanwhile, in the wake of the board decision extending the withdrawal period, Mr. Fleming expressed severe disappointment at what he described as the exchange's failure to come to grips with long-standing problems. These include the failure of:

- Some syndicates to properly manage their own underwriting.
- The exchange management to deal with major back-office accounting problems.
- The exchange community—exchange management, underwriters and brokers—to cooperate to resolve the difficulties that have come to a head in recent months.

"We are still facing problems we were facing two years ago, and that doesn't speak well of any of us," he said. "We did not keep control. We did not control ourselves and we did not control each other."

"We could have been a factor in the marketplace. We could have been a help to a lot of people," Mr. Fleming lamented. "It was a wonderful opportunity for a lot of people and we dropped the ball badly." ■

New Lloyd's syndicates

Continued from page 2

and new tax liabilities. Therefore, only about 50% of the syndicate's business will be U.S. based, Mr. Thomas said.

Syndicate 1034 will have an initial stamp capacity in 1988 of about 10 million pounds ($17 million), 85% of which will be used for short-tail risks, 7.5% for long-tail risks and 7.5% for miscellaneous risks, according to Mr. Thomas.

Of the short-tail business, 45% will be "open-market" business; for example, risks that are insured individually rather than those packaged by an agent or broker with binding authority.

More than 60% of the syndicate's open-market business will emanate from the United States, he predicts. About half of the syndicate's long-tail business will be excess-of-loss reinsurance treaties.

David Newman, underwriter of new non-marine syndicate 1096, also thinks the U.S. market still holds opportunities for Lloyd's.

Syndicate 1096, managed by Cassidy, Davis Ltd., will have a total 1988 stamp capacity of 8 million pounds ($13.6 million). U.S. business will account for 70% to 75% of the business written by the syndicate, he said.

The syndicate's long-tail account will be "almost entirely claims- made type business," according to Mr. Newman.

The syndicate also will write a small amount of casualty clash reinsurance—policies that respond when a single, major catastrophe involves a a large number of the ceding companies' policyholders—for certain American companies.

These policies will contain "sunset clauses," limited reinstatements and commutation clauses, according to Mr. Newman.

The syndicate also will write:

- U.S. medical malpractice insurance "principally as reinsurance of doctor-owned mutual companies."
- Crime-related coverages for financial institutions worldwide, which the syndicate will insure and reinsure on a treaty basis. More than 50% of this business is likely to come from the United States.
- Directors and officers liability insurance for mainly U.S. risks, which the syndicate will insure and reinsure on a treaty basis.
- Errors and omissions insurance worldwide, covered under both primary and treaty reinsurance policies.

New non-marine syndicate 1102, managed by Warren Barber Underwriting Agencies Ltd., will write short-tail U.S. and non-U.S. excess-of-loss catastrophe reinsurance.

The syndicate, with underwriter Peter Murrell, will have a stamp capacity in 1988 of 5 million pounds ($8.5 million).

Its portfolio will consist of U.S. treaty business, international treaty reinsurance and aviation liability and hull, said a spokesman.

U.S. risks will account for about 60% of the business written by non-marine syndicate 1069, managed by Cotesworth & Co. Ltd., according to underwriter Malcolm Warrington. The syndicate will have a total 1988 stamp capacity of about 8.5 million pounds ($14.5 million).

Most of the syndicate's business will consist of bankers' blanket bonds and fidelity bonds in financial institutions. However, Mr. Warrington states in the syndicate's prospectus that "it is not my intention to have any involvement in the direct U.S. (long-tail) liability market nor to enter into any reinsurance arrangements, facultative or treaty, with any U.S. cedants for this class of business."

The largest of the new non-marine syndicates, syndicate 1095, managed by Wellington Underwriting Agencies Ltd., projects an 18 million-pound capacity ($30.7 million). But, only about 25%, 4.5 million pounds ($7.7 million), will be used to write North American reinsurance business, according to underwriter Bill Petzold.

Also limiting its U.S. business is non-marine syndicate 1086, managed by Lambert Brothers. North American risks will account for only 40% of its business. The syndicate will have an initial stamp capacity of about 5 million pounds.

Physical damage insurance, covering industrial, mercantile, retail and personal lines, will represent about 75% of the syndicate's premium income, Mr. Hallett said.

New non-marine syndicate 1098 is even more wary of U.S. risks. The syndicate plans to specialize in professional indemnity and political risk insurance; however, none of the syndicate's professional indemnity business will come from the United States.

The syndicate, with an initial stamp capacity of 5 million pounds, is managed by Polwring Underwriting Agency Ltd., a new underwriting agency jointly formed by Lloyd's agency John Poland & Co. Ltd. and Polwring underwriters Miles Wright, Malcolm Nightingale and Michael Golding.

"Four million pounds ($6.8 million) of our capacity will be used to write professional indemnity and third-party liability insurance," none of which will be written for U.S. risks, Mr. Wright said.

The remaining capacity will be used to underwrite political risks, including U.S. policyholders, he said.

Non-marine syndicate 1104, managed by Merrett Underwriting Agency, also is setting its sights principally on the U.K. market. The syndicate will have a stamp capacity of about 10 million pounds, said underwriter Edwin Simner.

The syndicate's portfolio will consist primarily of U.K. commercial, short-tail business with up to 70% of the syndicate's business coming from regional offices of U.K. brokers, according to the syndicate's prospectus.

Non-marine syndicate 1104 will write no reinsurance business and no U.S. risks, said Mr. Simner.

Non-marine syndicate 1101, managed by Trafalgar Underwriting Agencies, will not write any U.S. casualty business either.

Trafalgar's underwriter is Brian Theakston, who took over syndicate 553 when underwriter Cyril Warrilow resigned from the syndicate in May, following the revelation of huge underwriting losses on North American liability business (*BI*, June 29).

The Trafalgar syndicate will have an initial capacity of 3 million pounds to 4 million pounds ($5.1 million to $6.8 million).

About 60% of its business will be personal accident risks worldwide and about 40% will be non-dollar liability business, he said. No U.S. casualty business will be written, according to the prospectus.

The new non-marine syndicate being formed by Devonshire Underwriting Agencies Ltd. also will not write any U.S. business, according to Brian Peters, the agency's managing director.

Non-marine syndicate 1079 will have an initial stamp capacity of about 4 million pounds.

The syndicate will write fire and business interruption risks, contractors' all risks, personal accident, other property risks and pecuniary loss.

The new marine syndicates that will begin underwriting in 1988 include:

- Marine syndicate 1081, managed by RHM Outhwaite (Underwriting Agencies) Ltd. The syndicate will have a stamp capacity of at least 10 million pounds, and about 60% of its capacity will be used to write U.S. risks, said underwriter Derek Sharman.

Its proposed book of business is marine cargo, 25%; excess-of-loss reinsurance, 35%; marine liability, 15%; war and political risks 5%; hull risks, 10%; oil and gas drilling rigs, 5%; and non-marine and miscellaneous risks 5%.

- Marine syndicate 1091, managed by R.M. Pateman Underwriting Agencies Ltd. The syndicate will have a capacity of about 10 million pounds and excess-of-loss reinsurance will account for 20% of its business; hull risks, 20%; cargo, 25%; war, 10%; rigs, 7.5%; marine liability, 7.5%; and miscellaneous marine, 10%, according to underwriter Christopher Trott.

About 10%-20% of the syndicate's business will be U.S.-based, said a spokesman.

- Marine excess-of-loss reinsurance syndicate 1084, managed by Cuthbert Heath Underwriting Ltd. The syndicate will have a capacity of about 3.5 million pounds ($6 million), and its underwriter will be Graham Naish, said Director Ian Sturrock.

The syndicate will write no U.S. business, he said.

- Marine syndicate 1093/94, managed by R.D. Underwriting Agencies Ltd. The syndicate will have a stamp capacity of about 7.5 million pounds ($12.8 million), and its underwriter will be Maurice Howell, according to the syndicate's prospectus.

About 10% of the syndicate's business will be U.S.-based, a spokesman said.

- Marine syndicate 1097, managed by F.L.P. Secretan & Co. The syndicate will have a capacity of about 8 million pounds ($13.6 million), and its underwriter will be Terry Jones.

However, Mr. Jones said it was too early to estimate how much business would come from the United States.

- Marine syndicate 1088/89, managed by Tamar Underwriting Ltd., a new underwriting agency formed jointly by Lloyd's underwriting agency A.R. Mountain & Son Ltd. and directors of Tamar.

The syndicate will have a stamp capacity in 1988 of 6 million pounds ($10.2 million), said lead underwriter Charles Tankard.

Hull all-risks will account for 40% of the syndicate's business; energy risks, 20%; cargo risks, 10%; excess-of-loss reinsurance, 10%; war risks, 7%; and miscellaneous risks, 13%, according to Mr. Tankard.

About 20% of the syndicate's business will emanate from the United States, he said.

The other two new syndicates are:

- Bloodstock syndicate 1083, managed by Cuthbert Heath Underwriting Ltd. The syndicate will have a stamp capacity in 1988 of 2.5 million pounds ($4.3 million).
- Aviation syndicate 1085, managed by Octavian Underwriting Ltd. The syndicate will have a first year stamp capacity of 3.5 million pounds ($6 million), said underwriter Tony Crow. ■

Has the P/C industry learned from mistakes of the past?

By MYRON M. PICOULT

Special to Business Insurance

GIVEN *Business Insurance's* 20th anniversary, our charge this month is to provide a perspective on the property/casualty business—past, present and future.

Given our druthers we would have preferred to report on the industry's annual Halloween bash. We surely could have pulled a few skeletons from the closets. It also would have been fun to watch the bobbing for underwriting profits in the tub of evaporating surplus.

In any event, we all tend to be a product of the last environment from which we came. Hence, the prevailing perception among many industry observers has been that the wind down of this current underwriting cycle could be a carbon copy of the last debacle. (When we refer to the term "cycle," we are talking about the underwriting cycle as opposed to the pricing cycle.) In fact, if one were to take the stock market at face value prior to last week's crash, valuations implied that this cycle was going to be worse. We have not and still do not subscribe to that theory.

In taking a peek at the past, one finds that the underwriting cycle was remarkably predictable except for the last nightmare. Going back to the latter part of the 1930s, we found that the average tenure between the low points of the combined ratios was 5½ years. Furthermore, if one were to exclude the last two underwriting cycles when the industry went through "de facto deregulation," the swing in the combined ratios from the bottom of the mountain to the top averaged about six points.

The $64 question is not whether history will repeat itself, but what lessons have been learned by the industry. We have said before and we say again: We believe the current underwriting cycle will ultimately have a trough that will be much more shallow than the 1984 washout. There are several reasons for this perspective, but the key factor is the tax bill. In essence, the legislation redefined



Photo: Arnie Adler

Mr. Picoult

taxable income between the recapture of a portion of unearned premium reserve, loss reserve discounting and a pro-ration of tax-exempt interest and dividends. For many years, the industry operated as a classic tax shelter. This is now gone. In addition, Uncle Same is no longer a 50/50 partner with respect to underwriting losses. In 1988, it becomes a 66/34 split with the industry on the long side of the stick. For the first time in a long time, property/casualty companies are going to write real checks. Hopefully some of them won't be made of rubber.

The real significance of the tax law changes is that they probably will inhibit expansive statutory surplus growth. For those managements still in a fog, it could actually result in some diminution. Frankly, we are amazed at how little understanding top managements apparently have about the impact of the tax bill on their respective companies.

The second factor to be aware of is the reinsurance marketplace. The last underwriting debacle was aided and abetted by the availability of cheap reinsurance. Some of this is now coming home to roost. The reinsurance marketplace has remained relatively tight, with clients "fleeing to quality." We believe that the reinsurance market will remain relatively tight for some time. Lloyd's of London and other foreign insurers have indigestion from the workouts of some casualty business took on. Furthermore, the recent storm in England and stock market setbacks have also given underwriters there some cause to pause.

Another factor to recognize is the ticking time bomb of reinsurance recoverables. In a study we did based on year-end 1986 data, we found that for a screen of 23 insurers reinsurance recoverables—including paid, unpaid, incurred-but-not-reported and unearned premium reserves—equaled 125% of year-end 1986 statutory surplus. A more realistic accounting of this item on company balance sheets will surely pare some surplus accounts.

Likewise, we believe that the industry as a whole remains underreserved to the tune of about 6% to 8%; this does not include some nasty toxic surprises either.

Finally, the stratospheric interest rates that fostered that cash-flow underwriting mentality of the last cycle are not present and are not likely to be revived soon. Interim cash flow pressures from guaranty fund assessments and unrealistic premium rates in residual markets also pressure cash flow.

Last, but not least, are the events of the last few weeks on Wall Street. The decline in the stock market has reduced the statutory surplus of *almost all* major underwriters. Our calculations for a representative grouping of 12 companies showed that on average they had 57.5% of their statutory surplus invested in common and preferred stocks. The premium-to-surplus ratio for this group of insurers was 2.35-to-1 at the end of June. Adjusting for the stock market decline, the ratio would have moved up to 2.83-to-1. The reserve-to-surplus ratio would have had a commensurate rise.

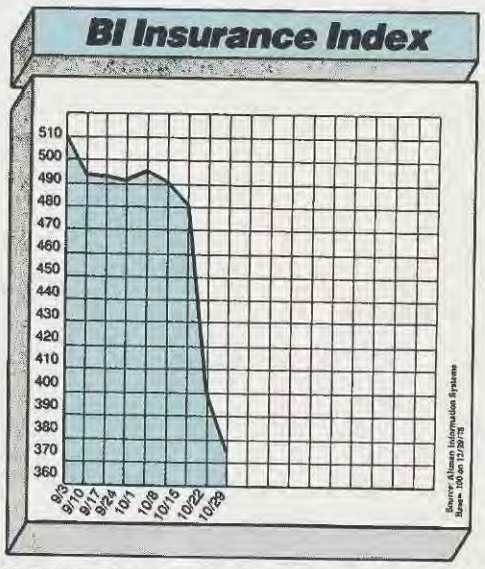
While the impact of this surplus decline may be more psychological than substantive, it should be noted that higher leverage ratios are viewed more positively when the underwriting cycle is improving than when it is heading south.

In the past we have seen that when statutory surplus stayed flat or declined, competition ceased and markets tightened. Not too long ago, many industry observers argued that the industry was overcapitalized and pointed to share repurchase programs. We would point these gurus to the poor quality of many balance sheets. We have not shared the excess capital perception. With respect to corporate buybacks, it would appear to

Continued on page 98

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. Mr. Picoult has written a monthly column for Business Insurance since 1980.

BI Insurance Index



Following last week's dramatic stock market plunge, insurance industry stocks continued to decline, although not as severely. The *Business Insurance* stock index fell 23.2 points to 376.7 on Oct. 29, from 399.9 on Oct. 22. Advancing stocks were led by: Aneco Reinsurance Ltd., up 14.1%; Selective Insurance Group, up 7.9%; American Heritage Life Investment, up 6.4%; General Re Corp., up 6.3%; and CNA Financial Corp., up 5.6%. Declining issues were led by: SCOR US Corp., down 28.6%; Provident Life & Accident Insurance Co., down 18.1%; Orion Capital Corp., down 17.5%; Argonaut Group, down 16.0%; and Trenwick Group Inc., down 15.6%. Heaviest trading stocks were: Sears Roebuck & Co. (Allstate), 48.7 million shares traded; ITT Corp. (Hartford Group), 47.2 million shares traded; American International Group Inc., 23.5 million shares traded; and General Re Corp., 21.8 million shares traded. The *BI* index performed worse than other market indicators, slipping 5.8% for the period. The New York Stock Exchange Composite dropped 3.2 points, a 2.3% decline; Standard & Poor's 500 lost 3.5 points, a 1.4% decline; and the Dow Jones 30 Industrials lost 12.1 points, a 0.6% decline.

British Issues

Oct. 29 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	325	12.0	17.8	5.5	328—	321
Genl Accident	793	8.1	38.3	4.9	793—	770
Gdn Royal Exch	870	10.8	46.5	5.4	870—	805
Royal	393	6.7	21.2	5.3	393—	375
Sun Alliance	820	9.0	32.2	3.9	870—	805
Brokers						
CE Heath	378	12.6	34.5	9.1	425—	370
Hogg Robinson	129	8.2	9.6	7.4	145—	129
JH Minet	335	12.2	12.9	3.9	349—	335
Sedg Grp	206	12.1	16.4	8.0	213—	206
Willis Faber	273	10.9	14.8	5.4	289—	271

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

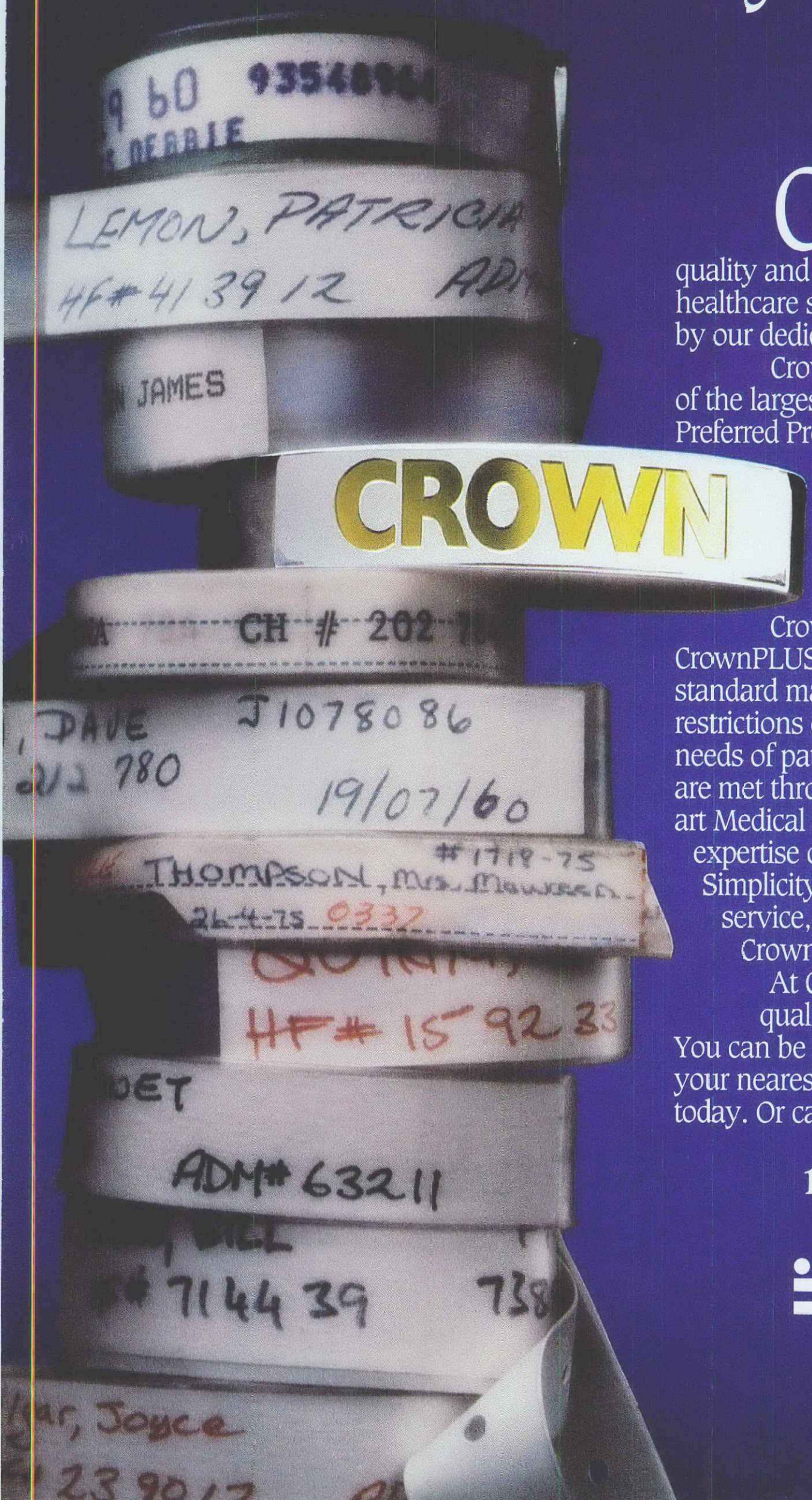
BI Industry Stock Report

OCT. 29, 1987 **10/23/87 THRU 10/29/87**

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	NYSE	17.75	-12.3	-33.0	32.00	17.13	405	1.00	5.6	15.7	2.98	5.96
Baldwin & Lyons Inc.	OTC	14.00	-12.5	-36.4	27.00	16.00	0	0.20	1.4	5.6	16.40	0.85
Corroon & Black Corp.	NYSE	24.63	-10.4	-24.5	37.50	22.00	541	0.84	3.4	11.5	6.31	3.90
Gallagher Arthur J. & Co.	OTC	16.50	-7.7	-37.1	31.00	16.50	111	0.40	2.4	10.9	4.81	3.43
Hall Frank B. & Co.	NYSE	4.75	-13.6	-67.2	19.00	4.00	379	0.00	0.0	10.9	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.00	0.5	-12.8	72.00	46.00	1382	2.40	4.5	13.2	5.14	10.31
Poe & Assoc Inc.	OTC	8.75	-2.8	-27.1	13.25	8.75	0	0.40	4.6	6.5	0.57	15.35
BROKERS	AVERAGE		-8.4	-34.0					3.1	10.9		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	21.25	-7.6	-19.0	37.00	18.75	596	0.28	1.3	5.3	13.72	1.55
Berkshire Hathaway Inc.	OTC	3025.00	-11.7	7.3	3792.00	2510.00	521	0.00	0.0	20.8	62.53	3.14
CIGNA Corp.	NYSE	53.25	-3.6	-3.2	69.50	48.00	956	2.80	5.3	6.8	42.01	1.27
CNA Fin'l Corp.	NYSE	53.88	5.6	0.2	66.50	47.00	256	0.00	0.0	10.9	42.71	1.26
General Re Corp.	NYSE	53.00	6.3	-4.5	68.88	46.00	2175	1.00	1.9	14.2	23.47	2.26
ITT (Hartford Group)	NYSE	53.00	2.9	-0.7	66.38	45.00	4719	1.00	1.9	10.6	44.08	1.20
Sears Roebuck & Co. (Allstate)	NYSE	34.63	-6.1	-12.9	59.50	30.75	4865	2.00	5.8	8.0	32.94	1.05
Transamerica Corp.	NYSE	31.25	2.5	-4.2	51.38	22.63	1313	1.84	5.9	5.9	26.94	1.16
CONGLOMERATES	AVERAGE		-1.5	-4.6					2.8	10.3		
INSURERS												
Aetna Life & Cas Co.	NYSE	50.75	-0.5	-10.4	68.13	46.00	1387	2.76	5.4	7.2	44.75	1.13
American General Corp.	NYSE	30.38	-5.1	-17.6	44.75	28.38	1371	1.25	4.1	8.1	27.13	1.12
Amer Heritage Life Invt	NYSE	25.00	6.4	-2.6	34.00	23.25	23	0.96	3.8	12.3	20.37	1.23
Amer Indty Fin'l Corp.	OTC	9.50	-7.3	-47.2	19.00	7.75	26	0.56	5.9	12.3	20.40	0.47
American Int'l Group	NYSE	66.25	-0.2	8.4	83.75	60.00	2349	0.30	0.5	13.2	29.02	2.28
Aneco Reins Ltd.	OTC	3.00	14.1	40.8	4.38	2.13	57	0.00	0.0	13.2	1.93	1.55
Aon Corp.	NYSE	22.88	-7.1	-13.3	29.88	21.00	391	1.20	5.2	7.9	15.23	1.50
Argonaut Group.	OTC	28.25	-16.0	34.5	52.13	21.00	323	0.00	0.0	5.8	14.60	1.93
AVEMCO Corp.	NYSE	16.50	-10.8	-37.1	25.25	13.25	203	0.28	1.7	9.8	6.94	2.38
Belvedere Corp.	AMEX	4.50	0.0	-47.9	9.13	4.13	29	0.01	0.2	56.3	6.71	0.67
Business Mens Assurn Co.	OTC	35.00	-1.4	35.2	48.25	25.25	175	1.10	3.1	56.3	22.15	1.58
Chubb Corp.	NYSE	58.38	-2.7	-1.5	73.50	52.00	788	1.88	3.2	7.7	39.52	1.48
Continental Corp.	NYSE	36.50	-6.4	-18.4	54.88	30.50	1051	2.60	7.1	7.3	41.62	0.88
Durham Corp.	OTC	20.50	-13.7	-25.9	34.00	20.25	8	0.92	4.5	13.4	26.15	0.78
Farmers Group Inc.	OTC	42.25	3.0	9.0	51.25	37.75	1573	1.20	2.8	12.4	19.95	2.12
Fireman's Fund Corp.	NYSE	31.63	0.4	-10.0	42.75	26.50	856	0.40	1.3	58.6	23.55	1.34
Fremont Gen Corp.	OTC	10.00	-7.0	-38.0	20.50	7.88	476	0.60	6.0	58.6	16.75	0.60
Home Group Inc.	NYSE	14.00	-3.4	-33.3	24.88	10.50	692	0.20	1.4	3.1	16.30	0.86
Hanover Ins Co.	OTC	24.50	-11.7	-22.8	37.25	23.75	44	0.36	1.5	5.6	21.16	1.16
Hartford Steam Boiler	OTC	23.00	-1.1	-2.4	36.63	20.25	198	1.00	4.3	9.2	10.17	2.26
Kansas City Life	OTC	23.25	-12.3	-9.7	31.50	21.50	0	0.00	0.0	9.2	0.00	N/A
Kemper Corp.	OTC	21.50	0.0	-14.0	38.75	20.00	1058	0.60	2.8	6.8	23.48	0.92
Liberty Corp. S.C.	NYSE	34.75	-10.0	-5.4	53.00	32.50	20	0.80	2.3	13.5	19.96	1.74
Lincoln Nat'l Corp.	NYSE	40.00	-4.2	-13.8	60.50	35.75	292	2.16	5.4	8.0	44.85	0.89
NAC Re Corp.	OTC	21.75	-3.3	-17.1	32.25	19.50	75	0.00	0.0	27.9	18.12	1.20
Nobel Ins Ltd.	OTC	9.63	-3.7	-40.7	18.50	9.25	96	0.00	0.0	27.9	9.04	1.07
Northwestern Nat'l Life	OTC	21.25	-8.6	-31.5	32.38	21.00	123	0.96	4.5	6.0	33.26	0.64
Ohio Cas Corp.	OTC	36.25	-3.7	-6.2	49.25	34.75	135	1.68	4.6	8.5	26.80	1.35
Old Rep Int'l Corp.	OTC	19.75	-15.1	-27.9	33.63	18.88	491	0.74	3.7	6.6	19.80	1.00
Orion Cap Corp.	NYSE	14.13	-17.5	-47.9	31.00	14.25	137	0.76	5.4	6.6	9.39	1.50
Phoenix Re Corp.	OTC	7.00	-9.7	-46.2	14.63	5.00	118	0.00	0.0	4.9	9.43	0.74
Protective Corp.	OTC	12.00	-3.1	-33.3	21.25	11.38	226	0.70	5.8	11.3	16.51	0.73
Provident Life & Acc Ins Co.	OTC	14.75	-18.1	-40.1	28.75	14.50	270	0.84	5.7	36.9	27.00	0.55
St. Paul Cos. Inc.	OTC	46.25	1.1	14.9	60.00	40.25	1537	1.76	3.8	8.6	29.89	1.55
SAFECO Corp.	OTC	28.75	-0.9	7.5	38.00	24.38	860	0.96	3.3	10.0	19.68	1.46
SCOR US Corp.	OTC	7.50	-28.6	-34.8	16.25	5.00	240	0.00	0.0	6.9	8.08	0.93
Seibels Bruce Group Inc.	OTC	12.25	-3.9	-16.9	19.00	9.75	126	0.80	6.5	8.1	11.88	1.03
Selective Ins Group Inc.	OTC	20.50	7.9	-5.7	27.50	17.25	234	1.08	5.3	6.5	16.02	1.28
Statesman Group Inc.	OTC	3.50	-12.5	-26.3	7.06	3.50	421	0.05	1.4	6.5	5.19	0.67
Tokio Marine & Fire Ins	OTC	67.75	5.2	21.2	103.38	50.75	169	0.19	0.3	57.4	0.00	N/A
Torchmark Corp.	NYSE	28.25	3.7	8.7	36.75	23.75	526	1.00	3.5	9.5	13.01	2.17
Travelers Corp.	NYSE	35.75	-10.4	-19.9	52.63	31.50	1690	2.28	6.4	7.4	45.03	0.79
Trenwick Group Inc.	OTC	9.50	-15.6	-42.4	19.13	9.50	59	0.00	0.0	11.7	13.83	0.69
United Fire & Cas Co.	OTC	21.25	-9.1	-35.6	33.00	20.25	32	0.96	4.5	6.2	18.32	1.16
United States Fid & Gty	NYSE	31.50	-7.7	-20.8	48.75	26.25	1178	2.48	7.9	6.7	20.19	1.56
UNUM Corp.	NYSE	17.38	-10.9	-35.3	31.38	16.75	512	0.40	2.3	6.7	26.81	0.65
USLIFE Corp.	NYSE	31.25	-0.8	-28.2	47.63	26.75	251	1.28	4.1	8.0	43.09	0.73
Washington Nat'l Corp.	NYSE	21.88	-6.4	-31.6	37.88	19.25	149	1.08	4.9	12.8	32.80	0.67
Zenith Nat'l Ins Corp.	NYSE	15.38	4.3	-42.0	24.00	13.50	192	0.80	5.2	7.9	11.19	1.37
INSURERS	AVERAGE		-5.4	-16.8					3.3	13.4		
ALL COMPANIES	AVERAGE		-5.2	-17.1					3.2	12.7		

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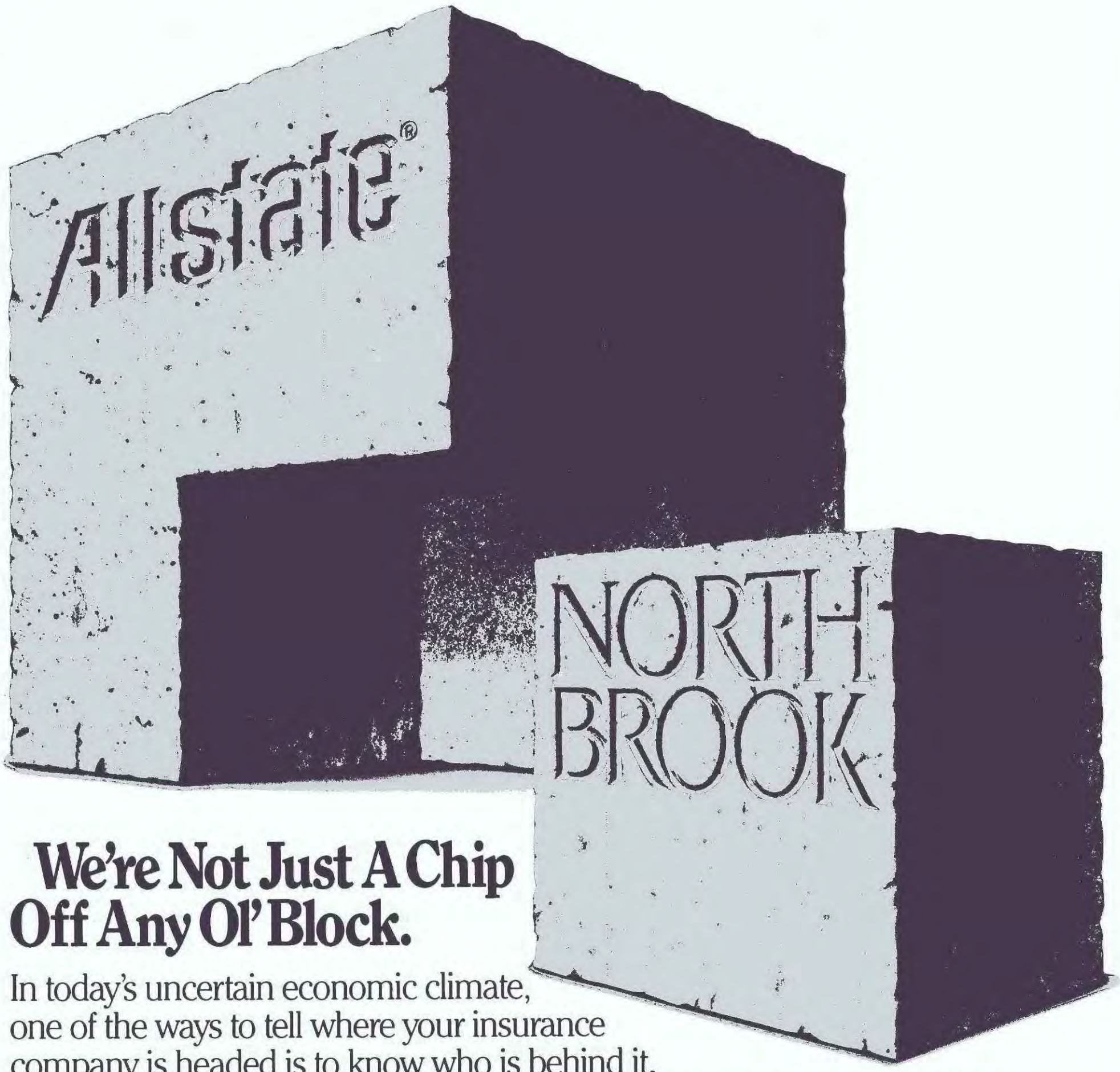
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