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update

Mentor's unpaid liabilities exceed $600 million: Report

HAMILTON, Bermuda—Gross unpaid liabilities of Mentor Insurance Co. Ltd., which is now in liquidation in Bermuda, could amount to $644.4 million, or $466 million more than the initial calculation made in June 1985 at the start of the liquidation, according to the latest report to Mentor's creditors by the liquidators.

The new estimate is based on an

Continued on next page

Grace settles pollution claims, sues 3 insurers

By STEPHEN TARNOFF

BOSTON—W.R. Grace & Co., which reached a $9 million settlement last week with 55 plaintiffs in toxic chemical litigation in Woburn, Mass., now is involved in a dispute with three of its insurers over coverage for the settlement and defense costs.

A Grace spokesman maintains that the "defense and settlement are covered by insurance and Grace will have no out-of-pocket expenses."

But the three insurers are disputing the coverage that the manufacturer contends it is owed.

Grace filed a lawsuit Sept. 5 in state court in East Cambridge against the three insurers—Maryland Casualty Co., Continental Casualty Co. and Hartford Accident & Indemnity Co. The suit seeks a declaratory judgment and damages due to the insurers' alleged failure to defend or pay in full defense costs in the Woburn action.

The suit also asks the court to rule that the insurers are obligated to reimburse Grace in full for any liability in the underlying litigation.

Grace already has paid more than $2.8 million in defense costs, according to the suit.

Maryland Casualty wrote primary comprehensive general liability coverage for Grace from at least 1963 to 1973, while Continental Casualty wrote primary CGL coverage for Grace from at least 1973 to 1976, the suit says.

Beginning in 1981, Continental Casualty sold primary environmental impairment liability policies to Grace. In addition, Hartford sold excess EIL policies to Grace beginning in 1981, the suit adds.

The settlement by Grace ends all of the litigation against the New York-based company relating to the Woburn site. Plaintiffs had alleged that chemicals disposed by Grace and Beatrice Foods Co. at the site contaminated two drinking wells, which led to deaths and injuries of local residents.

Eight families had sued Grace in federal court and six more had filed or were contemplating filing suits in state court.

Six persons, including five children, died of leukemia allegedly because of exposure to several chemicals, including trichloroethylene and tetrachloroethylene.

The plaintiffs also alleged a host of physical and mental ailments, including damage to their immune, nervous and cardiovascular systems.

Last July, following the first phase of the litigation, a jury found after the four-month trial that Grace had substantially contributed to contamination of the two wells but that Beatrice had not (*BI*, July 28; Aug. 4).

Plaintiffs currently are considering whether to appeal the Beatrice finding.

Two other phases of the trial, addressing whether the chemicals caused the deaths and injuries and to award damages, were scheduled to follow.

However, on Sept. 17—shortly before the second phase of the litigation was to begin—U.S. District Judge Walter Skinner granted Grace's motion for a new trial of the litigation's

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Lloyd's tells six syndicates to stop writing for rest of '86
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Capitol action

Risk retention bill close to passage

By JERRY GEISEL

WASHINGTON—Legislation to expand the federal Risk Retention Act is on the verge of winning final congressional approval.

The House of Representatives, on a voice vote with no opposition, approved the measure, H.R. 5225, that would make it much easier for employers to set up special captives known as risk retention groups or buy commercial casualty insurance on a group basis.

The House vote last Tuesday came less than one week after the House Energy and Commerce Committee approved the measure. The Senate approved a related bill, S. 2129, in July on a 96-1 vote.

Employers must "never again be left with no alternative to traditional forms of insurance," said Rep. James Florio, D-N.J., who helped steer the measure through the House.

The proposal, championed by a broad coalition of groups, including the Risk & Insurance Management Society, the National Assn. of Insurance Brokers and the American College of Nurse-Midwives, must clear one more hurdle before it can win final approval and be sent to President Reagan for his signature.

Since the bills passed by the House and Senate are somewhat different, those differences—many of them of a technical nature—still must be resolved.

These differences could be ironed out by joint conference committee. Or, sources say, the Senate might accept the House bill, eliminating the need for a conference committee.

The major differences in the two bills are:

- The House bill makes clear that the Risk Retention Act would not pre-empt state laws that set financial responsibility requirements for employers engaging in certain activities. The Senate bill lacks such a provision.

For example, a state may require that hazardous-waste haulers purchase a minimum amount of coverage from a licensed, admitted insurer.

Under this amendment, if a risk retention group had not qualified as a licensed, admitted insurer, a state still could say that an employer that had obtained coverage through the risk retention group did not satisfy its financial responsibility requirement.

However, under the House bill, a state could not discriminate against risk retention groups for satisfying financial responsibility requirements. For example, a state could not say that all forms of insurance—except

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Welfare plan rules too complex: Experts

By JERRY GEISEL

WASHINGTON—The non-discrimination rules for welfare plans laid down by the Tax Reform Act of 1986 are so confusing and complex that some employers may find it easier and cheaper to ignore them, benefit consultants say.

Employers' plans may well be in compliance with the tests, but the administrative burden of deciphering the rules and applying the tests to welfare plans may be overwhelming, the consultants add.

"The welfare rules are an abomination," declared Stuart J. Brahs, executive director of the Assn. of Private Pension & Welfare Plans in Washington. "There is no way an employer can figure out these tests."

"The rules are intimidating. Employers may resist doing the various tests," added Tom Butterworth, a partner in the Rowayton, Conn., office of benefit consultant Hewitt Associates.

The welfare plan non-discrimination rules, which comprise 40 pages of the 886-page conference report accompanying the final version of the tax overhaul legislation, were released last week. The legislation is expected to receive final congressional approval this week.

The non-discrimination rules are designed to determine if a welfare-type program—like an employer-provided health care plan—covers too great a proportion of highly

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Panel to decide fate of health pool plan

By JERRY GEISEL

WASHINGTON—A House-Senate conference committee will decide whether employers should be required to help pay the health care expenses of high-risk uninsured individuals.

A budget reconciliation bill, H.R. 5300, approved by the House last week includes a provision to require states to set up pools to provide comprehensive health care coverage for the uninsured (*BI*, Sept. 8).

If premiums paid by these people are insufficient to cover the pools' costs, as is almost certain, employers would be assessed to make up the difference.

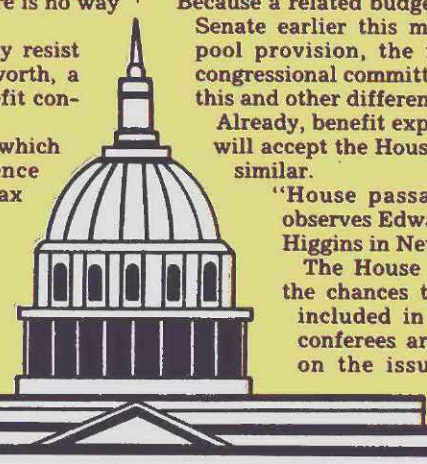
Because a related budget bill, S. 2706, approved by the Senate earlier this month, lacks a health insurance pool provision, the issue will be fought out in a congressional committee that will meet soon to resolve this and other differences in the two measures.

Already, benefit experts are worried that the Senate will accept the House's pool provision, or something similar.

"House passage is a very ominous sign," observes Edward J. Davey, vp with Johnson & Higgins in New York.

The House vote "dramatically" increases the chances that the pool provision will be included in the final budget bill because conferees are unlikely to spend much time on the issue as their attention will be

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update

Mentor liabilities estimated

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independent actuarial evaluation of Mentor's liabilities conducted by Tillinghast/Towers, Perrin, Forster & Crosby, the report says.

The report, which was sent to 551 creditors, says the company's estimated shortfall as regards unsecured creditors is $474.2 million, or about $444 million higher that the corresponding figure released in June last year.

According to the report, Mentor's unpaid liabilities include $547 million for incurred-but-not-reported losses and $97.4 million for outward letters of credit issued to insurers that ceded business to Mentor, a subsidiary of Ocean Drilling & Exploration Co. of New Orleans. A total of $70.6 million has already been drawn on the letters of credit as of June 30 this year, the report says.

While Tillighast said it does not expect the unpaid liabilities to mature before 2004, liquidators Charles Kempe and Michael Arnold say they now plan to negotiate claims with the aim of paying an interim settlement to creditors after December 1990.

In a related development, a U.S. District Court in New Orleans has denied a motion by former Mentor Chairman Douglas Higley, one of 11 defendants named in a fraud lawsuit filed by Mentor's liquidators, to disqualify the liquidators' law firm (*BI*, July 14).

Mr. Higley said he was tricked by attorneys at New York-based Lord, Day & Lord into revealing confidential information about Mentor that was later included in the lawsuit.

The liquidators' lawsuit, which seeks $300 million to $500 million to cover Mentor's insolvency, also named ODECO as a defendant.

17 bank firms form captive

HAMILTON, Bermuda—Seventeen regional bank holding companies have formed Financial Institutions Reserve, Ltd., a group captive insurer that is offering primary and excess directors and officers liability coverage with limits of up to $20 million.

FIRL—with more than $40 million in capital contributed by the 17 shareholders—was incorporated in Bermuda on Sept. 19 and already has issued its first policies, according to Peter J. Willitts, president of FIRL and an assistant vp of J&H Ltd., FIRL's Bermuda-based management company.

Johnson & Higgins, J&H Ltd.'s parent, had earlier undertaken a feasibility study for the formation of a bank holding company captive, Mr. Willitts said. A private placement of FIRL shares was begun June 3 without the use of a U.S. investment banking firm.

Mr. Willitts would not comment on whether the insurer will write coverage for non-shareholders and declined to estimate how many additional shareholders FIRL might attract.

FIRL is offering broad-form D&O coverage on a claims-made policy form designed by the shareholders. The maximum $20 million in limits offered by the insurer can be written on either a primary or excess basis, Mr. Willitts said. FIRL also expects to eventually offer bankers blanket bond coverage, he added.

The initial shareholders of FIRL are: AmeriTrust Corp. of Cleveland, Ohio; AmSouth Bancorp of Birmingham, Ala.; Bank South Corp. of Atlanta; Barnett Banks of Florida Inc. of Jacksonville, Fla.; Citizens & Southern Corp. of Columbia, S.C.; Dominion Bankshares Corp. of Roanoke, Va.; Fidelcor Inc. of Philadelphia; First American Corp. of Nashville, Tenn.; Manufacturers National Corp. of Detroit; and Mercantile Bancorp Inc. of St. Louis.

Also, National City Corp. of Cleveland; NBD Bancorp Inc. of Detroit; Rainier Bancorporation of Seattle; Signet Banking Corp. Richmond, Va.; SunTrust Banks Inc. of Atlanta; United Virginia Bankshares Inc. of Richmond, Va.; and U.S. Bancorp of Portland, Ore.

Firms cited for cleanup costs

LOS ANGELES—A dozen major U.S. corporations that dispose of hazardous waste at the Stringfellow acid pits should be held liable for the estimated $40 million cost of cleaning the dumps, a federal court official recommends.

The official was appointed to help manage a massive lawsuit brought by the U.S. Justice Department and the state of California against the owners of the Stringfellow dump site and the dozens of companies that dispose of hazardous waste there.

Harry V. Peetris, a retired Los Angeles Superior Court judge, recommended that the Justice Department motion be granted for summary judgment against the operators of the dump site and 12 of the hazardous waste generators.

Stringfellow, located about 50 miles east of Los Angeles, is on the Environmental Protection Agency's national priority list and is considered one of the nation's worst hazardous waste dump sites.

Judge Peetris' recommendations are now in the hands of U.S. District Judge James Ideman, who is presiding over the lawsuit. If he accepts the recommendations, the case will likely go to trial.

Defendants named in Judge Peetris' report are expected to file objections shortly with Judge Ideman. The defendants include: Alumax Inc.; General Electric Co.; McDonnell-Douglas Corp.; NI Industries Inc.; General Steel & Wire Co.; Montrose Chemical Corp.; Northrop Corp.; Quemetco Inc.; Rheem Manufacturing Co.; Rockwell International Corp.; Rohr Industries Co. Inc.; and Stauffer Chemical Co.

Judge Peetris also recommended that a separate trial be held to decide the liability of a number of other generators alleged by the government to have disposed of hazardous waste at the Stringfellow site, including: Alcan Aluminium Corp.; Deutsch Co.; National Distillers Corp.; Rainbow Canyon; and Weyerhaueser Co.

According to Judge Peetris, these defendants raised genuine issues of fact as to whether their waste was hazardous or was actually disposed of at the Stringfellow site.

Judge Peetris will hold an informal status conference with all of the Stringfellow defendants Oct. 7 to discuss his report and any motions the defendants plan to make in the case.

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Lloyd's tells six syndicates to halt writing for rest of '86

By STACY SHAPIRO

LONDON—Lloyd's of London is forcing its largest non-marine syndicate, as well as five other non-marine syndicates, to stop underwriting most new and renewal business for the rest of this year.

Lloyd's last week directed syndicate 799, underwritten by Robin A.G. Jackson and managed by Merrett Underwriting Agency Management Ltd., and five syndicates underwritten by Bill Maitland to halt underwriting for the rest of 1986 because they are likely to exceed their premium limits.

The move could reduce capacity for U.S. policyholders that are scheduled to renew policies with the syndicates later this year, Lloyd's observers say.

But Mr. Jackson says the order will not have a material effect on his clients because the syndicate had stopped writing before the order was issued by Lloyd's and was not planning to write much business for the remainder of the year. And, he will still be able to renew claims-made policies.

However, the syndicate will make major changes next year. According to a letter sent by Merrett to syndicate 799 members, the syndicate currently is planning to write no new business next year. In addition, the letter notes that the syndicate had exceeded its premium limit by a wide margin in 1985.

Mr. Jackson's syndicate was the largest non-marine syndicate at Lloyd's based on 1985 stamp capacity and writes mostly U.S. business (*BI*, Sept. 1).

Mr. Maitland writes for syndicates 989 and 1031, managed by Janson Green Ltd.; syndicate 279, managed by Crescent Underwriting Agencies Ltd.; syndicate 1041, managed by Bolton, Ingham (Agency) Ltd.; and syndicate 650, managed by Scimitar Underwriting Agencies.

Lloyd's stated last week that "the directions require that the syndicates immediately cease underwriting insurance business with an inception date prior to Dec. 31, 1986, until such time as the (Lloyd's) Committee revokes or varies the direction."

However, Lloyd's did not say how much premium the syndicates had written or whether they actually had exceeded their premium limits.

In addition, the syndicates are allowed to renew business that they are legally liable to renew, such as coverage with three-year policy periods, or which if canceled would increase the syndicates' premium volume. Such policies would include claims-made policies with extended reporting periods, Lloyd's sources say.

And the syndicates are allowed to begin work on 1987 renewals.

Lloyd's says that the agencies have until Oct. 9 to "make further representations to Lloyd's" to show that they will not exceed their premium income limits if they wish to resume underwriting this year.

Mr. Jackson, chairman of Lloyd's Non-Marine Underwriters' Assn., disagrees with Lloyd's that his syndicate is on the verge of overwriting its premium limits, pointing out that he has been monitoring his syndicate's premium income throughout the year to make sure that it does not exceed 85% of the syndicate's gross capacity, let alone 100%.

These measures were taken, he explains, because syndicate 799 did overwrite its premium limits last year.

The syndicate wrote an estimated 250 million pounds ($362.5 million) in premium last year, compared with a premium limit of 149.2 million pounds

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Product liability bill gaining momentum

By JERRY GEISEL

WASHINGTON—Backers of federal product liability legislation are winning new support as they mount a last-ditch effort to win Senate approval before the congressional session ends.

As the Senate began debate last week on the legislation, S. 2760, four senators who previously had voted against the bill at the committee level said they would be co-sponsoring a substitute bill on the Senate floor.

That substitute bill—backed by Sens. Slade Gorton, R-Wash., Ted Stevens, R-Alaska, Don Riegle, D-Mich., and Daniel Inouye, D-Hawaii—strips away a controversial settlement provision from the measure narrowly approved in June by the Senate Commerce Committee.

That settlement provision, blamed for the close vote on a bill that backers thought had much greater support, would cap non-economic dam-

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Court says Prop 51 is not retroactive

By ROBERT A. FINLAYSON

OAKLAND, Calif.—Proposition 51, the California ballot initiative that eliminates the application of joint and several liability to non-economic damages in third-party lawsuits, should not be applied retroactively, a state appeals court has ruled.

The California 1st District Court of Appeal ruled Sept. 19 in *James Russell vs. Asbestos Claims Facility* that the law should not be applied to cases that were pending in the state's courts when the initiative became law on June 4.

Among other reasons for its ruling, the court said the initiative did not include a provision specifically stating that the law would be applied to cases pending at the time of enactment.

The court also said it would not rule on the constitutionality of Proposition 51.

The case was the first appellate decision in a statewide legal controversy over the application of Proposition 51 to thousands of third-party lawsuits now pending in California trial courts.

Several similar cases that question whether Proposition 51 applies retroactively are before appellate courts in three other California judicial districts (*BI*, Aug. 18).

Defendants in the Russell case are planning to appeal the appellate court's decision to the California Supreme Court, according to William H. Armstrong of McCutchen, Doyle, Brown & Enerson of San Francisco, one of the law firms representing the defendants.

Both defense and plaintiffs' attorneys say it is not clear whether the state Supreme Court will take the Russell case or wait to see if any of the other appellate courts issue decisions differing from the 1st District's ruling.

Proposition 51, officially known as the "Fair Responsibility Act

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inside

- A single federal agency should be established to centralize the employee benefit plan regulation and policy development functions now handled by several different offices, the week's editorial says. **PAGE 8**
- The cost of providing mental health care benefits is predictable, and offering wider coverage does not lead employees to over-use services, according to Dr. Kenneth A. Kessler of American PsychManagement Inc. in a Perspective column. **PAGE 47**
- While this year's federal tax legislation will kill meaningful tax benefits for offshore group captive insurance companies, there may still be good reasons to form group captives offshore, says Donn P. McVeigh, chairman of Creative Risk Concepts International, in a Speaking Out column. **PAGE 50**
- Marine underwriters attending the International Union of Marine Insurance say hull and inland marine insurance rates are increasing, while the price of cargo and offshore oil rig coverages are still low. **PAGE 74**

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Benefit innovations

401(k) programs will survive blow dealt by tax plan

By JERRY GEISEL

WASHINGTON—401(k) salary reduction plans will be hurt by tax reform but they will survive by re-emphasizing their basic strength—that they are a superb retirement savings plan, experts say.

Just a blip on the horizon only a few years ago, 401(k) programs, which often are added to existing corporate savings and thrift plans, have become the fastest-growing employee benefit program of the 1980s because of their unmatched versatility.

Employee access to funds have made 401(k) plans a popular way to save to meet such later needs as paying for a child's college education or making the downpayment on a house.

In addition, when an employee leaves a company, he or she doesn't have to wait for retirement to take the money.

At the same time, liberal non-discrimination rules and a rich $30,000 annual maximum on individual contributions have made 401(k) plans a perfect vehicle to provide generous benefits to the highly compensated.

But, in one massive stroke, the Tax Reform Act of 1986, expected to receive final congressional approval this week, robs 401(k) plans of much of their vaunted versatility.

New restrictions and higher taxes on pre-retirement withdrawals and distributions all but wipe out 401(k) plans as a tax-preferred savings account where employees have been able to temporarily park extra cash.

And much tighter non-discrimination rules and a $7,000 annual limit on salary deferrals means an end to 401(k) plans that served as lush executive compensation programs.

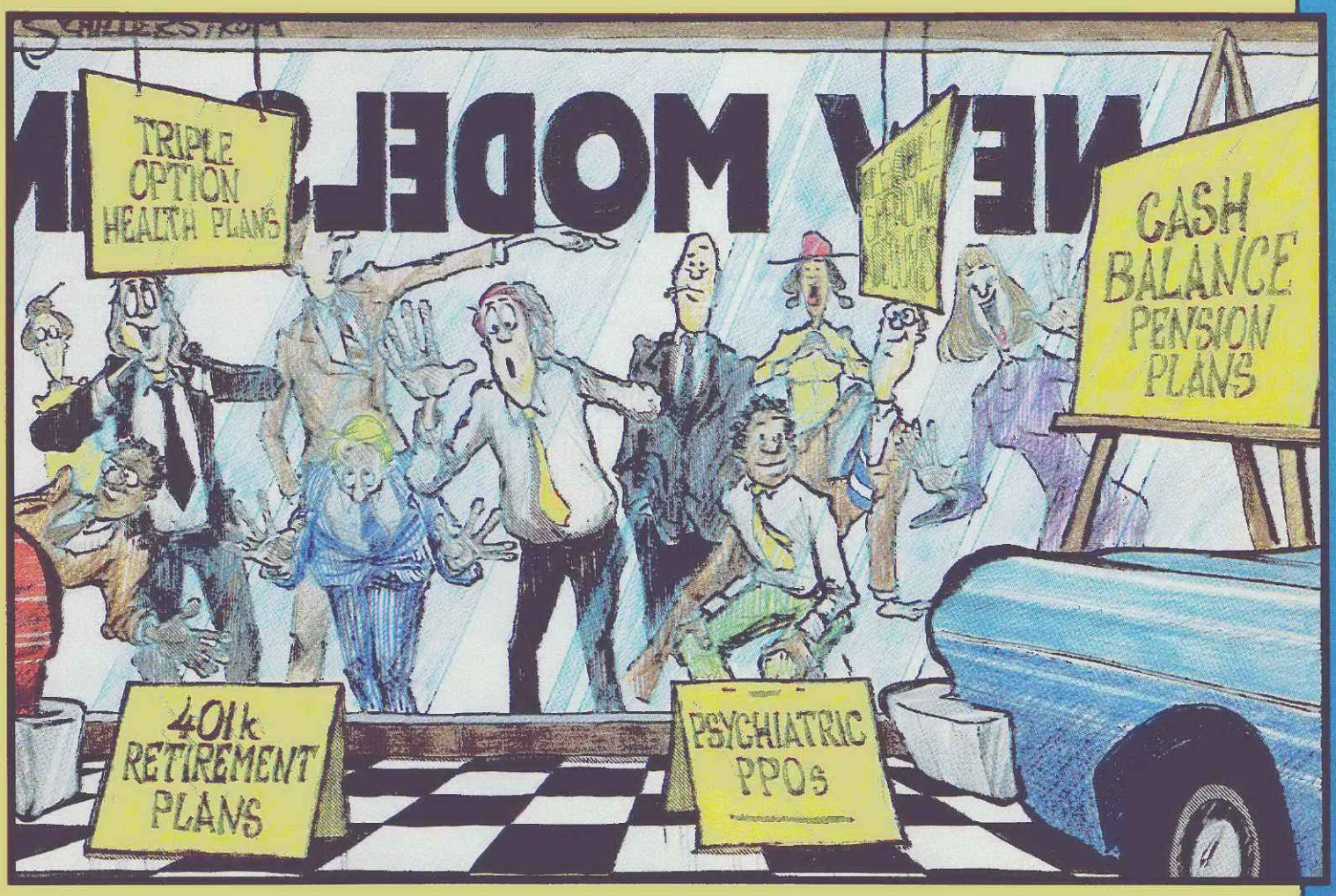
However, the new tax law does not damage 401(k) plans' attractiveness as a tax-effective way for employees to save for retirement.

"Our 401(k) plan is the jewel in our benefits program. Even with the new tax law, the program still is a jewel," says Russel Wert, director of benefit services at Aetna Life & Casualty Co. in Hartford, Conn.

Indeed, employees still will be able to contribute pretax dollars, often matched by employers, to a 401(k) plan, where those dollars will accumulate tax-deferred interest.

Employees who don't touch contributed funds until retirement can avoid

Continued on next page



Firms seek psychiatric cost control

By JOANNE WOJCIK

An increasing number of employers are looking for ways to trim psychiatric costs—the fastest-growing medical treatment expense in most employee health care programs.

Until recently, utilization review and case management programs were about the only options available to cut the cost of mental health care. But now, psychiatric preferred provider organizations are beginning to spring up across the country, mostly as offshoots of these case management programs.

"Companies with liberal benefit plans realize that their dollars are not being spent wisely" for mental health care, explains Dr. William Cunnick, vp and medical director for Metropolitan Life Insurance Co. in New York.

"There's a lot of excess all over the health care field, especially in psych care" because treatment often is not provided in the most efficient setting, says Walt Wood, a group consultant in the Washington office of benefit consultant The Wyatt Co.

"Hospitals are used when outpatient care would be not only less expensive, but better for the patient," he explained.

Dr. Cunnick agrees, saying, "Between 5% and 15% of those being hospitalized for psychiatric diagnoses don't need to be there. There can be enormous savings if you provide quality care on an ambulatory basis," which is the method of treatment most psychiatric PPOs encourage.

And, by providing employees incentives to use psychiatric PPOs, employers can trim the cost of treatment for mental disorders by 10% to 30%, according to some of the PPOs.

Mental health care is the fastest-growing segment of the U.S. health care industry for several reasons, according to observers (see story, page 38).

Between 1980 and 1983, the economic cost of mental disorders rose 35.2% to $73 billion from $54 billion, according to the U.S. Alcohol, Drug Abuse and Mental Health Administration.

And, observers expect that the amount employers will pay to cover psychiatric treatment for employees will continue to increase as the stigma associated with being treated for substance abuse and "mental and nervous" disorders diminishes.

Much of the increase in psychiatric benefits costs also can be attributed to improved coding of claims payments, adds Donald Penn, consulting principal for employee benefit consultant A.S. Hansen Inc. in Deerfield, Ill.

"As we become more open about it, and as we try to identify the providers and the treatment, we get better data," Mr. Penn explained. "For example, I think AIDS (acquired immune deficiency syndrome) has been around for many, many years, but we haven't called it that."

"As we become more open about it, and as we try to identify the providers and the treatment, we get better data," he explained.

Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates, agrees. "We're seeing a lot more expenses now attributed to chemical dependency," which falls under psychiatric treatment in most health plans.

The cost of psychiatric treatment generally is calculated by multiplying the provider's reported per-diem cost per bed by the average length of stay and then adding an additional charge for ancillary services.

In this equation, both the cost of care and the length of time required to deliver the care contribute to the overall cost-effectiveness of a provider.

With the cost of one day in the psychiatric wing of an acute-care hospital averaging between $500 and $700 per day, reducing length of stay for inpatient mental health care by one week through utilization review can save an employer up to $4,900.

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Cash balance plans

Cash balance pension plans are attracting the interest of more employers, but most are wary of actually making the switch until some questions surrounding the plans are answered. See story, page 15.

Hospital insurers

Mounting losses are causing mounting doubts and problems for some hospital systems that charged into the group health insurance business over the past two years. See story, page 23.

Multiple options

Employers now can purchase group health insurance contracts combining traditional indemnity, preferred provider and health maintenance organization options in one program. See story, page 28.

FSA survival

After a tough fight with two federal agencies, flexible spending accounts are still alive, and Employers report that FSAs still can be an important part of a benefit program. See story, page 40.

AIDS care options

Companies nationwide are using more humane and cost-effective options like case management, home health care and hospice programs to care for employees with AIDS. See story, page 53.

401(k) plans

Continued from previous page

the new special taxes. And, employees who leave a company and want to take 401(k) money with them still can do so—and avoid pre-retirement tax penalties—if the funds are rolled over into an Individual Retirement Account.

These changes, laid down by the tax act, will bring a singular identity to 401(k) plans, experts say.

"401(k) plans no longer will be capital accumulation plans. They will be capital accumulation plans for retirement savings," said Theresa Stuchiner, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

"In some cases, the plans were considered bank accounts. Now, 401(k) plans will be considered retirement plans more than ever," adds Frederick Rumack, director of taxes and legal services with Buck Consultants Inc. in New York.

But this transition of 401(k) plans from multipurpose savings programs to retirement plans will require employers to develop new communications strategies.

"The message employers will have to deliver to employees is: 'If you want to save for retirement, 401(k) participation still is a very good deal.' It is quite a challenge, but not an insurmountable one," says Denise Georgemiller, a consultant with Hewitt Associates in Lincolnshire, Ill.

Employers already are preparing for that communications task.

"In the past, we stressed the short-term availability" of funds, says Paul Nordine, benefit consultant with San Francisco-based BankAmerica Corp., which has had a 401(k) plan since 1983.

"Now, we are going to have to stress to employees what the long-term advantages are," he adds.

But words alone won't be enough to keep employees—especially the lower-paid, who will be most concerned about less access and more penalties on withdrawals—in the plans, experts agree.

It also will take more money, such as improving employer matching contributions.

"It is hard for an employee to say no when there is a matching contribution," says Murray Becker, vp with Johnson & Higgins in New York.

At the same time, loan provisions will be added by more employers to compensate for the penalties for pre-retirement withdrawals.

"Loans can be administratively complex, but will have to added to attract lower-paid participation," said Jim Geld, a principal in the San Francisco office of benefit consultant William M. Mercer-Meidinger Inc.

While more ingenuity and money will be required, employers say they are prepared to make that extra commitment.

"We will go that extra mile to make the plan work. That may mean more communications or more contributions or a change in plan design," says Mr. Nordine.

And for most employers, termination of 401(k) plans isn't even being considered, because of the massive blow such a drastic move would have on employee morale.

"Employees think our 401(k) plan is our best benefit," says Sally Bullen, director of employee compensation and benefits at Kemper Group in Long Grove, Ill.

In addition, 401(k) plans will become even more attractive to many middle- and upper-income employees, who, because of another provision in the tax bill, will no longer be able to make tax-deductible contributions to IRAs, says Peter Hutchings, a partner with Kwasha Lipton.

Employers recognize, though, that despite their best efforts, employee participation in 401(k) plans will slip. Some companies, like Kemper Group, report that up to 85% of eligible employees participate in their 401(k) plans; a 60% participation rate is common.

Such a high participation rate most likely no longer is possible because some employees will not participate if it means that funds no longer can be withdrawn without penalty to meet family needs.

Indeed, while experts are optimistic that 401(k) plans can survive if promoted as retirement savings plans, everyone agrees that employers will have an uphill battle to convince employees to participate because of the changes.

The changes in the new tax act that will have the most negative effect on 402(k)s include:

- Hardship withdrawals. Currently, employees can make in-service withdrawal of funds to cover such hardships as uninsured major medical expenses, payment of a child's college expenses and the down payment required for purchase of a primary residence.

The tax bill still allows in-service hardship withdrawals, but makes them more expensive: A 10% additional tax, except on funds taken out to pay for uninsured medical expenses that exceed 7.5% of an employee's adjusted gross income, will be imposed on most hardship withdrawals.

For example, if an employee deferred $20,000 to a 401(k) plan and then withdrew the funds to make a down payment on a house, a special $2,000 tax penalty, exclusive of income taxes due on the withdrawal, would be assessed.

In addition, employees no longer could make in-service withdrawals of interest earned on salary deferrals, while employer matching contributions that are aggregated with deferrals for purposes of satisfying non-discrimination rules also could not be withdrawn.

- Pre-retirement distributions. This same 10% tax would be imposed on pre-retirement (generally before 59½) distributions.

The tax, though, would not apply if the funds were rolled over into an IRA or used to purchase an annuity payable over the life expectancy of an employee. The tax also would not be imposed on the withdrawal of aftertax dollars contributed to a plan.

Employers and consultants acknowledge that these new restrictions on in-service withdrawals and the higher taxes on pre-retirement distributions are bound to reduce employee contributions, though there is disagreement on how major an impact those restrictions will have.

"Many of our employees save for educational expenses. The 10% penalty tax certainly will be an impediment to save," says Don Hillier, vp-compensation and benefits at Maryland National Corp. in Baltimore.

"The lower-paid will be discouraged from participating," adds Robert Penzkover, director of employee benefits at Quaker Oats Co. in Chicago.

But Kemper Group's Ms. Bullen doubts that the higher taxes and restrictions on withdrawals will have much of an effect on its 401(k) plan's 85% participation rate. "Our employees think it is a good, long-term savings plan," she says.

These penalties, however, could be fatal to 401(k) plans that are funded solely through employee salary deferrals.

"You need an incentive to get employees into the plans," says Lou Valentino, a consultant and a member of The Wyatt Co.'s national defined contribution administration practice committee in New York. "You will see an end to employee-only (funded) 401(k) plans."

Continued on page 6

When you know the facts-the benefits are obvious.

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401(k) plans

Continued from page 4

Already, 401(k) plans that are funded solely through salary deferrals are the exception; Hewitt Associates found that 84% of 199 plans it surveyed last year had matching employer contributions (*BI*, March 25, 1985).

There also could be a cutback in 401(k) plans that allow aftertax contributions because they will be more complex to administer.

"The rules of the game with respect to administration of 401(k) plans with aftertax contributions change rather dramatically," says Edward J. Davey, vp with Johnson & Higgins in New York.

Employers actually have a good reason not to offer an aftertax contribution feature to their 401(k) plans. A little-noted provision in the tax bill will, for the first time, subject aftertax contributions to 401(k) plans, as well as to other savings plans, to non-discrimination rules that compare contributions of lower-paid employees to the higher-paid.

As a result, an aftertax option to a 401(k) plan will add yet another layer of administrative complexity without producing employee participation, experts say.

Loan provisions will be a necessary, though administratively messy, feature that must be added to keep lower-paid employees—concerned about less access to funds—active participants.

"Loans can be administratively complex. . .but they have to be added," says Mercer—Meidinger's Mr. Geld.

But, new software packages have simplified loan administration, said Howard Weizmann, manager of benefits planning and design at Sun Co. Inc. in Radnor, Pa.

Experts advise, though, that while an employer may want to carefully evaluate record-keeping systems needed to administer loans, the availability of loans should be quickly communicated.

"You don't have to put in loan provisions immediately, but the communication should be made immediately. That will get employees to participate immediately," said J&H's Mr. Becker.

Under both the current law and the proposed changes, the maximum loan that a 401(k) plan can make to a participant is $50,000.

One thing everyone agrees on is that the new 401(k) rules mean high-paid executives will get far less out of the plans.

First, the maximum individual annual contribution will be cut to $7,000 from $30,000, effective next year. And, the new, tighter non-discrimination rules mean that executives at some companies may not even come close to that limit.

Under a popular non-discrimination test now used, the average deferral percentage (ADP) of the top-paid one-third can be 250% higher than the ADP of lower paid two-thirds—as long as the difference between the two does not exceed three percentage points.

For example, if the lower-paid's ADP is 7%, then the higher-paid's ADP could be 10% under this test.

By contrast, under the tax bill, a new, tougher, test would limit the ADP of the higher-paid (defined somewhat differently compared with current law) to 200% higher than the lower-paid, as long as the difference does not exceed two percentage points.

Employers whose plans are passing the current ADP tests acknowledge that contributions of the higher-paid will have to be lowered to meet the new tests.

For example, at Sun Co., the ADP for the lower-paid two-thirds is 4.9%, compared with 7.9% for the higher-paid two-thirds—too great a difference in ADP to pass the new non-discrimination test.

"Absolutely, we'll have to cut back on contributions by the higher-paid," said Mr. Weizmann. Employees can now contribute up to 5% of salary on a pretax basis, which the company matches dollar for dollar. Employees also can contribute another 10% of salary, either on a pretax or aftertax basis, which is not matched.

Employers undoubtedly will face pressure from upper-income employees to make up for the reduced benefits from 401(k) plans. Obvious options include providing benefits through special, unfunded supplemental compensation plans or just giving them more cash.

But employers are unlikely to drop 401(k) plans just because the higher-paid will get less.

"The fiction is that a substantial number of employees will be affected by lower contribution limits," says Tom Butterworth, a partner in the Rowayton Conn., office of Hewitt Associates.

"The fact is that at many companies, the highly compensated employees will amount to 5% or less of the workforce. Unless the plan was put in just to benefit that 5%, the plan still will be the best game in town for most employees," Mr. Butterworth adds.

Certainly, though, administration of 401(k) plans will become much more difficult.

"A lot of things will have to change. Record-keeping systems will have to be changed to monitor grandfather provisions," says Harry Gross, a partner with Kwasha Lipton.

"Regrettably, employers should expect to make greater investments in their administrative systems," adds Hewitt's Mr. Butterworth.

And, with the 401(k) and other benefit changes in the tax bill set to take effect next January, companies have just three months to communicate the rules.

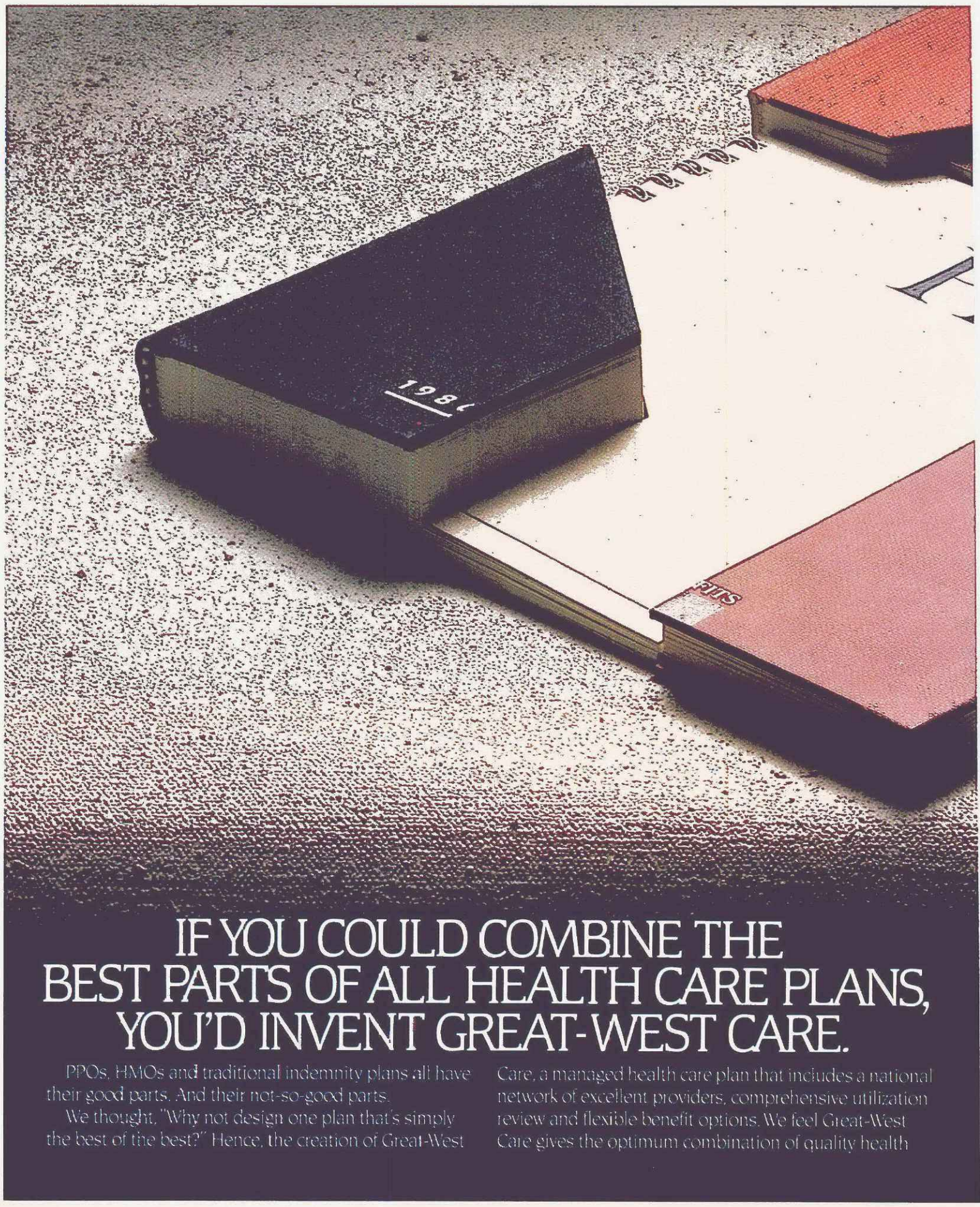
"Everyone is going to be very busy for the next three months," says Don Hasbargen, a partner in Hewitt's Minneapolis office.

While the tax act probably spells an end to massive, congressionally ordered changes to benefit plans like 401(k) plans, employers shouldn't rest easy that there won't be more tinkering next year.

"Just as there was a Tax Reform Act of 1986, there will be a Technical Correction Act of 1987," says Stuart J. Brahs, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

It would be naive to think, he says, that the technical corrections bill would be limited to "dotting the I's and crossing the T's."

Indeed benefit lobbyists say they hope to undo some of the damage to 401(k) plans through changes in a technical corrections bill. ■



Tax bill affects almost all aspects of 401(k)s

WASHINGTON—The Tax Reform Act of 1986 changes virtually every rule covering 401(k) plans, including non-discrimination tests, maximum contributions and hardship withdrawals.

And, other rules broadly aimed at savings plans, also will affect 401(k) programs.

The tax law's rules affecting 401(k) plans include:

● **Non-discrimination rules.** Currently, employers are required to compare salary deferrals made by the top-paid one-third of employees to the lower-paid two-thirds to determine if the plan favors the highly compensated.

But, under the tax bill, 401(k) discrimination will be tested by comparing deferrals by the lower-paid employees with deferrals by a new group of highly compensated employees, defined as:

- Employees who own more than 5% of a company.
- Employees earning more than $75,000 annually.
- Employees earning more than $50,000 annually who also are among the highest-paid 20% of the company's workforce.
- Officers who earn at least 1½ times the maximum defined contribution plan limit or $45,000.

In addition, the tests for comparing the average deferral percentage (ADP) of the higher-paid compared with lower-paid employees becomes much tougher.

Under the bill, the average salary deferral elected by the highly compensated cannot exceed the greater of these two amounts:

- 125% of the ADP of the lower-paid employees.
- The lesser of either 200% of the ADP of the lower-paid employees or the ADP of the lower-paid employees plus 2%.

● **Contributions.** The tax bill lowers maximum contributions in two ways.

First, the maximum annual salary deferral is cut to $7,000 from $30,000.

Second, the new maximum is an individual limit, while the current maximum is a plan limit.

Under the plan limit rule, an employee changing jobs could defer up to $30,000 into each 401(k) plan in which he or she participated during a year.

With the new individual limit, the maximum an employee could defer into a 401(k) plan would be $7,000—regardless of the number of 401(k) plans involved.

● **Withdrawals.** Currently, employers generally allow employees to withdraw funds from 401(k) plans for such "hardships" as uninsured major medical expenses, a child's college costs and the down payment on a primary home.

The bill would allow such hardship withdrawals, but access to funds would decrease somewhat and the cost would rise.

The interest earned on those contributions and matching contributions that were aggregated with deferrals for purposes of satisfying non-discrimination tests could not be withdrawn.

In addition, employees would be slapped with a special 10% additional tax on amounts withdrawn for most hardships. This tax would be over and above any other income taxes that were due.

However, this 10% tax would not apply for hardship withdrawals used to pay uninsured medical expenses that exceed 7.5% of a taxpayer's adjusted gross income.

And, the 10% tax would not be imposed on aftertax contributions that were withdrawn, but it would apply to earnings attributable to aftertax contributions.

● **Distributions.** Employees will face a 10% tax on pre-retirement distributions, generally before age 59½, unless the distribution results from death or disability.

The 10% tax would not apply if the funds were rolled over into an Individual Retirement Account or used to purchase an annuity payable over the life expectancy of an employee. The special tax also would not be imposed on aftertax contributions distributed.

● **Order of withdrawal.** While this provision is not specifically aimed at 401(k) plans, it nonetheless will have an impact.

Currently, an employee that makes pretax and aftertax contributions to a 401(k) plan can first withdraw the aftertax contributions. Since these funds already have been taxed, no additional taxes are imposed.

For example, if an employee deferred $5,000 to a 401(k) plan and made $5,000 in aftertax contributions, he could withdraw $5,000 and not pay any taxes.

That so-called order of withdrawal will continue. However, when an employee withdraws aftertax contributions, he or she also will have been considered to have withdrawn the taxable earnings on the aftertax contributions.

● **Forward averaging.** The bill wipes out a favorable tax calculation known as 10-year forward averaging for lump-sum distributions from 401(k) and other pension plans.

Ten-year forward averaging is now available, regardless of an employee's age.

By contrast, under the tax bill, only five-year forward averaging will be available and only to employees over age 59½.

However, under a special transition rule, employees who were age 50 or older on Jan. 1, 1986, still could elect 10-year averaging, using the current tax rates, or five-year averaging using the new, lower, basic tax rates.

—By Jerry Geisel



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opinions

Single benefit agency needed

WE'VE SEEN IT happen time and time again. Congress, with little thought, passes sweeping legislation affecting employee benefit plans and then leaves it up to regulators in different agencies to work out the details.

Regulators, swamped with other projects, can't get rules out on time and employers are forced to operate in the dark.

When rules do come out—often years after they were due—employers find that their interpretations of the law were not the same as the regulators' and they are forced, at great time and expense, to amend their benefits programs.

There must be a better way.

We believe a single federal agency should be established whose sole responsibility would be employee benefit plan regulation and policy development.

At least five federal agencies—the Treasury Department, the Labor Department, the Department of Health & Human Services, the Equal Employment Opportunity Commission and the Pension Benefit Guaranty Corp.—now are involved in the regulation of employee benefit plans. But, with the exception of the PBGC, the other agencies' responsibilities extend beyond employee benefits.

When rules do come out—often years later—employers find their interpretations were not the same as the regulators' and are forced, at great time and expense, to amend the plans.

As a result, it is not surprising that it took the Treasury Department, for example, six years to draft the regulations covering flexible benefit plans.

In fact, in light of the hundreds of issues with which the Treasury Department must deal, it is somewhat of a miracle that its staff members have the time to draft any employee benefit plan rules at all.

But things would be different if one agency were responsible for employee benefit policy and regulation. Since that agency's sole responsibility would be employee benefits, regulations would come out faster and would be better written.

But it isn't only regulations we're concerned about. The absence of a single agency has resulted in a total lack of long-term federal policy development on employee benefit issues.

When policy is developed, it occurs on a crash basis, usually in the context of tax legislation. And such policy that is decided on the fly usually has little to do with what is best for employee benefit plans and participants.

For example, the top benefit experts in the country say the non-discrimination rules for welfare benefit plans included in this year's tax overhaul measure are virtually impossible to figure out, and they say that employers will face a nightmare trying to comply.

Given the fact that those rules were drafted in less than a month by Treasury Department and congressional staffers who were immersed in many other issues, messy, complicated non-discrimination rules that don't hang together are the inevitable result.

But if there had been a single federal benefit agency, the issue of non-discrimination rules—just to take one example—could have been decided on a more thoughtful basis. Better rules certainly would have been the result.

Yet, despite late or poorly written rules—or no rules at all—employers are showing increasing ingenuity and innovation in designing their benefit plans.

As we reported this week in our spotlight report, some employers are considering working with the government to "privatize" Medicare, by using Medicare funding together with private funding to produce a better, more cost-efficient system of retiree health care.

Other employers are purchasing multiple-option health care programs, in which traditional indemnity coverage and coverage through health maintenance organizations and preferred provider organizations can be purchased in one group health insurance plan.

Still other companies are weighing the pros and cons of cash balance pension plans, which combine the features of defined benefit and defined contribution plans.

But these and other similar employer innovations aren't going to continue without new and better direction from Washington.

More than 50 years ago, Congress decided that the securities industry had become so important that it created the Securities and Exchange Commission.

Today, employer-sponsored benefit plans are the principal source of retirement and health care coverage for workers. Given the vital role that these programs serve, the time has come for Congress to recognize their importance by creating an agency to smooth problems with benefit regulation and to help devise a national benefit policy.

letters

Who should pay for insuring the uninsured?

To the editor: Without being pedantic, I should like to comment on the *Business Insurance* editorial of Sept. 15, 1986, in which you state that "35 million people lack health insurance. . . .This is a major societal problem. . . ."

Then, the editorial writer goes on to "object. . .to this unwise proposal," that is contained in H.R. 5300.

And, the writer concludes by urging Congress to "strip the pool proposal from the bill."

But—you give no opinion or suggestion as to who should pay for this major problem, only that employers shouldn't.

Two things I always teach my risk management students at the College of Insurance and at New York University are:

- Never go to your boss with a problem without suggesting solutions.
- And, a major duty of risk managers is to recommend alternative risk management methods to senior management.

I'm sure it was an oversight on the editorial writer's part. Tell us—who do you suggest should pay for insuring the uninsured?

Norman Hoffman
The College of Insurance
New York, N.Y.

■ *We wish the problem of the uninsured was so simple and clear-cut that we could say: "This is the solution."*

Unfortunately, the problem is very complex, one that involves balancing the goal of protecting individuals from catastrophic health care bills while not burdening businesses with excessive costs.

Perhaps a solution can be found to this thorny problem. But, as we wrote, a sensible solution only is possible after careful debate where the pros and cons of various proposals are aired and analyzed. The pool proposal has not begun to receive the rigorous analysis that it deserves. After that debate has occurred, we will be better able to judge what approach should be taken to ease problems faced by the uninsured.

Our experience, especially in the employee benefits legislative arena, is that quick fixes or "solutions," can lead to a new set of Problems. For example, if the pool proposal were adopted, some employers might cut back or even eliminate their group health insurance plans if they also had to pay for the uninsured. That hardly would be in the public interest.

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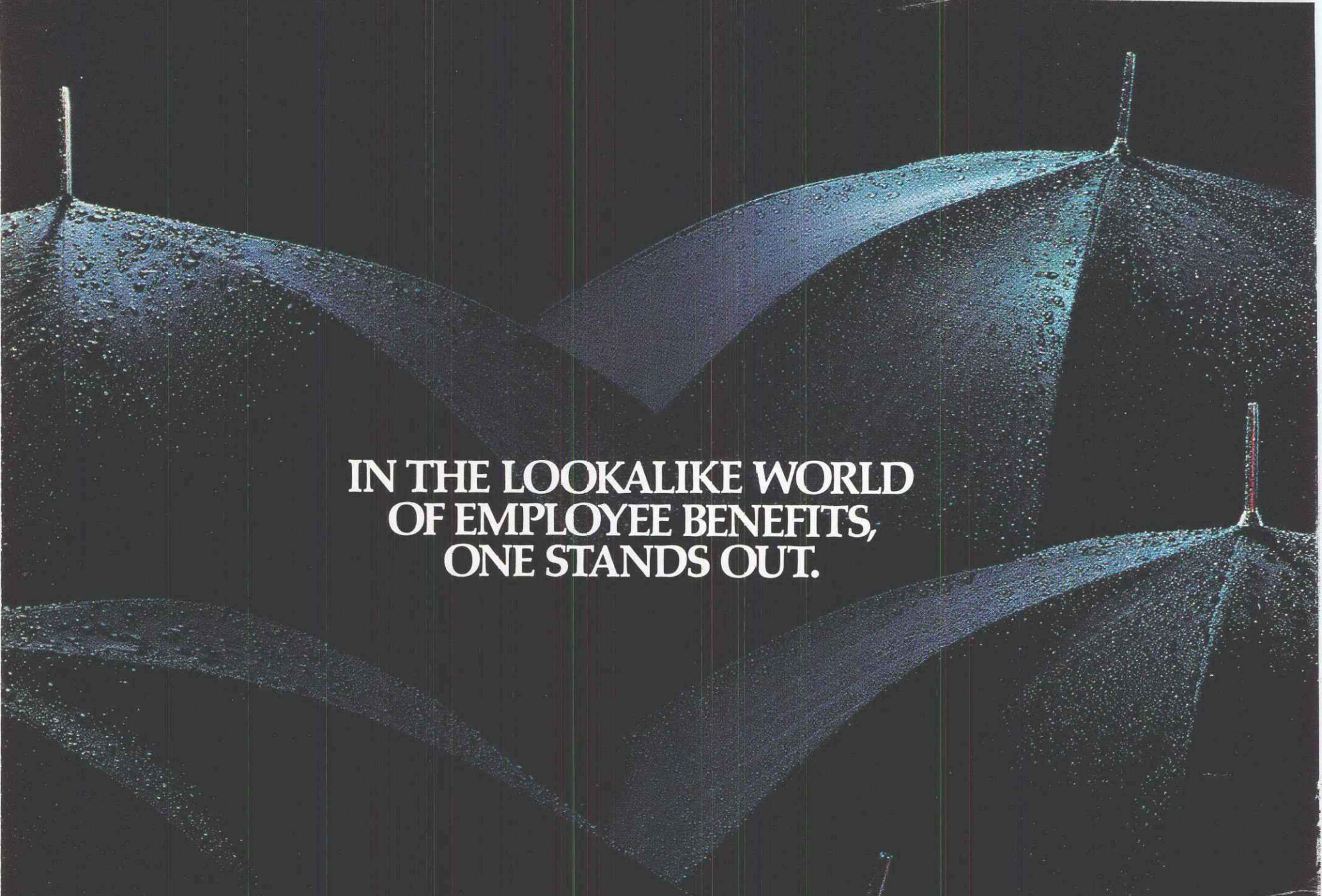
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Employers weigh Medicare benefit administration

By ROBERT A. FINLAYSON

Employers, anxiously attempting to gain control over rapidly escalating retiree health care costs, are now studying whether they could administer retirees' Medicare benefits more cost-effectively than the federal government.

Under such a scenario, an employer would receive from the federal government a fixed amount for each of the employer's Medicare-eligible retirees and dependents. The amount given to the employer would be based on a percentage of the estimated cost of the retiree's Medicare benefits under the current government system.

In exchange for this fee, the employer would provide health benefits equal to those the retiree is entitled to under Medicare.

Some employers believe that combining their retirees' Medicare benefits with employer-provided supplemental health benefits and applying cost-containment measures—like utilization review and pre-admission certification—would cost less than operating both programs separately.

Such a program would make the retirees' Medicare benefits go further, they say, which could decrease the cost of the employer-sponsored programs.

The concept is not new: The Reagan administration has been promoting it for several years as part of its plan to "privatize" the Medicare system.

However, for the first time, several employers apparently are giving the idea serious consideration.

The federal Health Care Finance Administration, which oversees Medicare, currently is holding discussions with two major companies, General Motors Corp. and Chrysler Corp., along with three labor unions, says Kevin E. Moley, director of HCFA's newly created Office of Prepaid Healthcare.

HCFA is looking for other employers interested in trying what it calls the "risk contract" concept on a demonstration basis.

Other employers also appear to be interested in the Medicare risk contract concept. Officials with Ford Motor Co. and American Telephone & Telegraph Corp. say they are looking into the concept, but have not yet held formal talks.

Neither GM, Chrysler nor the unions—which would have to give the automakers their go-ahead—has committed to entering into such a demonstration project, but the automakers appear to be seriously considering whether they would benefit from employer-administered Medicare programs.

"We think we can be far more efficient in the delivery of quality care" by administering retirees' Medicare benefits, says Donald Longnecker, manager of finance and planning-health care and group insurance at Chrysler Corp. in Detroit.

GM and the unions declined to comment.

Employee benefit experts say unions view employer administration of Medicare benefits as a means of simplifying the health claims process for retirees by eliminating the need to file claim forms with both the Medicare program and the employer offering supplemental coverage.

But, the observers continue, the unions also see potential problems, such as the potential for employers to curtail Medicare benefits.

"Both sides"—the employers and unions—"are jockeying for position, but neither wants to blow the deal" with HCFA, says one benefit expert who asked not to be named.

HCFA's Mr. Moley says the agency will publish a notice this month explaining the concept and asking for response from employers that are interested in entering into a demonstration project.

The Reagan administration hopes the success of such demonstration projects, which likely would not get off the ground until late 1987 or early 1988, would prompt Congress to pass legislation allowing HCFA to implement this concept on a broad basis.

Currently, HCFA only has legislative authority to try the concept on a demonstration basis.

At the behest of the Reagan administration, Sen. David Durenberger, R-Minn., introduced a bill last December that would have given HCFA more authority to contract out to various groups to provide Medicare benefits on a prepaid basis. But the bill has received little congressional attention.

HCFA is now developing legislation that would give it very broad authority to contract out with employers.

"One would think that if these demonstrations were successful, it would encourage Congress to go forward" with legislation that would give HCFA the authority to contract out with employers, Mr. Moley says.

Consultants and benefit experts say there is simply not enough data available on retiree health care costs to evaluate whether the Medicare "risk contract" concept is a good idea for most employers. However, they note that GM and Chrysler are in an unusual situation.

The automakers are required under their labor contracts to pay the difference between the amount that Medicare pays for health care and the actual cost of their retirees' medical bills, explains Elliot Segal, a principal in the Washington office of William M. Mercer-Meidinger Inc.

"Because the automakers are

Continued on page 14

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Medicare

Continued from page 12

liable for everything that Medicare doesn't pay, they will, in effect, be looking at the whole picture themselves, and they'll try to find a way to cut the cost because they're the deep pocket," Mr. Segal says.

By agreeing to a Medicare risk contract, he explains, the automakers would know they were getting a fixed amount of dollars for every one of their Medicare beneficiaries.

"Then they'll go out and create an at-risk arrangement with some health care providers—as opposed to just around waiting for the providers to eat up that Medicare-eligible person's money," he says.

Mr. Segal and others point out that very large employers, like GM and Chrysler, have the financial leverage and the large numbers of retirees necessary to extract guaranteed-cost arrangements from health care providers.

GM already has made such arrangement for active employees and retirees by contracting with preferred provider organizations that provide care at a guaranteed cost, he notes.

Whether Medicare risk contracts make economic sense for other employers depends a lot on the employers' retiree population and the level of health care benefits the employer provides to its retirees, consultants say.

"Basically, unless you have a very generous plan that you're trying to integrate with Medicare in some way, there is virtually no incentive" for agreeing to a Medicare risk contract, says Deborah Chollet, a senior risk associate with the Employee Benefit Research Institute, an benefits think-tank in Washington.

Employers with rich benefit plans for retirees that want to consider Medicare risk contracts should begin collecting data on retiree health care costs and utilization patterns, she says.

"If I were counseling employers about whether or not they should be interested, I would say start out with one or two years of good data on what the costs of retiree plans are now before you take on a partnership with Medicare that seeks to manage these costs," Ms. Chollet says. Employers need to find out what share of the total cost of retiree health benefits are paid by Medicare, she adds.

"If it's a big share, it may be worthwhile taking on because you may feel you can achieve efficiency and reduce your actual cost by taking the whole system in-house, integrating it and managing it," Ms. Chollet explains. If the Medicare portion is a small share of total retiree health costs, it may not be possible to achieve any great efficiency that would reduce the cost of providing benefits now administered by Medicare, she adds.

Chrysler is now collecting data to determine the feasibility of a risk contract, according to Mr. Longnecker. The automaker is working with HCFA and the United Auto Workers to develop a joint data base that would help Chrysler determine whether this program would be cost-effective for the company.

The current thinking, he explains, is that the data would be turned over to a consultant, which would assemble reports for analysis by Chrysler, the UAW and HCFA. Chrysler and HCFA are in the process of selecting the consultant that would assemble the data, he says.

Mr. Longnecker says Chrysler would use this data to make sure that the amount that HCFA would pay it to administer its retirees' Medicare benefits would be sufficient to cover the cost of those benefits. HCFA is willing to pay employers taking part in demonstration projects 95% of the average adjusted Medicare cost per retiree in exchange for paying and administering Medicare benefits, HCFA's Mr. Moley says. However, it's not yet known how these rates will be adjusted.

Mr. Longnecker says it is critical that the adjusted rate reflects a group comparable to Chrysler's retirees in demographics and utilization experience. "We want to make darn sure that any adjustments take into account how different our Medicare population is from the aggregate Medicare population, so that we don't buy a lot of adverse risk," he adds.

Chrysler officials also believe that by applying cost-containment features to retirees' Medicare and employer-sponsored health care programs, it could substantially reduce retiree health care costs, Mr. Longnecker explains.

The current system makes it nearly impossible for employers to apply cost-containment features, like utilization reviews and preadmission certification, to the Medicare portion of the retiree health benefit since the government administers the benefit.

"Right now, all the cost-containment programs that we are putting into place can't be applied against Medicare-eligible people because of the Medicare regulations," he explains.

However, if Chrysler were to administer its retirees' Medicare benefits, it would be allowed to introduce cost-containment strategies, though Mr. Longnecker says the company does not yet know what strategies it would employ.

Chrysler's "suspicion and hope" is that applying cost-containment measures to retiree health care programs would result in a savings of more than 5% of the average adjusted Medicare cost, Mr. Longnecker said.

Like Chrysler, AT&T is also considering the Medicare risk contract concept, largely because the employer provides retirees with very generous health care benefits and it wants to begin to manage those costs.

"We're interested in anything that would help us to manage the health care of our retirees," says Kathleen Holness, district manager for benefits planning and analysis at AT&T's corporate headquarters in New York. Her office oversees benefits for the communication giant's 330,000 employees and 75,000 retirees.

But Ms. Holness says AT&T has not yet had any formal talks with HCFA about participating in a demonstration project.

Before such a plan could be implemented, she says the company would need a lot more data about how much of a retiree's health care bill Medicare pays as opposed to how much the company pays. Ms. Holness also says she is somewhat skeptical about whether cost-containment measures could make up the 5% difference between what HCFA would pay employers participating in this program and what Medicare is now paying for these benefits.

For example, she says, enrolling employees in an HMO "results in savings in the first year or two, but the rate of increase in costs for HMOs hasn't been any different than than the rate of increase in overall health care costs."

"So I'm approaching it from the point of view that it sounds interesting because it's the managed care environment, but I really will have to see some numbers to figure out how it could work," she says.

"The other problem is going to be, how our retirees would view this. Yes, you can get the government to agree, but then you have to get your retirees to feel comfortable in that environment." ■



Employers wary of cash balance pensions

By AVRA WING

Although employer interest in cash balance pension plans is growing, only a handful of employers have switched to this new breed of pension plan and only a few intend to make the switch soon, consultants report.

Employers' unfamiliarity with the cash balance concept is the main reason that few have adopted cash balance plans, but acceptance also has been curbed by concern over the costs of the plan and uncertainty about the impact of tax legislation on cash balance plans, according to consultants.

Many companies are sitting back and waiting to see how others fare with their new plans before committing themselves to changing their plans, the consultants say.

Large companies—particularly those with high employee turnover—and employers with overfunded pension plans are the most likely candidates for cash balance plans, the observers say.

In addition, cash balance plans are attractive to businesses that want more predictable pension costs, consultants noted.

Generally, employers that are "willing to look at something new" are the most likely to consider or adopt the cash balance plan, noted Larry Brennan, a partner at Kwasha Lipton of Fort Lee, N.J.

The cash balance concept "has loosened people's minds," according to Mary Riebold, a principal at William M. Mercer-Meidinger Inc. in Washington, D.C. "They're saying, 'Look at all the fancy things we can do if we want to.'"

Under a cash balance plan, an employer establishes cash account for each employee when he or she becomes a plan member. On a monthly basis, the employer credits each account with funds based on an employee's pay and years of service. The accounts earn interest at a predetermined rate.

And, in most cases, cash balance plans offer faster vesting schedules than the 10-year vesting commonly found in defined benefit plans.

Cash balance plans are considered a type of defined benefit plan because they guarantee a particular benefit, but they have several features common to defined contribution plans, such as rapid vesting (*BI*, Feb. 17).

Consultants say the plans that some employers have adopted recently tend to be similar to the plan adopted by San Francisco-based BankAmerica Corp. (see story, page 22).

But in many cases, employers' examination of cash balance plans leads to an "affirmation of the worthiness of the present (defined benefit) system," noted consultant Michael Hayes, manager of Hewitt Associates' Detroit office.

"There's tremendous interest in the plans but a lot of confusion," noted Allan Grosh, a vp with The Wyatt Co. in Minneapolis. "We hear employers say, 'We can cut our costs.'"

But, costs will not be cut if the employer wishes to maintain the same level of benefits it had under its prior plan, Mr. Grosh maintains.

The primary reason that employers do not opt to switch to a cash balance pension plan is the high cost of funding the plan, observers say.

Consultants note that pension costs under a cash balance plan will be higher if the employer offers the same level of benefits that were provided under a defined benefit plan, because employees generally vest sooner under a cash balance plan. Therefore, many mobile employees who would not stay with an employer long enough to qualify for benefits under a defined benefit plan will be entitled to benefits under a cash balance plan.

"Any early buildup plan is more expensive than a defined benefit plan," Ms. Riebold said. "Many companies the cash balance programs appeared attractive to, saw it was too expensive."

In addition, many companies have rejected switching to a cash balance plan because they feel that defined benefit plans provide the desired level of "adequate retirement income to live on," Mr. Hayes said.

A defined benefit plan "automatically adjusts" for salary leaps, because benefits are based on an employee's final average pay, Mr. Hayes noted. However, the cash balance plan does not base the entire benefit on the final, highest-paid years of employment.

Meanwhile, many of the employers considering switching to a cash balance pension program are holding back their decisions pending the outcome of the tax bill Congress is now finalizing, according to consultants. Employers are most concerned about provisions under the new tax law that would:

- Place a 10% excise tax on early distributions from qualified pension plans. Under this provision, if an employee leaving a company prior to retirement took the funds in his cash balance account as a lump sum, he would be liable for an additional 10% tax.
- Speed vesting requirements in qualified plans. Under this provision, all qualified plans—including defined benefit, defined contribution and cash balance—would have to offer one of two minimum vesting schedules: 100% vesting after five years, or 20% vesting after three years of service, with vesting continuing at a 20% annual rate until an employee is fully vested after 10 years.
- New discrimination tests that limit the amount of benefits that can be paid to highly compensated employees.

Yet, under certain circumstances, there are advantages to the cash balance programs that make them good bets for certain employers, consultants say.

For example, switching to a cash balance plan is attractive to a business with an overfunded defined benefit plan, Mr. Grosh noted.

Since cash balance plans are considered defined benefit plans for legal purposes, the defined benefit plan does not have to be terminated and tax does not have to be paid on the excess assets. Instead, an employer only has to amend its defined benefit plan to take the form of a cash balance plan.

In addition, because actuarial funding methods are used in a cash balance plan, an employer does not necessarily have to contribute the full amount promised, because favorable investment returns will increase the plan assets to the promised amount, consultants explained.

Continued on next page

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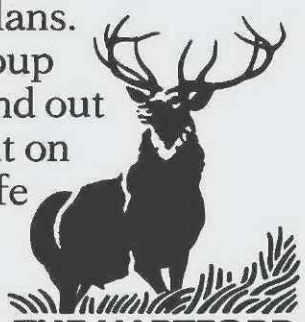
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Cash balance

Continued from page 16

And, if the rate of return on a company's investments is higher than the interest rate paid on employees' accounts in the pension plan, the employer reaps the benefit.

Because the excess assets from an overfunded defined benefit plan are not taxable when an employer switches to a cash balance plan, the cash balance approach also may provide employers a transitional step between a defined benefit and defined contribution plan, without "cutting the string immediately" by terminating the current plan, Mr. Grosh pointed out.

Going to a cash balance plan "is a way to ride the fence for a while" between defined benefit and defined contribution plans, pointed out Joseph Sapora, senior vp and actuary at Hay/Huggins Co. Inc. in New York. The plan allows an employer to wait and see "how the cash balance plan works, how it is received by employees, and how the tax act provisions materialize."

In addition, Ms. Riebold noted, an employer can reduce its pension plan costs switching to a cash balance plan and cut the level of benefits below those provided by an in-place defined benefit plan. This method will "mask" benefit cuts.

Because it is so difficult for an employee to figure out what he or she is entitled to under a defined benefit plan, employees generally are unable to compare their benefits between a defined benefit plan and a cash balance plan, she explained.

When employees do understand their pension benefits, or when the current pension system is tied to another popular benefit, such as a profit-sharing plan, it would be difficult to gain employee support for a switch, Ms. Riebold predicted.

'There's tremendous interest in the plans but a lot of confusion,' says Allan Grosh, a vp with The Wyatt Co.

Although most of the interest in cash balance plans has come from larger corporations, Mr. Grosh of Wyatt said thinks smaller firms would do well with cash balance plans because they are easier to administer than a defined benefit plan.

Mr. Grosh said that companies involved in mergers and acquisitions also would find the plans attractive for the same reason.

In addition, a cash balance plan is viable for those employers that provide their employees more expensive pension plans but are "not getting commensurate playback from the employees" in terms of their satisfaction with the pension plan, he noted.

Those that have accepted the plans "came to the conclusion that, on the human resources side, it made sense," he said.

The "portability" of the cash balance plan is appealing to today's more mobile workforce, according to consultants. They noted that many workers probably will not stay at a company for more than a few years, and they would not otherwise receive pension benefits. Therefore, companies that tend to hire mobile workers might be interested in offering this benefit.

Harry Young, a Mercer-Meidinger consultant in Orange County, Calif., said high-tech companies are good candidates for cash balance plans because they require attractive benefit programs, with short vesting requirements, to attract highly educated workers who will only stay with the company for several years.

Also, employers that perform a lot of contract work for the government may find cash balance pension plans appealing, because those employers often hire employees on a short-term basis, Ms. Riebold added.

Although "fast-track" employees—those employees whose salaries rise fastest in their last few years before retirement—are concerned that they would do better under a final average pay defined benefit plan, that concern is minimal, according to Kwasha Lipton's Mr. Brennan.

Some have said that cash balance plans would hurt these workers because they will not have high salaries long enough for cash balances to accumulate commensurate to their final pay.

"Key executives would have special deals, anyway" that would supplement their pension plan benefits, Mr. Brennan pointed out.

The possibility of a smaller benefit "would not be a huge drawback. The availability of the account could be very attractive to them," he said, referring to the faster vesting schedule under a cash balance plan.

And, by adopting one or more transition provisions, employers can mitigate the concerns of retirement-age employees that the changeover to a cash balance plan will deprive them of benefits they had counted on, Mr. Brennan said. Several employers, including BankAmerica, have adopted these provisions.

Often, employeers that switch to a cash balance pension plan do so for a variety of reasons.

For example, First Bank System Inc. of Minneapolis switched because it had high employee turnover and an overfunded defined benefit pension plan, it wanted more predictable pension plan costs and it often makes acquisitions.

The bank "did a lot of looking" at its former final average pay plan before deciding to go with the cash balance concept in July, according to Merle Flaata, vp of employee benefits. It discovered that only 15% of its 9,000 employees were "reaping the benefit" from the defined benefit plan.

First Bank realized that its employee population had changed dramatically. Ten to 15 years ago, many workers had 20, 30, or 40 years of service with the bank, Mr. Flaata said. But, most of the bank's employees today do not stay with the bank long enough to qualify for benefits under the old defined benefit plan, which had a 10-year vesting requirement.

First Bank felt that a cash balance account was attractive to employees and that the plan was easy for them to understand.

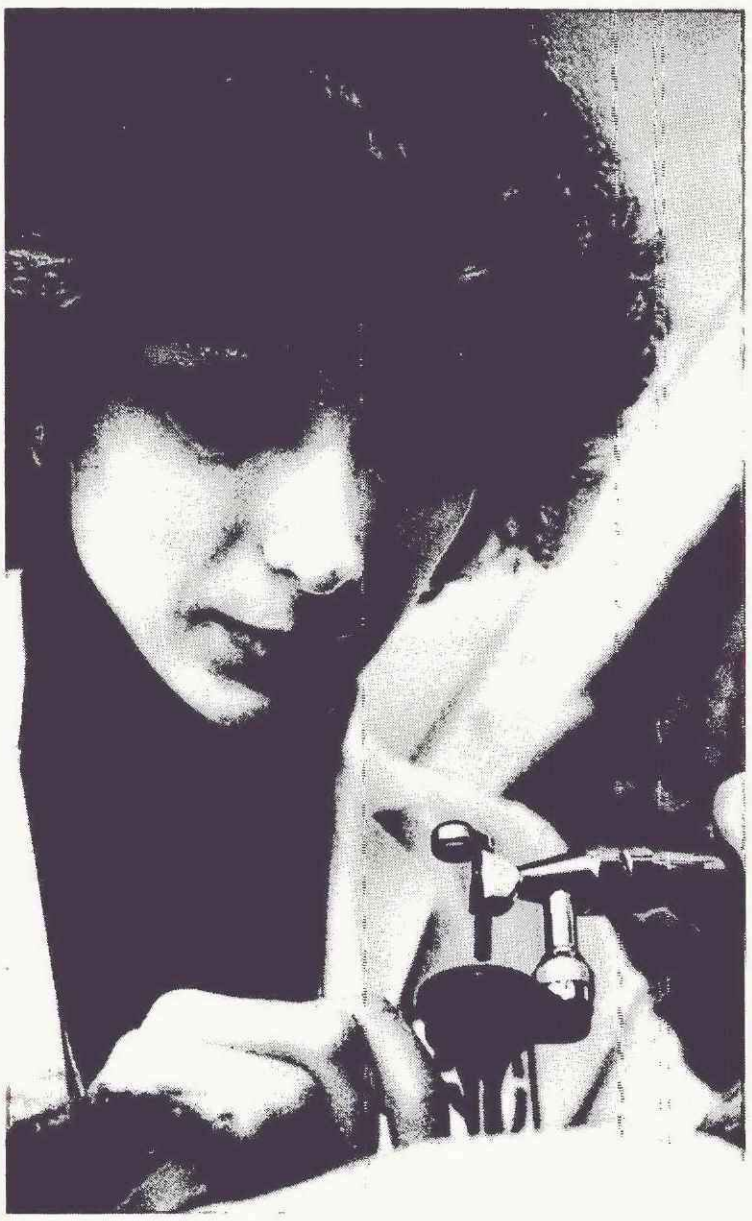
In addition to employee satisfaction, First Bank wanted to recover assets from its overfunded pension plan to secure "a better rate of return for shareholders," Mr. Flaata said.

Because First Bank has been involved in a series of divestitures and is planning some merger and acquisition activities, the ease of administration and of integrating new employees provided by the cash balance plan was especially attractive, Mr. Flaata noted.

The new plan is projected to be less expensive than the prior pension program, Mr. Flaata said, noting that actual savings had not yet been calculated.

He noted that, in some cases, benefits will be lower for some workers—employees who have been with the bank for several years and are not eligible under the plan's grandfather clause to retain all of the benefits they would have

Continued on page 20



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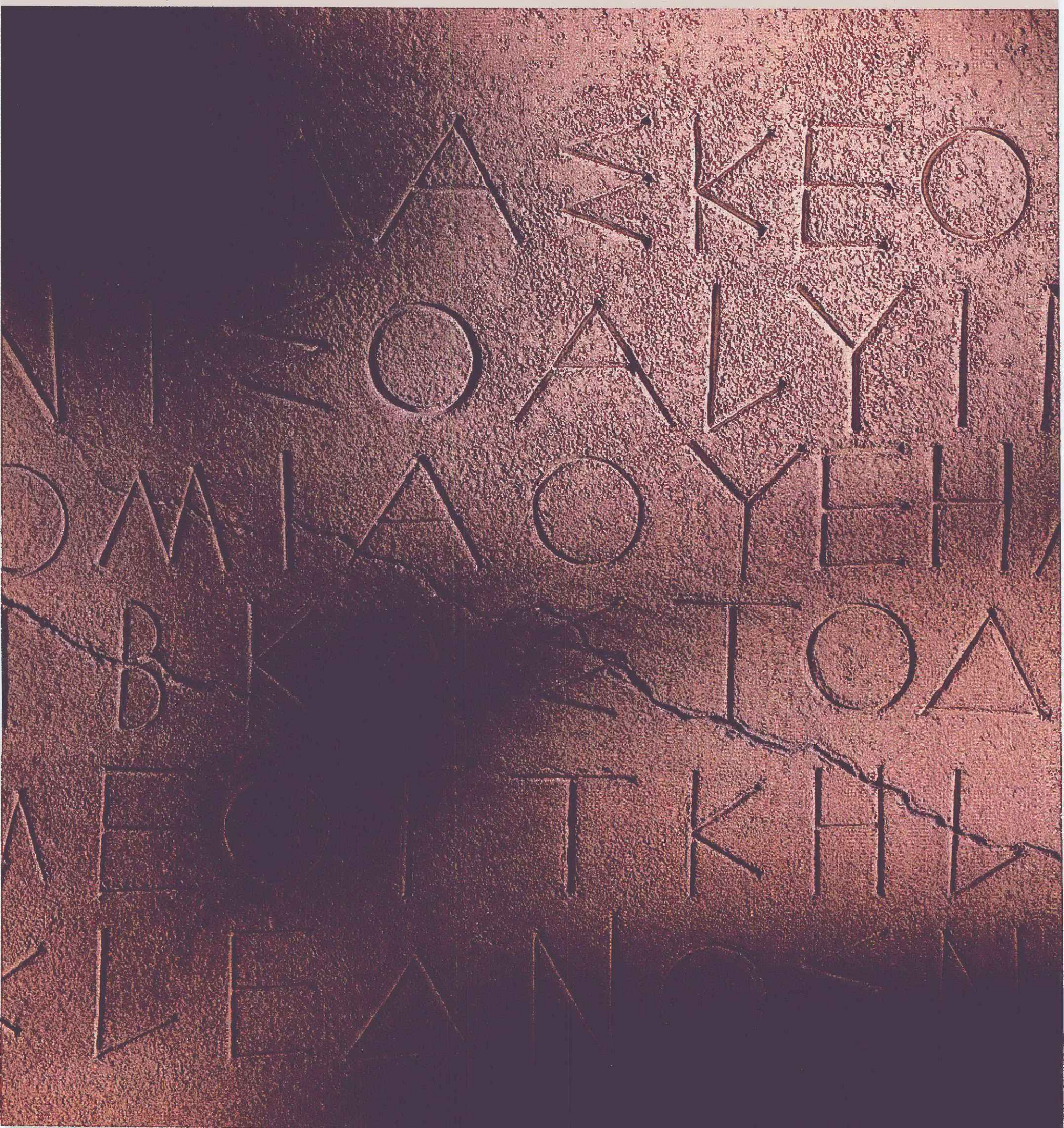
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Cash balance

Continued from page 16
received under the previous plan.

The plan's grandfather provision guarantees that retirement-age employee will be enrolled in either plan whichever provides the employee the greater benefits. Retirement-age employees are those employees who were eligible for early retirement or whose age plus service equaled at least 75 as of Jan. 1, 1986.

However, benefits under the cash balance plan may be higher for some employees: those who leave the company early in their careers will earn benefits that they would not have under the previous traditional benefit pension plan.

Mr. Flaata, characterizing the new cash balance plan as a "career average defined benefit plan," said that each employee's account will be credited monthly with 3% of total compensation, plus 3% to 6% of compensation in excess of $5,000. The level of the additional compensation would be tied to length of service.

The accounts currently accrue interest at an 8% rate, but a new interest rate will be set in October based primarily on government bonds. That rate will go into effect next January.

Employees are 50% vested after five years, and then vest an additional 10% a year.

Transitional benefits have been established so "older workers won't be hurt so badly," Mr. Flaata said. An additional 5% to 17% of pay will be credited to these workers, the rate again depending on length of employment. This benefit will be gradually lowered.

Although Mr. Flaata said that tax bill considerations did not influence First Bank's decision to adopt a cash balance plan, he noted the company might have adopted a vesting schedule that would have conformed to the vesting requirements in the tax bill.

So far employee reaction has been good, although some workers who perceived their benefits would be lowered were upset, he noted.

To educate its employees about the differences between the cash balance plan and the previous defined benefit pension plan, plan instructors visited each of First Bank's 150 locations.

First Bank then printed a brochure answering questions from the training sessions, made a videotape explaining the switch and sent individual statements showing the amount with which each employee's account would initially be credited along with projections of accrual at various ages.

Next month, the bank will send each location a microcomputer program with which employees can run their own projections.

Desert Hospital of Palm Springs, Calif., switched to a cash-balance plan July 1 from a "very modest, very conservative" defined benefit plan because the institution was "looking for something that would be more of an attraction to employees who didn't look down the road years ahead," according to John Mininger, executive vp.

Pension costs should run about the same as under the hospital's former plan, he noted, adding that the primary motivation was to "improve the benefit."

About 1,000, or 60%, of the hospital's approximately 1,700 employees are now enrolled in the plan. Employees become eligible for enrollment after one year of full-time service.

Desert Hospital employees receive contributions to their accounts equal to 2% of salary, plus 4% of all compensation over one-third of the Social Security wage base. Employees are 20% vested after six years, and then vest an additional 20% a year.

The interest rate is tied to Treasury bills and is set on April 1. The current rate is 7.4%.

Employees' current pension balances were converted into cash balance accounts, and any employee eligible for retirement within the next five years will be able to take the greater of the benefits provided by the new and the former pension plans.

In conjunction with the new pension, the hospital is offering a tax-deferred annuity plan, under which it will contribute 25% of the first 6% of an employee's salary deposited in a TDA account.

A financial institution in the Northeast that is a Hay/Huggins client adopted its cash balance program early this year. The plan covers all of its 250 employees.

The company had an overfunded pension plan but did not want to take the reversion. It found that adopting the cash balance system was a good way to avoid being taxed on the recovered funds, according to Mr. Sapora, who would not identify the company.

Cutting pension costs was not a consideration, Mr Sapora said, noting that the company will probably budget about the same amount for the new plan as it did for its defined benefit plan.

For employees earning less than $30,000 annually, 3% of salary is credited toward their accounts during the first five years of service. After five years, 4% is credited. For those earning more than $30,000, 7% is credited for the first five years, and 9% is credited after five years.

Funds accrue interest at the average Treasury bill rate for the prior year.

Employees become 40% vested in the plan after four years, 45% after five years, 50% after six years, 60% after seven years and an additional 10% in each succeeding year.

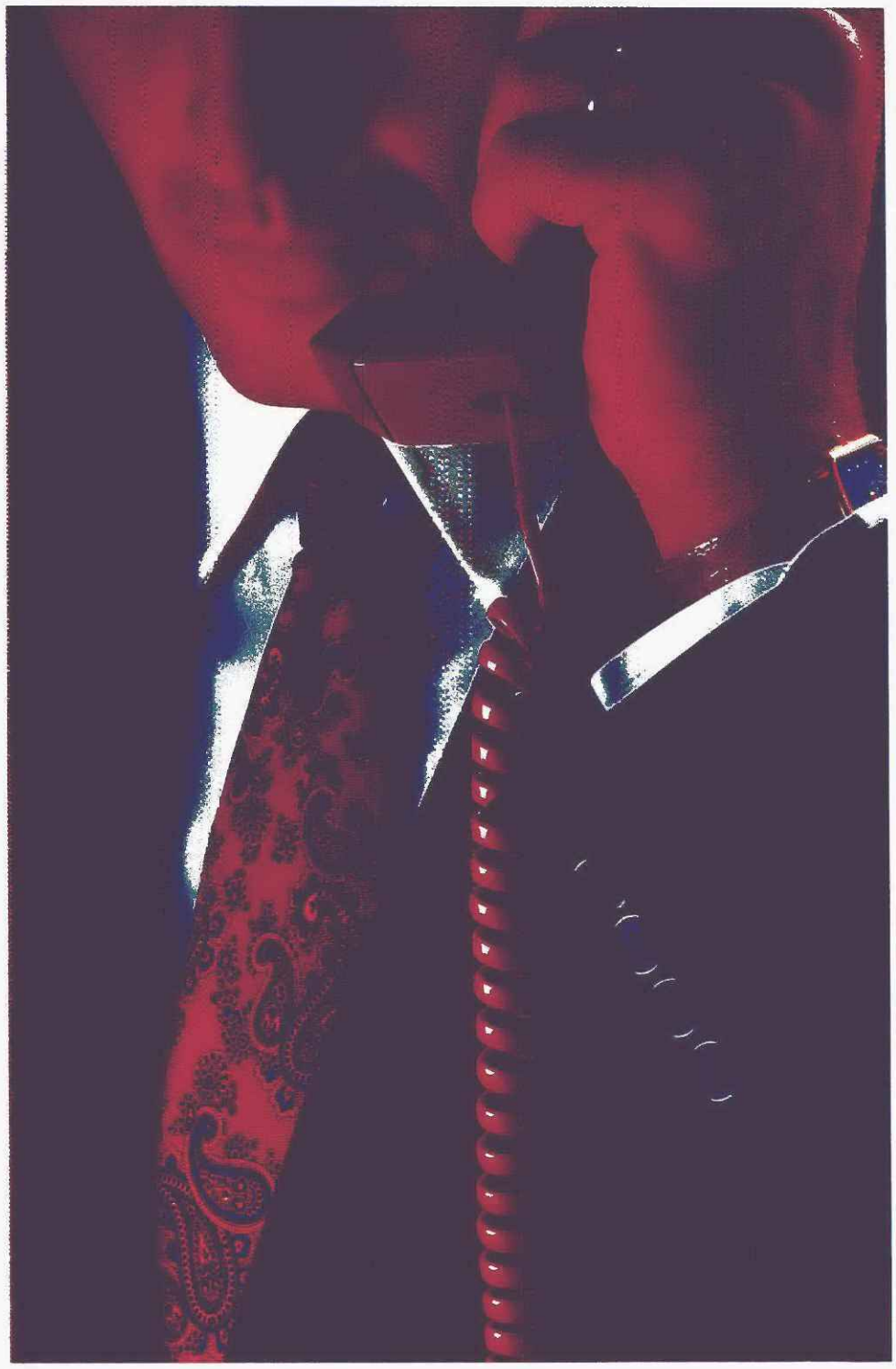
Other employers that have cash balance plans include:

- Cooper Industries Inc., a diversified manufacturer of industrial equipment in Houston.

All salaried workers—approximately 12,500—are affected by the switch from the final average pay plan. The company declined to discuss the plan further.

- A Fortune 500 manufacturer that is a Kwasha Lipton client. The employer has combined several different traditional pension plans into a single uniform cash balance plan for 15,000 salaried employees out of a total workforce of about 60,000. The cash balance plan went into effect July 1.
- A Midwest manufacturer, that intends to have its plan running by the end of the year. The plan, designed with the help of Hewitt, will affect about 2,000 workers. ■

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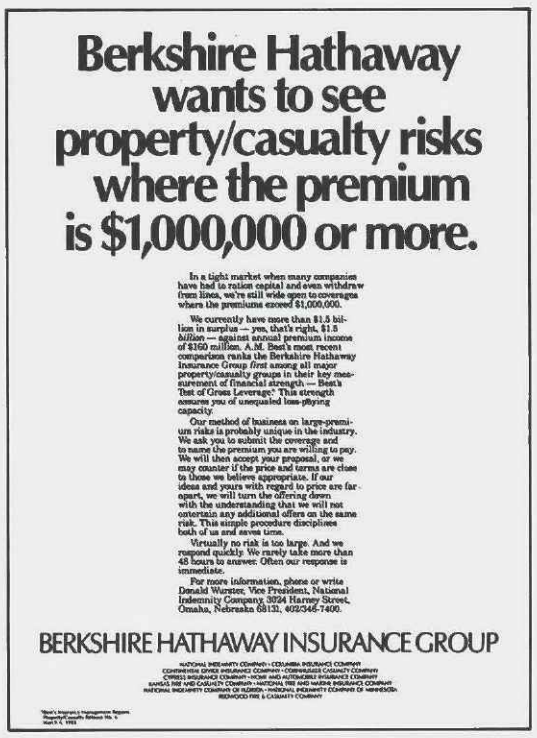
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Communication key to new pension plan

By AVRA WING

SAN FRANCISCO—A long-term communications program is essential when instituting a cash balance pension plan, according to BankAmerica Corp., the first company to adopt such a plan.

"Communication is a long, long-term thing," said Paul Nordine, a BankAmerica benefit consultant. "When in doubt, do more.

"It is a complex educational process," he added, one which the bank undertook with the help of consultant Kwasha Lipton of Fort Lee, N.J., which conceived the cash balance plan (*BI*, Aug. 26, 1985).

BankAmerica plans to concentrate heavily on employee education at least through July 1990, when the grandfather provision in the cash balance program expires.

The provision provides that employees planning to retire within five years after the cash balance plan was implemented will receive the benefits they would have received under the former defined benefit plan.

BankAmerica introduced its cash balance plan, called BankAmeraccount, in July 1985. The plan combines aspects of both defined benefit and defined contribution plans.

Under the cash balance plan, BankAmerica establishes a cash balance account for each member.

On a monthly basis, BankAmerica credits the account of an employee with 10 years or more of service with 5% of pay, less a Social Security offset. Employees with less than 10 years of services are credited with 4% of pay, less the offset.

An interest rate for accumulated funds is determined each year. The 1986 rate is 9%.

Vesting occurs at a rate of 10% for each year of employment. Employees are eligible to participate after one year of service, but their accounts are credited retroactively for that first year.

If an employee leaves the company before retirement, he or she can take the accrued benefit as a lump sum or leave it in the plan until retirement. At that time, the former employee can elect to receive monthly disbursements or a lump sum.

The bank has taken several steps to explain the plan to employees.

Beginning in March 1985, it distributed written information on the plan, including general information and specific benefit calculations for each of its 60,000 employees, all of whom are covered by the plan.

The bank also showed a videotape that explained the program, and it conducted special educational seminars for middle managers, who inform employees about the new plan.

Most recently, the bank began distributing personal computer diskettes that allow employees to "run their own numbers," Mr. Nordine said.

Because employees can easily determine how much money has accrued in their accounts, the pension plan becomes more understandable and meaningful to employees, he explained.

But that high degree of employee awareness of the cash balance plan can become a double-edged sword, he observed. For example, if the changes in benefits from the old plan are not fully or clearly explained, employees could become confused—and resentful.

BankAmerica's communication effort was complicated by its recent financial difficulties. The bank lost $640 million in the second quarter, primarily because of loan charge-offs and an increase reserves for future loans. The bank also lost $337 million in 1985.

Because of BankAmerica's recent financial problems, "there's concern over the status of the pension plan," Mr. Nordine said. However, the bank has "had some success" communicating to employees that the financial problems will not affect the plan, he said.

Younger workers, overall, have been more enthusiastic about the new pension plan than older workers, Mr. Nordine said. "Older workers see the plan as not as beneficial" as the former final average pay defined benefit plan.

Under a cash balance pension plan, "fast-track" employees—or those whose salary rise substantially during the last years of employment—will not have high salaries long enough for cash balance contributions to accumulate commensurate to their final salaries. These employees generally fare better under a defined benefit plan, in which benefits are based on final average pay.

However, "the old plan will be there for them" under the plan's grandfather provision, he said.

The bank now is concentrating on providing additional information to grandfathered employees, Mr. Nordine said.

BankAmerica also provides transitional benefits for long-term employees not covered by the five-year grandfather clause. Any employee whose age plus years of service with the bank is between 50 and 60 as of July 1, 1985, are eligible for those benefits. Over the next five years, these employees, depending on age and years of service, will receive additional benefits amounting to between 3% and 30% of current pay.

Although the new plan generally "produces a somewhat lower benefit" than an employee would have received under the prior system, that cost savings was not a major motivation for instituting the cash balance system, Mr. Nordine said.

The company projects it will reduce its pension costs to $50 million from $68 million by switching to the cash balance program, but it intends to spend "all of that and more" on an expanded 401(k) savings plan it implemented last fall to supplement the cash balance plan, Mr. Nordine said.

The savings plan is now open to employees with at least one year of service.

For employees with 10 or more of service, the bank fully matches pretax salary deferrals of up to 4% of pay, and it matches 50% of the next 2% of pay deferred.

For those with less than 10 years of service, employee deferrals are fully matched for the first 2% of pay and are 50% matched for the next 4%.

Employees can withdraw matching contributions after five years.

Eventually, BankAmerica hopes to include 90% of its employees in the savings plan. Fewer than 60% are currently participating.

The bank has been reluctant to launch a "full-scale initiative" to increase participation because of uncertainty over tax legislation, Mr. Nordine said. ■

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Group insurance losses sting hospitals

By DONNA DiBLASE

Some hospital systems, which charged into the group health insurance business over the past two years, are now having second thoughts as the losses mount.

The group health plans marketed by American Medical International Inc. and Humana Inc., two giant hospital systems, each absorbed more than $25 million in losses last year, prompting AMI to kill its program and Humana to launch an effort to save its product.

Meanwhile, National Medical Enterprises Inc., which also purchased an insurer and had planned to market group health coverage, now is reconsidering whether it will enter the market because of the problems encountered by AMI and Humana.

"Perhaps the most important reason why these companies didn't make it was that they got into a business they didn't understand," noted Bernard Tresnowski, president of the Blue Cross & Blue Shield Assn. in Chicago.

The AMI and Humana losses are "a case of not understanding the insurance business at all," agreed Byron Nimocks, an assistant vp with E.F. Hutton & Co. Inc. in New York.

Randy Huyser, senior health care services analyst at Montgomery Securities in San Francisco, added: "These companies miscalculated the cost of entry into the health insurance business."

However, observers say that several hospital systems that currently are establishing joint ventures with group health insurers have a much better chance of success than the hospitals that bought insurers to market group health coverages, such as AMI, Humana and NME.

Beverly Hills, Calif.-based AMI announced last month that it was discontinuing its 1½-year old AMICARE preferred provider group health product after losing $25 million on the venture in fiscal 1986, which ended Aug. 31. In addition, AMI says that it will take an $80 million write-down in its fourth quarter to account for its expenses in discontinuing AMICARE.

An AMI spokesman said the company's Group Health Services division would have lost $100 million in 1987 if it had continued to offer group insurance plans.

AMI attributes the loss to an "extraordinarily competitive marketplace," the spokesman said (*BI*, Sept. 1).

AMI purchased Los Angeles-based Fidelity Interstate Life Insurance Co. in late 1984 when it set up its Group Health Services division.

The division offered employers health maintenance organizations, the AMICARE preferred provider organization and a Medicare supplemental insurance program.

AMICARE was offered in about six markets in the Southwest and Florida, according to the spokesman. AMI will retain Fidelity Interstate at least until all current contracts are honored.

However, AMI has not discontinued its four HMOs, located in Denver; Washington, D.C.; Omaha, Neb.; and Birmingham, Ala.

Humana has lost $26.1 million so far this year on its 2-year-old group health product, Humana Care Plus, said a company spokesman. The company lost $2.9 million on the product during the corresponding period last year, he noted.

Humana acquired Commercial State Life Insurance Co. two years ago to underwrite its group plans (*BI*, July 22, 1985). The company since has been renamed Humana Insurance Co.

Humana Care Plus is a managed-care group health product that operates as a health maintenance organization in some markets and as a preferred provider program in others, the spokesman explained.

The PPO gives enrollees freedom of choice of providers but offers economic incentives such as waived deductibles to encourage enrollees to use preferred providers. The plan is available in 40 markets, according to the spokesman.

Humana's losses stem mainly from operational problems and not competition in the health care marketplace, he said.

"We experienced a rapid growth in enrollment. Rather than acquiring an existing plan, we started our own. So we went from zero enrollees to 650,000 enrollees in two years," the spokesman explained.

"We also experienced an overutilization problem. We were not capturing admissions and utilization in Humana hospitals—which was where we could control costs. But, because insurance claims have a long tail, it took us two years to see what was happening," he said.

"Now, we are in the learning curve of the program," the spokesman added.

The company has implemented "corrective actions" in an effort to make Humana Care Plus profitable.

"We are focusing Care Plus in our strong hospital markets" to better control cost and utilization of hospital care, the spokesman pointed out.

"We have also initiated a utilization control program that includes pre-admission review and concurrent review and other controls. We are also transferring more Care Plus patients who have been admitted to other hospitals to Humana hospitals," he said.

"In emergency cases, we wait until the patient is stabilized enough to move and then transfer them," he added.

"Other companies, like AMI, have abandoned their plans. But, Humana was one of the first companies to go into vertical integration programs and we remain committed to the program," the spokesman explained.

"We are a very tightly focused company and all we're doing now is fine-tuning the plan."

To avoid major losses, Los Angeles-based National Medical Enterprises decided not to offer the group health plans it had intended to, according to Dr. Alan London, vp of NME's Health Plans Division.

The company recently sold one of its HMOs, AV-MED in Miami, Fla., to Santa Fe Healthcare Systems Inc. in Gainesville, Fla. The plan has 100,000 enrollees.

Dr. London said that figures on AV-MED's annual premium volume and the losses that NME incurred because of the plan are not available.

NME acquired Denver-based Assured Investors Life Co. last

Continued on next page

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Hospital insurers

Continued from previous page
year and planned to use the insurer to underwrite group health and life programs. The company also planned to use Assured Investors to reinsure its HMO subsidiary, AV-MED.

While Assured Investors does reinsure the HMOs, the other products never got off the ground, Dr. London said.

"A couple of years ago, we decided, like the other hospital companies, that it would be good to own a PPO or an HMO. That's when we purchased AV-MED of Florida in 1984. The idea then was to offer that product in markets where we had facilities," he explained.

"However, during the development of the HMO—which we found to be more difficult, time-consuming and costly than we had anticipated—we found triple option insurance plans were becoming more popular," he said (see story, page 28).

And, after NME purchased Assured Investors, the health care marketplace began to change rapidly, Dr. London continued.

"Competition stiffened and premium rates had leveled off, so profit margins were lower. The marketplace was saturated and it took millions of dollars to market a plan. Plus, it's tough to get good, experienced HMO managers.

"So, NME got in and out of the business as fast as it could," he explained.

"Looking at what happened to AMI and Humana, it was the right move," Dr. London observed "I think we saw what was coming long before the others, and we decided to halt any further HMO expansion last summer."

However, NME does plan to eventually offer a triple option insurance product in its two successful markets—New Orleans and Modesto, Calif. "But, we're not sure yet whether we'll use Assured Investors for those plans or contract with other insurers," Dr. London said.

AV-MED of New Orleans has about 6,000 members and generates about $6 million in annual premiums, according to Dr. London. AV-MED in Modesto has about 4,000 members and generates about $4 million in annual premiums.

"In these areas, people are very familiar with our plans and facilities, so it makes sense to keep the plans to complement our hospitals," he explained.

However, in other markets, NME "decided instead to attract other non-NME HMOs and contract with them instead of starting our own plans," Dr. London said.

"NME decided that it is much easier for the experts who have been in the health insurance business—and have it down to a science—to enter a new market with a plan than it is for us to start a new plan," he explained. "We don't think being at risk for a lot of health care dollars is the best way to conduct our business."

In addition to underestimating the insurance business, experts say there are other reasons hospital companies had difficulty with their managed-care plans.

"The problem is that it's difficult to run two businesses that are inherently different at the same time," Mr. Nimocks of E.F. Hutton pointed out. "Success in managed care is to reduce utilization. Success in a hospital company is to fill beds or increase utilization."

However, "that's not to say someone like Humana will not make it. AMI never really put much into the plan from the start. But Humana has been spending a lot on Care Plus—and losing a lot. I think AMI's plan was more of a spur-of-the-moment type of business," he added.

While Humana has had its problems, Mr. Huyser of Montgomery Securities said he thinks "they will be successful in the long term because they have learned from their losses."

"Their biggest error was that they had zero utilization review and that the physician needs to be part of a delivery network—the physician and utilization review are all tied together," he said.

Another expert speculated that the hospital parents may have offered policyholders rates that were too low to ensure profitability of the plans.

"They were so anxious to get a book of business that they offered rates that were too low," said Mr. Tresnowski of BC/BS. "And the buyers today are sophisticated, so they will take advantage of those rates. We lost a lot of business to these outfits," he said, adding that "there was no way they could sustain those rates and survive.

"You cannot play games with rates because that will come back to bite you," Mr. Tresnowski added. "It's not like putting prices on shoes. You really have to play straight up."

Humana offered employers either two- or four-year rates that were guaranteed not to rise more than 5% to 10% above the overall inflation rate, the Humana spokesman said.

AMI would not comment on its rate structures. However, AMI guaranteed the city of North Miami, Fla., that its rates would not rise faster than the inflation rate for two years if city employees enrolled in AMICARE obtained 75% of their covered care from AMI facilities and providers, according to Diane Howard, the city's risk manager.

About 170 of the city's 430 employees are enrolled in AMICARE, according to Ms. Howard.

The total monthly premium was $107.98 for individual coverage, $208.84 for an employee and one dependent, and $245.34 for coverage of an employee and two or more dependents.

The city paid the full premium for individual coverage and $126.27 of the premium for the other coverages, Ms. Howard noted. The city now is negotiating a new group health contract, she said.

Meanwhile, other hospital parents, like Dallas-based Voluntary Hospitals of America and Hospital Corp. of America in Nashville, have entered into joint ventures with major health insurers instead of buying insurers and offering their own products.

VHA is teaming up with Aetna Life & Casualty Co. of Hartford, Conn., and HCA is joining with The Equitable Life Assurance Society of the United States of New York in a joint venture.

Experts say these ventures may be successful.

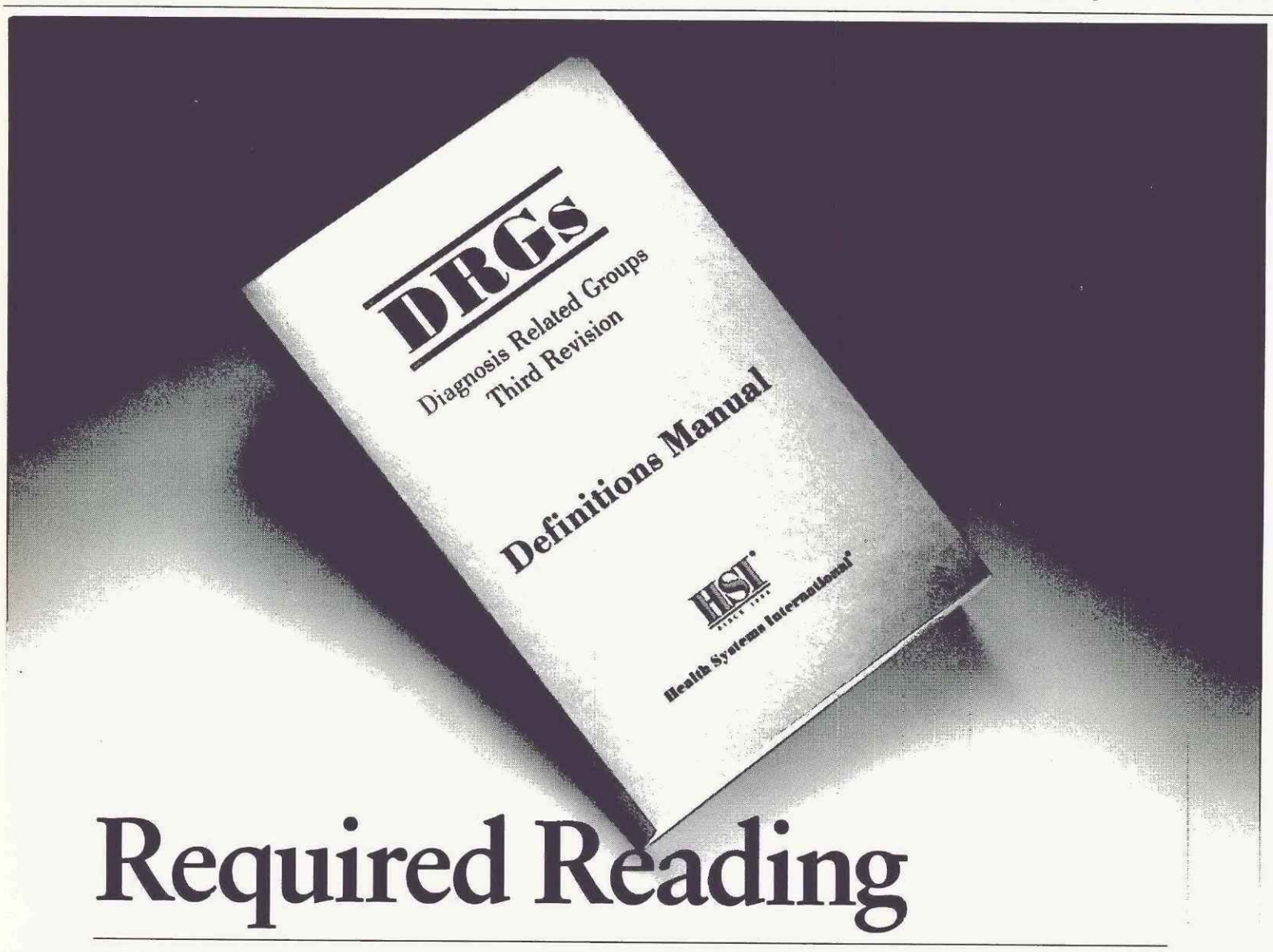
"I've said before that Humana's insured product was about as close to the future of managed health plans as we would see right now," noted Clifford Ritt, principal in the group consulting practice in the Washington office of benefit consultant The Wyatt Co.

"But, these large insurance company and hospital joint ventures are going to do it. The others are too small" to capture the market, Mr. Ritt asserted.

"There are three reasons why they can do it—marketing, marketing and marketing. It will take a sustained five-year marketing plan to change employers' and employees' perception of managed care," he predicted.

"I am more optimistic about HCA and Equitable making it, but they've got a tough road ahead of them," said Mr. Nimocks.

Continued on page 26



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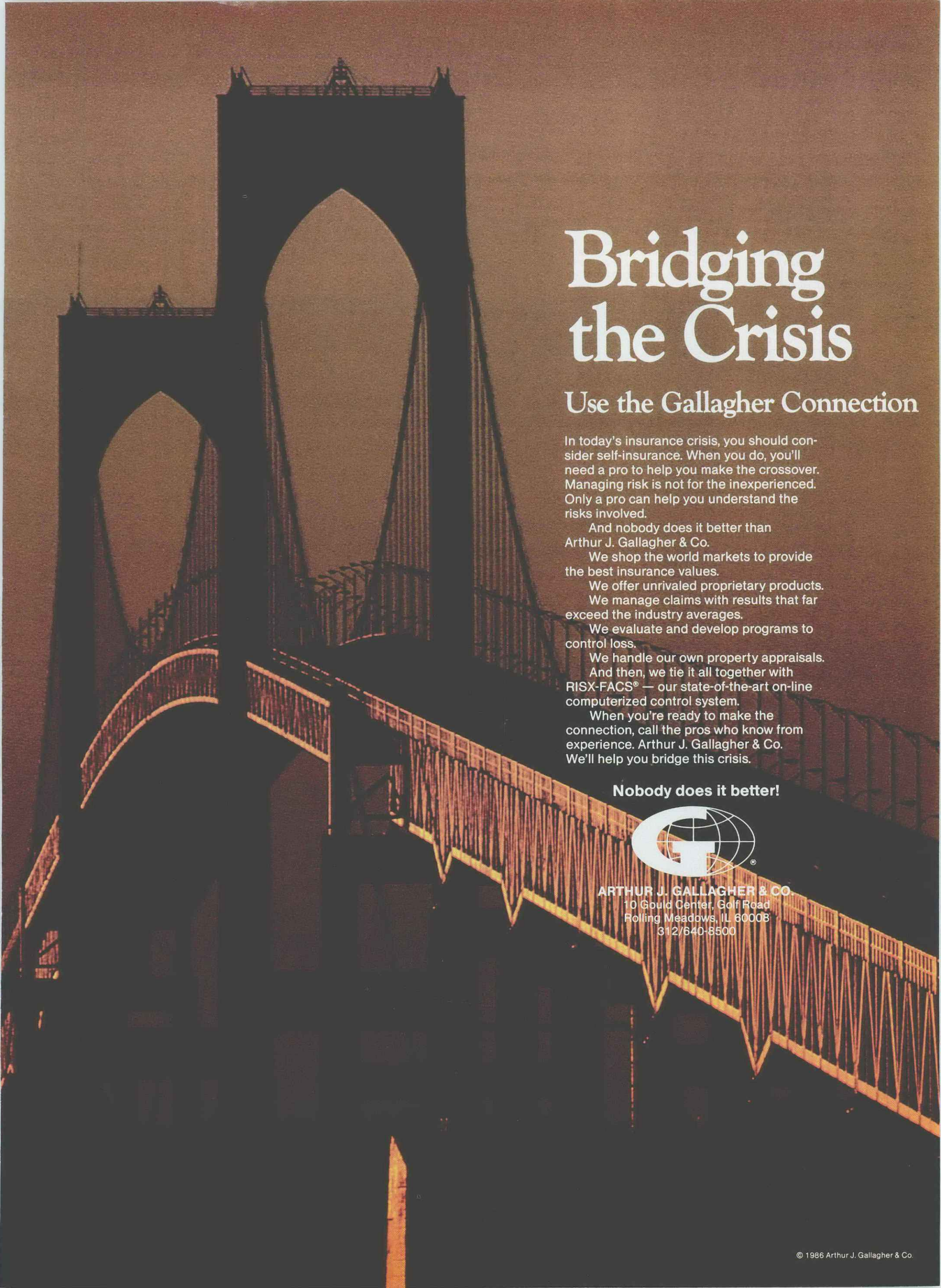
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Hospital insurers

Continued from page 26

Mr. Huyser said he also thinks "these companies will take years to get rolling, but they have the potential to be very successful at managed care."

"The joint ventures are going to have their problems, too," he said, adding, "they have to develop a symbiotic relationship—if the hospital is only going to be out to fill beds and the insurer just wants to cut costs, they will not be successful."

Officials of the joint ventures say they are optimistic about their chances for success because they have carefully developed and marketed their plans.

"We took a very cautious approach, and we're happy not to report any catastrophic losses," said Robert Duggins, senior vp of marketing for Philadelphia American Life Insurance Co. in Houston. "Joint ventures have a potential for offering a more successful operation. There almost has to be more cooperation between insurer and provider groups.

Last year, PALICO entered into a joint venture with Universal Health Service Inc., a multihospital company in King of Prussia, Pa. The companies offer Universal Health Share, a group health indemnity plan with a PPO option.

The plan is offered to small employers with up to 250 employees, according to Mr. Duggins.

Currently, the plan covers 1,000 lives in Reno and Las Vegas, Nev. He would not reveal the annual premium volume of the plan.

However, the companies have modified the plan's direction. "We have changed our direction a bit. We have started tailoring our plan to larger customers that are self-funded," he said, explaining that PALICO has started contracting with providers for employers and has "found this to be much better than offering traditional insured PPOs."

PALICO is now offering another group health insurance plan with a PPO option to clients in Pennsylvania, New Jersey and Delaware through InterGroup Corp., a Radnor, Pa.-based PPO.

"We have also formed our own utilization review system, and we are working with employers on monitoring their PPOs," Mr. Duggins noted.

Other hospital companies that have entered joint ventures with major health insurers also report slow, but steady, success with their plans.

"We have started slower than we would have liked, but ultimately we have a better designed product than some of the other companies," said Dale L. Thomas, chairman of Voluntary Health Plans of America, the joint venture between Voluntary Hospitals of America Inc. and Aetna.

VHPA currently offers a managed premium PPO called Partners National Health Plan in Louisville, Ky., Kansas City, Mo., and Portland, Ore. While VHPA is reluctant to disclose enrollment figures and annual premium volume for all of its plans, about 37,000 people are covered by the plan in Louisville, Mr. Thomas said.

Under the hybrid HMO-PPO plan, employers are guaranteed a limited annual premium increase if 50% to 75% of health care services are obtained from VHA facilities, he explained. Employees can choose any provider, but their copayment is lower when they use preferred physicians and hospitals.

VHPA also began marketing a new national PPO, Partners National Advantage, in July. The provider network, which will at first be a hospital-only program, includes about 580 hospitals across the country. The plan is now available in about nine markets, but the company expects it will be in 30 markets by the end of the year.

Mr. Thomas said he believes VHPA's plan is more successful than other hospital plans because VHPA "didn't make as drastic a move as they did. We believe putting doctors at risk ensures success of the plan. But, AMI and Humana didn't do this, so it was easier to introduce their plans, but it ultimately was harder to maintain their plans."

The joint venture between Hospital Corp. of America and Equitable is expected to be finalized by early October, according to Paul Tidwell, vp with New Century Life Insurance Co., an insurer acquired by HCA last year.

HCA and Equitable are forming a new company, Equicor, which will provide managed care plans in addition to traditional indemnity plans. In April 1985, HCA purchased New Century and planned to underwrite group health and life policies as well as offer PPOs and HMOs starting late last year.

However, "New Century has really just begun to function on its own. We issued most of our contracts this year," Mr. Tidwell said.

New Century insures some of the managed care systems offered by HCA in about 13 states, he noted. There are some 755,000 enrollees in HMOs and PPOs operated by HCA in these areas.

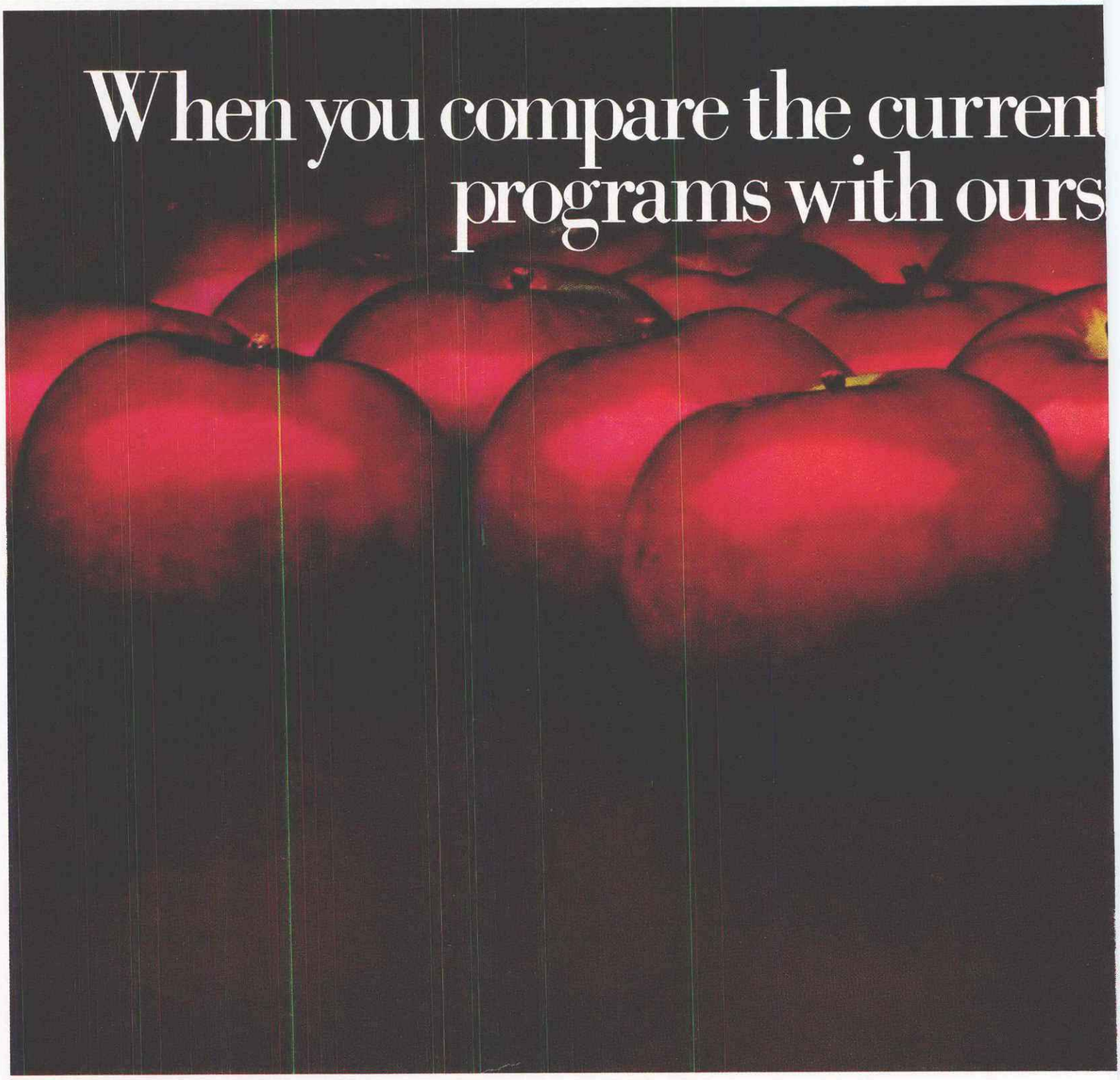
Now, "New Century will reinsure the group health and life business of Equitable in the new company, Equicor," he explained. "Equitable will have absolute control over the management and service of the plans."

As Equitable's current group policies approach their renewal dates, Equicor will offer the policyholders the option of retaining their indemnity plans or selecting a new triple option managed care plan, Mr. Tidwell said. These plans will be developed over the next three years.

"What should happen is that HCA will have a combination of managed-care plans and Equitable will have 15 million people insured. This will be an attempt to match that 15 million in areas where HCA has facilities," he said.

Employees covered under Equicor plans will be given the option of using their own non-preferred providers or using preferred providers and paying lower deductibles or copayments.

"We're talking about 15 million lives. The potential for income is quite large," Mr. Tidwell said. "The opening balance sheet on the closing of the joint venture agreement will already be $438 million, made up of contributions from both sides." ■



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Metropolitan shuns ventures with providers

By DONNA DiBLASE

NEW YORK—Contrary to the approach taken by several group health insurers that are starting joint ventures with health care providers, Metropolitan Life Insurance Co. says it plans to remain firmly on the buyer's side of the health care purchasing equation.

"As negotiators of care, we can seek out hospitals and physicians' groups that are trying to reach a particular market. But, because we are on the buyer's side and the providers don't own us, we can change providers when they aren't efficiently providing quality care," noted Executive Vp John D. Moynahan Jr.

"We have had a number of opportunities to joint venture with some very significant organizations, but when we looked at joint venturing several years ago we saw a fundamental conflict in it," he said.

The conflict in these arrangements arises between insurers and the providers, according to Mr. Moynahan: Insurers want to contain costs by controlling utilization and prices, while providers seek to increase their profits by increasing utilization of their facilities.

"Where the interests of the health plan are different from the goals of the hospital, there will be problems," he predicted.

However, because there are so many benefits options available to today's benefit managers, many buyers may not recognize this conflict, says Mr. Moynahan.

"There's a quick-fix aura to these plans, and a lot of employers will jump at this. I think it's going to take a while before employers realize this conflict of interest, but I think it will happen soon."

Although buyers have greater leverage because of the competition in the health care marketplace, they must be knowledgeable about the marketplace to make the most of their negotiating position, Mr. Moynahan said.

"We find ourselves operating as a buyer's representative, and with anything of this nature, you're looking at constant change," he noted. "The deal you strike in 1986 may not be such a good deal in 1987 because providers, technology and employers' needs change constantly."

However, Metropolitan believes it is well prepared to act on employers' behalf in health care purchasing, Mr. Moynahan said.

"We are in an advantageous position to do this because we are able to gather and interpret a lot of data on health care providers."

As a buyer's representative, Metropolitan also has been able to make employers' purchasing habits more efficient, according to Mr. Moynahan.

"We can bring employer groups together to create one large negotiating block," he explained.

Rather than offering managed care plans through a joint venture with one provider, Metropolitan instead offers MetElect, a preferred provider product. Metropolitan negotiates provider contracts for employers under these plans.

The insurer also offers health maintenance organizations through its subsidiary, MetLife HealthCare Management Corp.

It also has developed a new utilization review program for ambulatory health care, according to Bill Rosenberg, director of analysis and development.

"Utilization review programs have emphasized hospital cost containment, and they have been successful," he explained. "So, if we do a good job in the hospital, why can't we do a good job out of the hospital?"

But, reviewing ambulatory care is very different from monitoring inpatient care, he noted.

"First of all, because the claims are not that large, it may be hard to see how the review can be cost-effective. In the hospital, saving one day of inpatient care more than pays for the cost of performing the review," he explained.

Determining the norms of outpatient treatment is difficult. However, Mr. Rosenberg noted that Metropolitan has modified its electronic claims system to include "Patterns of Treatment," outpatient utilization norms developed by Dr. Donald C. Harrington of Pioneer, Calif.-based Concurrent Review Technology Inc.

In the computerized system claims are compared with detailed ambulatory utilization norms for specific diagnoses.

Claims that exceed these norms are identified electronically and are more closely examined by doctors and nurses in Metropolitan's Medical Action Centers, Mr. Rosenberg explained.

"If the normal number of claims for a specific procedure or diagnosis is seven, and an eighth claim is submitted, the claim will automatically be looked at," he said.

With this new system, the insurer can review doctors' office visits, laboratory tests and diagnostic procedures, Mr. Rosenberg said.

The centers also operate a health care "HELPLINE" for patients to call with medical questions.

"Ambulatory review is very important because it used to be that 60% to 65% of the benefit dollar went toward hospital care," he said.

But now, with the emphasis on outpatient treatment, more benefit dollars are being spent on these services.

The program was introduced in July and is available both through MetElect PPOs and traditional indemnity plans, he said. ■



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Multiple-option plans offer flexibility, savings

By DONNA DiBLASE

Employers, which only several years ago initiated alternative health care coverage options like HMOs and FPOs, now can obtain a multiple-option group indemnity plan with managed care services under a single group health insurance contract.

Several group health insurers now are marketing benefit programs that include a traditional fee-for-service plan, a preferred provider plan and a health maintenance organization option.

While these multiple-option plans provide employees with more health care choices and lower out-of-pocket costs when certain providers are used, they also are easier for employers to administer than if all of the elements of the plan were purchased from separate insurers, according to the insurers.

But, some benefit consultants are wary of multiple-option plans, noting, among other things, they could subject employers to medical malpractice lawsuits.

One insurer now marketing multiple-option plans is CIGNA Corp, whose "FlexCare" plan "is set up as a single benefit program, from a financing perspective," explained Chip Sharkey, vp of marketing in the group insurance and services division in CIGNA's Bloomfield, Conn., office.

Employers can offer employees FlexCare in two different ways:

- Under one plan, the employee has two options: an indemnity plan option or an HMO—called an "exclusive provider option."
- Under the other plan, an employee has three options: the exclusive provider HMO option, a traditional indemnity option or the indemnity plan with incentives—such as lower deductibles and copayments—to use preferred providers, Mr. Sharkey explained.

"Once a year, employees have the chance to select the EPO and lock into using those providers, or they can select a continuous option plan with incentives to use providers in the PPO. Their choice is to lock in on an HMO basis or opt in and out as they wish," he explained.

The PPO networks are made up of providers participating in the HMO, he noted.

And, like the HMO and PPO options, the indemnity option "still has all of the cost-containment features, like utilization review case management and outpatient incentives," Mr. Sharkey noted.

FlexCare is offered either on a fully insured basis or on an administrative-services-only basis for self-insured employers.

CIGNA plans eventually to offer the program on a nationwide basis. It began test marketing it in Los Angeles and San Diego last year, he says, and it has since spread to Phoenix, Ariz., Seattle, St. Louis and Kansas City, Mo.

Mr. Sharkey said that the plan's major advantage is the cost-savings for employers: Under FlexCare, the employer is charged one rate for all of the options in the plan.

"The key advantage for the employer is that the HMO is experience-rated instead of community-rated, so employers pay for exactly the amount of health care services their employees use," he says.

Under the community-rating practice, HMOs determine their premium rates based on the utilization of health care by all groups in the HMO. Therefore, premiums do not reflect the actual usage of services by each employer group separately.

HMOs that are federally qualified by the U.S. Department of Health and Human Services Office of Prepaid Health Care are required to use the community rating practice.

However, because the HMOs offered through FlexCare are not federally qualified, they have more flexibility in setting premium rates for each employer that reflect the usage by that employer's group, Mr. Sharkey explained. And, while employers in the past have complained that it is often difficult to obtain reports of employee utilization from HMOs, FlexCare provides these reports for employers, Mr. Sharkey said.

FlexCare currently covers about 102,000 lives and "has generated about $73 million worth of business so far," Mr. Sharkey noted.

"We are very pleased. We believe that integrated products like this are really the benefit product of the future," he added.

Metropolitan Life Insurance Co. introduced its "triple option" plan earlier this month.

Like FlexCare, the plan is experience-rated and is offered on either an insured or administrative-services-only basis, according to Neil Waldren, director of product development for the New York-based insurer.

Under the plan, employees are offered an indemnity option, an HMO and a PPO.

HMO coverage is provided through Metropolitan's subsidiary, MetLife HealthCare Management Corp, while the PPO offered as MetElect, in which Metropolitan negotiates provider contracts for employer clients.

The PPO option is a point-of-service plan in which employees can choose either preferred providers or non-preferred providers when they obtain health care.

However, employees are encouraged by lower or waived deductibles and copayments to use preferred providers, Mr. Waldren noted.

"Managed care is the wave of the future and we think the triple option plan is the best way to deliver it," he added.

But, unlike CIGNA's plan, Metropolitan offers employees the opportunity to opt in and out of the HMO option more easily.

"There will be a three-month lock-in on the HMO option, but after the initial three months, employees can give 30' days notice if they want to change to the other plans," Mr. Waldren explained.

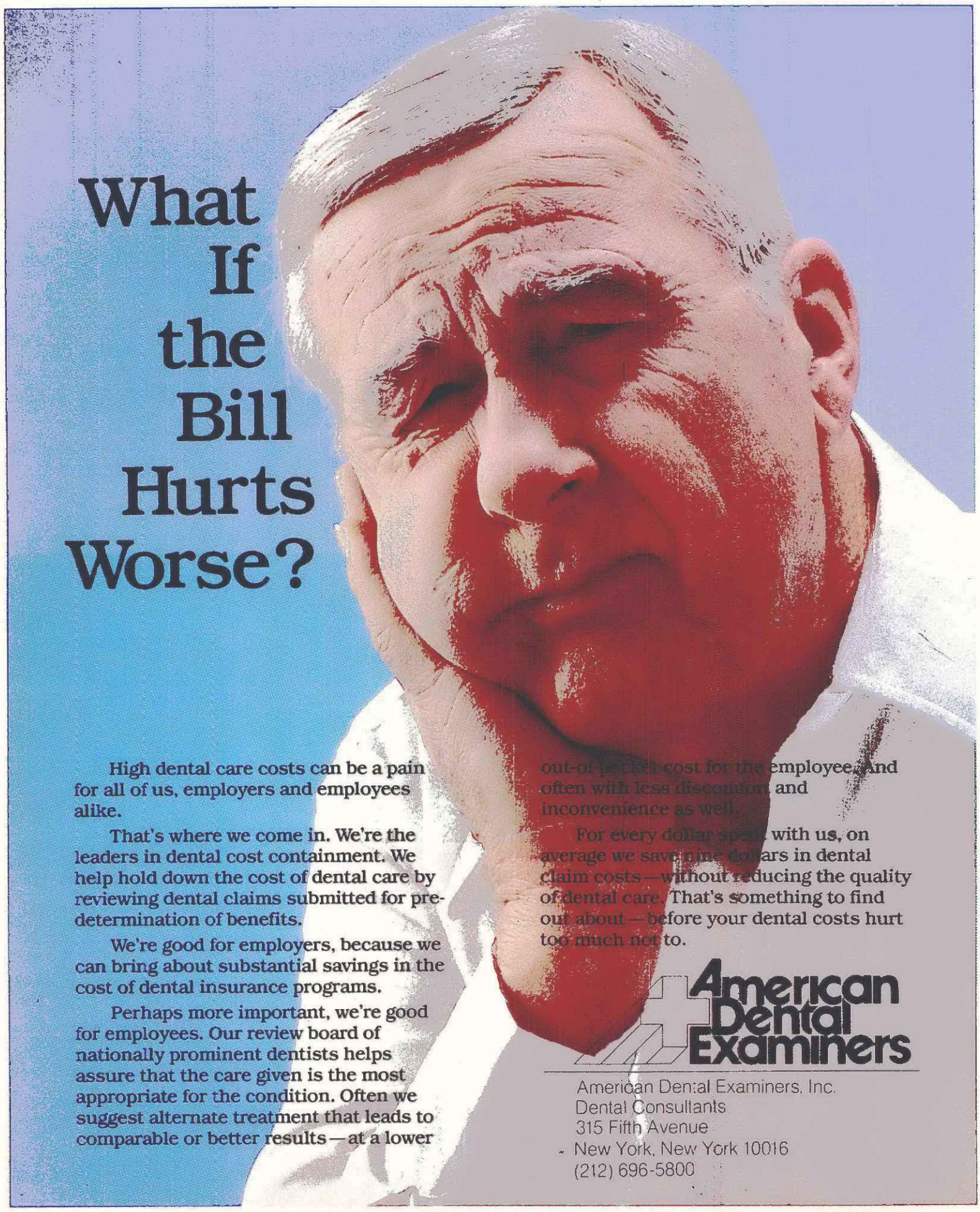
Along with experience-rating, the plan also offers employers the advantages of a uniform utilization review system for all of the options and the ability to obtain statistical utilization information under the HMO option, he said.

Mr. Waldren estimates that the insurer has sold the plan to four or five employers, but he was unsure how many lives it covers.

PrudentialPlus, offered by Newark, N.J.-based Prudential Insurance Co. of America, is a managed care plan that also includes an indemnity option, a PPO and an HMO.

The plan was introduced in Jan-

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Psychiatric care

Continued from page 3

Thus, the greatest potential for cost containment is to reduce lengths of stay, experts say.

To that end, utilization review is often the first and least expensive step employers can take to reduce health care expenses. Many firms that provide medical reviews also will study psychiatric treatment, according to Hewitt's Mr. Tucker.

For example, one Hewitt client reduced the number of inpatient days for psychiatric care by 15% by implementing a utilization review program, Mr. Tucker noted. He declined to identify the company, which employs about 1,200 people in California.

And, when used in tandem with utilization review, firms that specialize in psychiatric case management can produce even greater savings for employers, those companies claim.

In a case management program, a health care professional monitors a patient's care to determine the most appropriate treatment for that person, with an eye on alternatives to hospitalization.

Now, some companies are combining utilization review and case management with groups of specially selected psychiatric treatment providers to form psychiatric PPOs that promise contracting employers savings similar to that offered by medical care PPOs.

Philadelphia-based Integra Inc., which originally provided case management and utilization review services, began marketing its HealthCap PPO last year to contain costs of employer-funded mental health and substance abuse treatment, according to K.C. Baldadian, Integra's executive vp.

Currently, 12 Philadelphia-area employers covering 200,000 people have contracted with HealthCap PPO, which also provides case management services, says Ms. Baldadian. The PPO network includes 20 to 25 facility providers as well as an affiliate network of therapists, some of whom are in private practice.

HealthCap users also have access to the New Beginnings Recovery Centers of America, Addiction Recovery Centers in Boston, the Renfrew Center in the Philadelphia area—which specializes in anorexia/bulimia cases—and a number of free-standing substance abuse facilities.

Integra uses a computerized tracking system to monitor treatment and determine the most cost-effective and successful providers, Ms. Baldadian said.

Emanual Malone, health cost containment program manager at the Space Systems division of General Electric Co. in Valley Forge, Pa., which has contracted with Integra, says his company was searching to gain control over its mental health care costs.

"Psych care is the highest single category of diagnosis in almost every location," Mr. Malone noted, adding that these costs had gotten "way out of hand."

The GE division, which employs approximately 10,000 people, pays more than $3 million a year for psychiatric care, compared with total medical care expenses of $18 million to $19 million, he estimates.

Mr. Malone blamed the lack of control over psychiatric treatment, citing cases where, in the treatment of adolescents, "the shrink literally comes in the room and waves" and then bills the client for an inpatient visit. "At that rate, the cash register starts ringing up the numbers fast."

Mr. Malone said he hopes to save 30%, or $900,000, a year by making psychiatric care provided through the PPO a separate coverage, like dental or vision care coverage, apart from its medical care benefit.

The company still is negotiating the fee structure with Integra. One option would be to pay an annual fee based on the number of plan participants, plus administrative expenses.

Space Systems' self-funded employee health care plan, which is partially administered by Blue Cross of Massachusetts and Metropolitan Life Insurance Co., currently discourages outpatient mental health care by paying 100% of employees' inpatient psychiatric treatment costs, but only 50% of outpatient costs. Under the major medical plan, there is a $125 individual deductible and $250 family deductible. Total benefits are capped at $500,000 lifetime.

But Mr. Malone is amending the company's benefit plan to steer more employees toward the less-expensive outpatient psychiatric services by providing incentives, such as discounted fees through the PPO.

One of the longest operating PPOs, Psychology Systems Inc. has negotiated discounts of up to 70% with 700 psychiatric providers in Western states, including mental health facilities in Los Angeles, Menlo Park and Milpitas, Calif.

Member providers cap rates at $50 per outpatient visit for the 100,000 lives covered under its Psych/Care Plan PPO by 250 employer clients.

Dr. John Brady, who had been in private practice in California as a psychologist for 10 years, launched the PPO five years ago after he was approached by several insurers that "just threw up their hands because there are no controls" in the treatment of mental illness, he said.

Psychology Systems is licensed in California under the Knox-Keene Health Care Service Plan Act of 1975, which regulates health care providers in the state, including PPOs and health maintenance organizations.

In addition to inpatient facilities and outpatient counseling, the PPO offers a substance abuse network that includes 18 hospitals, an employee assistance program benefit and a professional review committee that monitors both inpatient and outpatient care.

"Our doctors actually go into the facility and examine the patient," Dr. Brady said.

Afterward, the committee will chart its findings and make a recommendation to the TPA, insurer or employer.

"We want to save these carriers money," Dr. Brady explained. "Our average charges per case are somewhere around $220," compared with $1,300 for non-PPO participants. "That's a pretty big differential," he said.

Word of the PPO's savings has spread, and as a result, the number of participants in the PPO has "doubled in the last year," Dr. Brady said. "And I think we're going to double again," he predicted.

It was the potential savings that attracted Joe Hausser, manager-industrial relations at Litton Electron Devices, a subsidiary of Litton Industries in San Mateo, Calif., to Psychology Systems.

To provide its 1,000 employees an incentive to use the PPO, a Litton employee with individual coverage pays nothing for the first five visits annually to a preferred provider. Under the family plan, the first 15 visits each year are free.

After those initial visits, the employee pays the same amount that he or she would for basic medical coverage under the company's self-insured plan, which is administered by Metropolitan Life Insurance Co.: 20% of the cost of treatment after a $100 deductible, with a stop-loss cap of $1,100 per indi-

Continued on next page



Continued from previous page
vidual and $2,200 per family. The benefits—for both medical and psychiatric care—are capped at $250,000 lifetime.

Until earlier this year, before it contracted with the PPO, the company would pay only $10 per psychiatric visit.

Litton Electron Devices pays $4.25 per plan participant per month to Psychology Systems. Since Litton only began contracting with the PPO in March, no tangible savings have been determined, says Mr. Hausser, though he adds employee response has been good.

Although an employee's use of the psychiatric PPO is confidential, Psychology Systems provides each contracting company with a breakdown of how the program is being used.

"We've had very good reception so far," he said. "Supervisors have been very appreciative of it."

'Companies with liberal benefit plans realize that their dollars are not being spent wisely' for mental health care, explains Dr. William Cunnick, vp and medical director for Metropolitan Life Insurance Co. in New York.

Twenty-eight Litton plan members used PPO providers during the first quarter, with 13 participants using the PPO for drug or alcohol treatment, according to a Psychology Systems report.

The University of the Pacific in Stockton, Calif., originally contracted with Psychology Systems for three reasons, according to Ed Case, the university's director of personnel services: to cover an area that was inadequately covered in the university's regular health plan, for EAP services and as a cost-containment measure.

The university realized a $60,000 savings after investing $30,000 in the PPO during the first year, Mr. Case estimated.

And, he anticipates even greater savings in subsequent years, since only the Stockton campus was enrolled during the pilot year.

The university offers its 1,400 full-time employees on three campuses three health care coverage options, explained Mr. Case:

- The university's self-funded medical plan, which is administered by ANPAC Administrators Inc. in Sacramento and includes the psychiatric PPO option.
- The Kaiser-Permanente Medical Plan HMO, which provides its own psychiatric care services.
- The Foundation Health Plan, an Independent Practice Assn./ HMO that does not include psychiatric providers. The PPO option also is offered to employees who opt for this program.

Incentives for using the PPO are the same as those offered by Litton Electron Devices. However, after the initial "free" visits, an employee pays $50 per visit, unless he or she has opted for the comprehensive coverage option offered under the university medical plan.

With the comprehensive option, the employee pays a $100 deductible and 20% of the next $2,000 of expenses for all types of care, including mental health care. The university then picks up 100% of costs, up to a maximum of $250,000.

Reports on the PPO's utilization indicate its success, according to Mr. Case. "We've had at least one suicide prevention, since the program also includes crisis intervention," he noted.

American PsychManagement Inc. in Washington, D.C., has reduced inpatient days by 25% for its seven employer clients by encouraging the use of outpatient services over inpatient care, noted Monica Oss, vp-marketing for the company. Some 400,000 employees are covered by the PPO.

The American PsychManagement PPO, which was established in 1983, stretches from Boston to Norfolk, Va., and includes 40 facilities and 400 therapists.

Because of the volume of patients for which it provides care, American PsychManagement has negotiated discounts of up to 15% for outpatient visits and 30% for inpatient treatment with member providers, she explains.

A spokesman for the FELRA & USCW Health & Welfare Fund, based in Baltimore, says the American PsychManagement PPO "takes the mystery and mystique" out of psychiatric care.

"In the past, the individual was always reluctant to get into psychiatric care" because of the cost or the stigma, he said. However, the PPO "makes available to members reasonably priced psychiatric care" that also is confidential.

The fund, which has contracted with American PsychManagement since Jan. 1, is especially pleased with the PPO because "we're getting a handle on substance abuse and the costs associated with it."

Members are given a financial incentive for using PPO providers: The Blue Cross/Blue Shield plan covering members only pays the PPO rate for psychiatric care, so if the member chooses a provider that costs more, he has to pay the difference, the spokesman explained, though he could not provide additional details of the coverage.

In addition to the PPO, American PsychManagement has started compiling a data base that can be used to measure quality of care by comparing the average length of stay by provider and diagnosis, Ms. Oss says.

The data base will provide answers to questions like, "Does a particular physician get the tough cases, and is that why they're staying longer" than other physicians' patients, Ms. Oss explained.

American PsychManagement also markets its case management services, which are included in the PPO contract, as a separate product, she says. In addition, an employer can purchase third-party administrative services from American PsychManagement.

Fees for these services vary according to what level of services an employer wants and the number of plan participants.

Another psychiatric PPO, Bethesda Provider Organization, is a joint venture between Denver-area providers and the Bethesda Psychiatric Hospital in Englewood, Colo.

BPO, which was launched in 1984, is owned by its 46 providers —12 psychologists and 34 psychiatrists. It also contracts for the services of a number of associate members, which include social workers and psychiatric nurses, explained Sally Belshaw, BPO's director.

So far, five employers that cover 15,000 lives have contracted with BPO in the Denver-Boulder metro area.

BPO's utilization review and quarterly utilization reporting service alone costs employers approximately $4 to $6 per person annually. The fee for the combined UR/PPO product amounts to $36 to $42 per participant annually, according to Ms. Belshaw.

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Psych PPOs

Continued from previous page

For that investment, employers can expect a 15% reduction in their mental health expenditures, Ms. Belshaw said.

The network got off to a slow start, according to Ms. Belshaw, who said it "just really got started in the last six months."

Like BPO, Psychiatric Providers of Georgia Inc. has had difficulty marketing its PPO, called Healthpoint Preferred. As a result, the fledgling PPO has not yet signed an employer contract, says Charles H. Hendry, executive director. However, Psychiatric Providers is providing utilization review to four HMOs in the Atlanta area.

While psychiatric PPOs are not yet common in all areas of the country, most employers do have access to utilization review and case management services.

A.S. Hansen recommends that many of its clients use psychiatric cost-containment programs provided by firms like Preferred Health Care Ltd., Mr. Penn said.

However, the consultant seldom advocates specific psychiatric PPOs because they're too specialized and Hansen's clients usually want a broader mix of providers from which to choose. Instead, employers usually are directed toward medical care PPOs that include psychiatric providers.

"But direct contracting has the biggest advantage in controlling costs," if the employer has the time and personnel to select and screen for truly "preferred" providers and negotiate fees, Mr. Penn explained.

Although Preferred Health Care is not an actual PPO, many consultants, providers and insurers think PHC is structured like one.

PHC is owned primarily by Four Winds Hospital, a mental health facility in upstate New York that specializes in "tertiary care"—treating patients who have had multiple admissions because no other facility has successfully treated them, explained Dr. Jay Reibel, chairman of PHC.

Dr. Reibel said that while 65% of all mental health patients in the United States are re-admitted within 12 months of treatment at an inpatient facility—excluding state hospitals—Four Winds boasts a less than 13% rate of recurrence within five years of treatment.

And that reputation is attracting a growing number of customers to PHC's psychiatric case management programs, he says.

"We protect the interests of the patient and the payer," while at the same time providing the attending practitioner with expert consultation from doctors at its Westchester, N.Y., facility, Dr. Reibel said.

"We understand the nature of the illness," he noted.

The company, founded eight years ago, now manages mental health care programs for approximately 500 companies covering 3.5 million people.

But PHC does not plan to form a PPO network. "To us, PPOs run the risk of being discount medicine," because there is a tendency to use the least-expensive provider, which may not necessarily be the best, Dr. Reibel explained.

Wyatt's Mr. Wood agrees.

"Most PPOs are marketing ploys by providers," he said, warning: "Buyers must be careful to make sure they are entering into a managed care program, preferrably one with independent utilization review."

PHC plans to gain more control over psychiatric treatment costs by sharing the risk with insurers.

Currently, PHC pays insurers a fee for the insurers to market PHC's services to employers along with the insurer's health care coverage programs.

In addition, PHC acts as a "subcontractor" for some insurers, in which PHC actively takes responsibility for mental health case management and claims payment for the insurer.

Now, PHC is applying for a license as a provider in California under the requirements of the Knox-Keene Act.

Under this arrangement, a contracting employer will pay a "premium" to PHC based on the client's psychiatric claims experience, less a discount. The discount will equal an amount PHC thinks it can shave off the employer's mental health care expenses. Yearly premium increases are tied to increases in the Consumer Price Index.

Dr. Reibel explained that at the end of the contract year, if the cost of the treatment provided to the company's employees is less than the amount it has been billed, PHC makes a profit; if not, PHC absorbs the loss. ■



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FSAs are flourishing, despite challenges

By MEG FLETCHER

Battle-scarred flexible spending accounts are alive and well, despite attempts by two federal agencies to cripple the plans.

An increasing number of employers still are adopting FSAs as part of their benefits programs, but at a slower pace than in the past, benefits experts say.

And, employers now are more likely to adopt FSAs as part of broad flexible benefits programs rather than as an individual benefit, experts point out.

Employers that adopted FSAs before May 1984—when the Internal Revenue Service published controversial rules that said any funds remaining in an FSA at the end of a plan year must be forfeited—say the number of employees that participate in an FSA has fallen since the rules took effect.

However, utilization among employees at companies that adopted FSAs since the rules took effect is increasing.

FSAs are accounts used to reimburse employees for certain nontaxable benefit expenses. FSAs can be funded through non-taxable employer contributions and/or pretax employee contributions.

The accounts have been used to cover three types of expenditures:

- Medical care expenses. Money from FSAs can be used to reimburse employees for medical care expenses that otherwise would be allowed as deductions from income and are not reimbursed by insurance. Typical eligible expenses include deductible or coinsurance payments under an employer-sponsored health plan and uninsured dental and vision expenses.
- Dependent care expenses. Employees can be reimbursed for household services or care of a qualifying individual, which can include a child under 15 years of age or a disabled dependent. The amount that can be reimbursed is capped at the earned income of a single employee or the lower of the earned income of the employee or his or her spouse.
- Legal expenses. Authorization that would allow employees to be reimbursed for personal legal expenses using FSAs expired at year-end 1985, but will be extended through 1987 by the tax legislation now pending in Congress.

Lincolnshire, Ill.-based benefits consultant Hewitt Associates recently found that 97% of the 200 companies with flexible compensation plans that it surveyed offer FSAs for health care expenses. Eighty-nine percent offered FSAs for dependent care expenses, while another 8% offer accounts for legal expenses, according to a Hewitt spokeswoman.

About 380 U.S. companies now offer FSAs, she added.

According to a different survey conducted last year by Hewitt, employers offering FSAs allowed workers to contribute an average of $2,950 to an account for medical expenses, $4,900 for dependent care and $2,875 for legal expenses.

Hewitt consultant Steven Fein said another study showed participating employees contributed an average of $350 to $400 to FSAs for health care expenditures, $1,400 to $1,500 for dependent care expenses and $350 to $400 for legal expenses.

But many eligible employees do not participate in FSAs, said Deborah Wagner, a consultant with Towers, Perrin, Forster & Crosby in Chicago.

About 25% to 50% of all eligible employees participate in medical FSAs, 5% contribute to dependent care FSAs, and a lesser percentage still contribute to legal expense FSAs, she said.

However, employees who use dependent care FSAs "use it big" because of the cost and frequency of the expense, she added.

FSAs were one of the most talked-about benefit ideas of the early 1980s, consultants note.

In 1982 and 1983, "FSAs were one of the hottest new concepts," said Jay Rzasa, assistant director of Aetna Life & Casualty Co. in Middletown, Conn., which administers FSAs for about 28 employers. "The market was just popping."

FSAs were quickly embraced by many employers as an ideal tool with which to help contain then-soaring health care costs. Allowing employees to pay for uncovered health care expenses with pretax dollars helped take some of the sting out of cost-containment.

"Flexible spending accounts are a good carrot," said Zelda Lipton, second vp for flexible benefits for Union Mutual Life Insurance Co. in Portland, Maine, which administered about 150 to 200 flexible benefits plans.

FSAs also give employees more awareness of health care costs and more choice in the kinds of benefits they receive, consultants say.

However, benefit managers were shocked in February 1984 when the Internal Revenue Service issued a terse, 2½-page news release that said most forms of FSAs were illegal, but gave little guidance.

After two months, the IRS finally issued rules in a question-and-answer format that clarified what was considered a valid FSA (*BI*, May 7). Under those rules:

- Participants must forfeit any unused funds, including employee contributions, that remain in an FSA at the end of a plan year—the "use-it-or-lose-it" rule.

Previously, employees were allowed to contribute to FSAs on a pretax basis and collect any unused funds as taxable income at the end of the year.

- Participants must determine at the beginning of a plan year how much money they will contribute to the FSA during the year for each type of benefit expense. The amount contributed cannot be modified during the year.

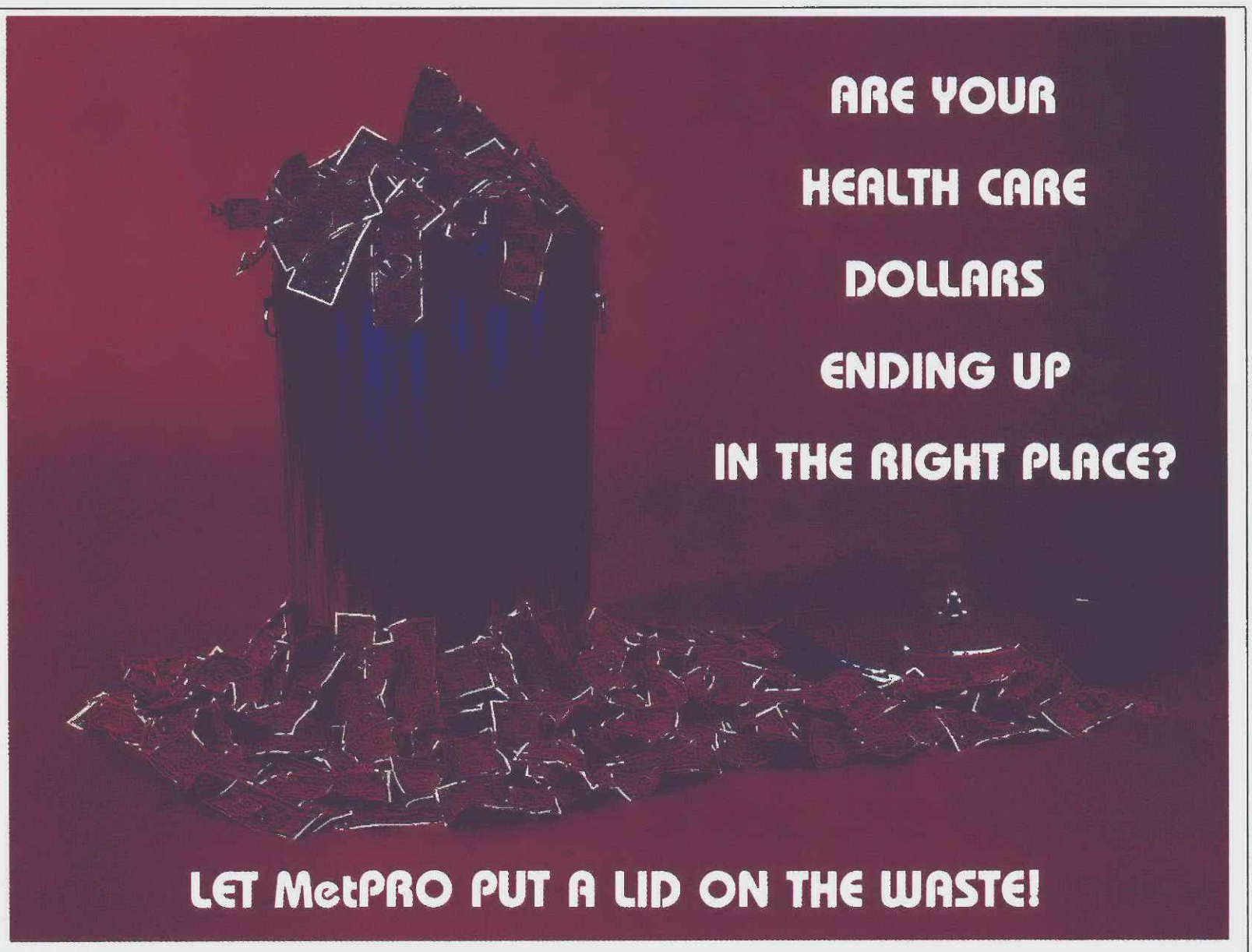
Previously, employees could vary the amount they contributed to FSAs as the year progressed.

Employers began a campaign to have Congress overturn the rules, and then-Rep. Barber Conable, R-N.Y., unveiled a plan that would let employees roll unused funds in an FSA over to the next year.

While that proposal failed, Congress did delay the effective date of the FSA rules until July 1, 1985, to give employers time to modify their plans to comply.

Then, in 1985, FSAs also survived an attack by the U.S. Department of Health and Human Services, which wanted Congress to ban FSAs because, an HHS study charged, they reduced federal tax revenues and undermined health care cost containment (*BI*, May 27, 1985).

Continued on page 42



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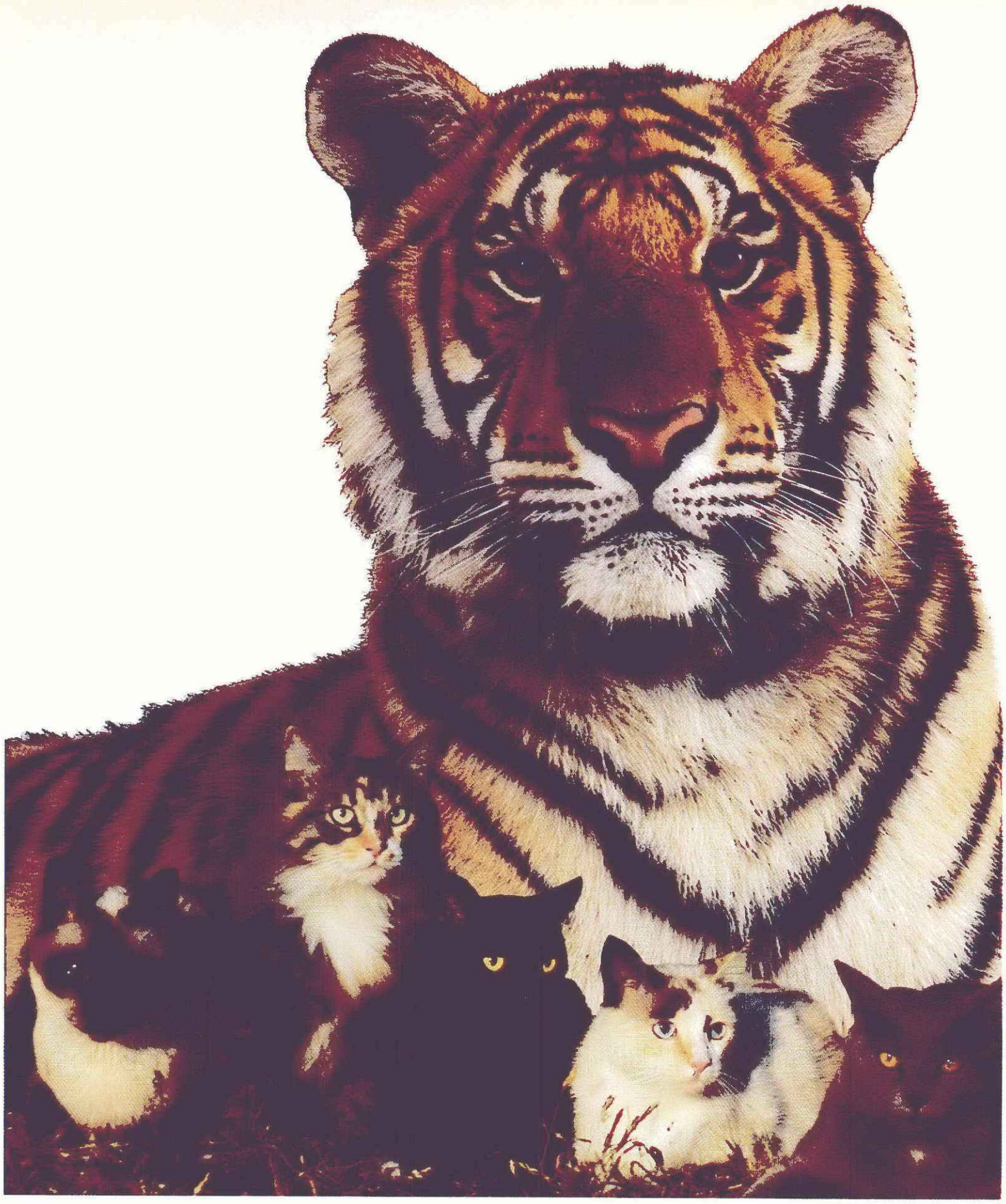
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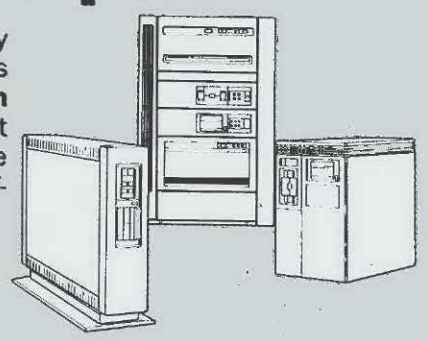
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FSA use

Continued from page 40

However, consultants said that HHS's conclusions were flawed because they overstated FSA utilization and did not factor in the higher levels of employee sharing that many FSA programs included.

Congress never acted on HHS's request. "I think we just got lucky," Ms. Wagner said.

Although FSAs continue to be offered by employers, the IRS rules make them not nearly as attractive to employees as they were previously. The prospect of losing unspent money caused fewer employees to make pretax contributions to FSAs.

"Use-it-or-lose-it put a damper on the attractiveness of the plans," said Ms. Wagner.

Some 40% to 50% of the employees at companies with FSAs participated in the programs before the IRS rules went into effect, but use-it-or-lose-it caused a 10% to 20% drop in participation, said Lance Tane, manager of The Wyatt Co.'s flexible compensation practice based in Washington.

Aetna's Mr. Rzasa said his company's clients had 60% participation before the rules went into effect, but only 25% afterward. That utilization figure was unchanged through the first quarter of 1986, he added.

Dayton-Hudson Corp., a Minneapolis-based retail chain, found that after the use-it-or-lose-it rule was adopted, "participation dropped off significantly" in an FSA that had been established in 1984, said Fred Hamacher, vp-compensation and benefits.

"It scared them," he said. "People overreacted to it.

"For people who plan, it is not a big issue," he said. However, "most people don't plan."

About 5,000 of Dayton-Hudson's 130,000 employees are eligible for medical and dependent care FSAs, which were adopted independently of a flexible benefits program. However, only 5% of those eligible now participate in either program.

FSAs at Dayton-Hudson are funded solely by employees through salary reductions, up to a maximum of $150 per month for medical care expenses and $500 per month for dependent care.

Instituting FSAs as part of a broad-based flexible benefits plan in early 1984 was "an unqualified success" and "the best thing we ever did," said Charles Peters, manager of compensation and benefits for the Space and Strategic Avionics division of Honeywell Inc. in Clearwater, Fla.

"It's a win-win situation for Honeywell and our employees," he added. "Our employees would actually rise up and lynch us if we took it away."

All 4,500 employees in the Honeywell division are eligible to participate in FSAs, and more than 40% use health care FSAs, while 10% make contributions to dependent care accounts.

While the program is funded primarily through employee salary reduction—up to a maximum of $2,400 annually for medical care and $4,800 annually for dependent care—Honeywell also contributes to the medical FSAs.

But Mr. Peters said use-it-or-lose-it caused "a great deal of consternation" among employees who were used to a zero-balance reimbursement account, which Honeywell had offered before the IRS rules and in which all eligible participated.

Under a ZEBRA account, now prohibited by the IRS, an employee submitted statements for uncovered benefit expenses to an employer, which then deducted the payment from the employee's paycheck so the worker was not taxed on that income. Then, the employer issued a second check to the employee, with no taxes withheld, to reimburse him.

While participation in FSAs dropped after the IRS rulings, Mr. Peters notes that a "significant" number of employees are again participating in the FSA program this year, but he could not elaborate on how many dropped out.

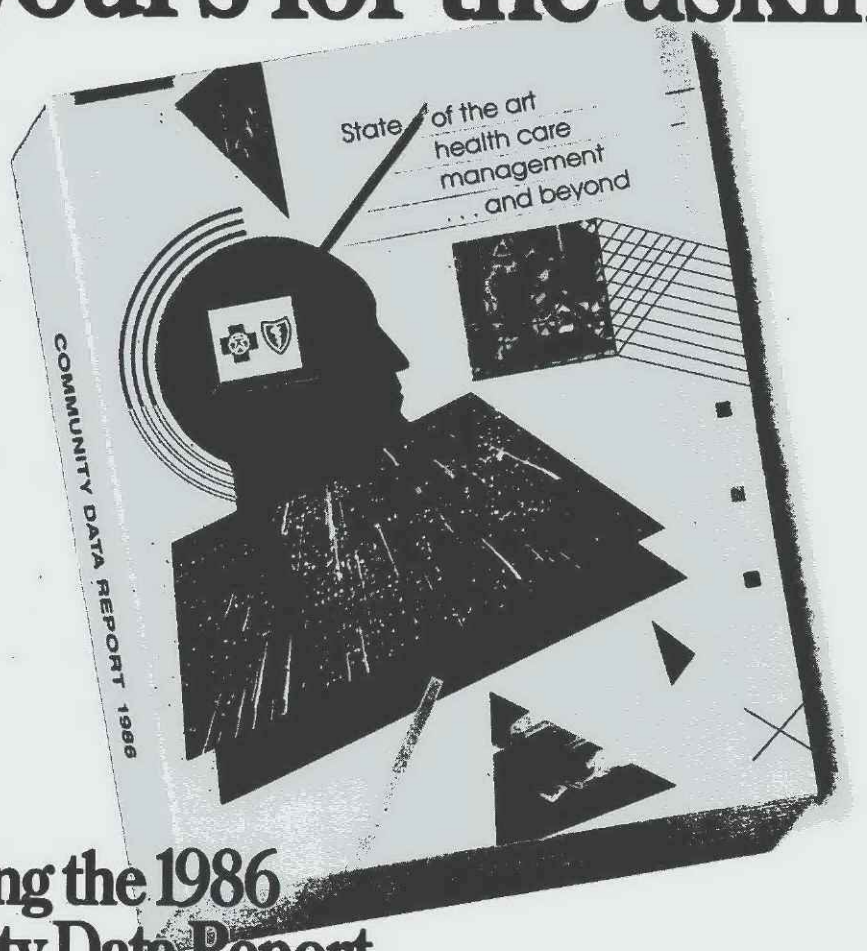
Use-it-or-lose-it also has made those employees who do participate in FSAs more conscious of the need to budget properly and more conservative when earmarking funds at the beginning of the year, experts say.

"Almost all employees are underestimating the amount they are budgeting for an FSA," Mr. Tane said, an observation with which most consultants and benefits managers agree.

In addition, benefits managers are trying to warn employees of surpluses in their FSAs as year-end approaches so they can spend

Continued on page 51

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FSA use

Continued from page 42

the funds on eligible expenses.

Employers typically provide employees with quarterly statements of their account balances, consultants report. However, some companies, like Grand Rapids, Mich.-based Steelcase Inc., send employees statements each time they make a withdrawal, said Clare Robison, Steelcase's supervisor of benefit administration.

Once alerted about a forgotten surplus, an employee often makes discretionary medical expenditures like scheduling a physical exam or ordering prescription sunglasses, observers report.

As a result, little money is actually forfeited, they say.

Estimates of the average amount of forfeiture range up to 10%, though Aetna's Mr. Rzasa says he knows of one isolated case in which an employee lost $5,000.

Hewitt's Mr. Fein said one survey found that employee's FSA forfeitures for 1985 averaged only $39 for health accounts, $20 for dependent care accounts and $32 for legal expense FSAs.

Most forfeited funds revert to the employer, though some employers donate any money forfeited to charity while others distribute the funds to all FSA participants or to all the company's employees, notes the 1985 Hewitt study.

Other factors also contribute to low participation rates in FSA programs, consultants note.

One stumbling block is a typical plan requirement that providers of services eligible for FSA reimbursement sign a form acknowledging the service was provided.

While the IRS says it does not require that such a form be submitted by an employee, many employers make the requirement to ensure that the employee's pretax contribution to an FSA is being spent appropriately, some consultants and benefit managers say.

"A lot" of baby-sitters who do not report their income for tax purposes don't want to sign anything that could create an audit trail, explained Linda Bartol, benefits manager for Boston-based New England Medical Center.

About 2,400 to 2,500 of the center's 4,000 employees are eligible to participate in medical and dependent care FSAs that the center began offering in January. Annual maximum contributions are $2,000 for medical care and $5,200 for dependent care.

Also, consultants note some employees find it more advantageous to take a tax deduction for dependent care expenses rather than to fund through an FSA.

However, the employers that implemented FSAs after the IRS rules went into effect can have 40% to 50% employee participation if they have good communication programs, Wyatt's Mr. Tane said.

Employees at Dallas-based UCCEL Corp., which did not have an FSA program until after the use-it-or-lose-it rule took effect, don't seem to mind the restrictions, says Stewart Gill, director of compensation and benefits.

"Some of the employees were negative" about the chance of losing part of their contributions, "but very few," he explained. "They just needed to be more cautious and put less money in."

About 350 of UCCEL's 1,000 U.S.-based employees are eligible for medical and dependent care FSAs offered by UCCEL, which sells mainframe systems software and banking applications software. About 35% actually participate.

Its FSAs are funded through salary reduction and subject to a $3,000 combined annual cap.

More employers are expected to establish FSAs, says Union Mutual's Ms. Lipton, especially in industries like banking, which has a very diverse labor force, or electronics, where the market for good employees is highly competitive.

A TPF&C survey of 300 large companies in the Northeast found that 31% are likely to offer flexible benefits programs, most of which would include FSAs, to employees in the next 12 months or already have decided to do so.

However, 34% have decided not to offer flexible benefit programs.

"These companies based their decisions on such perceived obstacles as administrative complexity, implementation costs, lack of senior management commitment to a flex program and the uncertain tax and legal status," the report said.

"These perceived obstacles, plus concerns about adequate internal computer resources and communicating the program to employees, are the reasons for many employers hesitating to adopt flex programs," the report added. ■

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New tax rates may make FSAs less attractive

By MEG FLETCHER

Flexible spending accounts will be affected more by the changes in individual tax rates contained in the tax overhaul measure than by provisions that will implement new employee benefit discrimination tests, benefit experts say.

Lowering personal income tax rates—the highest overall rate will be 33%, compared with 50%—is expected to reduce the attractiveness of FSAs to some employees and their employers, observers say.

Employees participating in FSA programs must make irrevocable decisions at the beginning of the plan year about how much pretax money to allocate into FSAs, which then can be used to finance unreimbursed medical care, dependent care or personal legal expenses. Any money remaining in an account at year-end is forfeited.

Employers will ask themselves, 'Why get involved with the mechanism of setting up the system when at lower tax rates they (employees) can take the money and take care of those issues themselves?' says Fred Hamacher, of Dayton-Hudson Corp.

"The amount of money employees will want to put at risk will be less" under the new tax law, said Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington-based benefits think tank. "People will be even less willing to lose it."

Currently, a person in the 50% tax rate is still better off putting $1 in an FSA even if he only uses 51 cents of that $1 to finance eligible expenses. However, an employee with a 15% tax rate must use 86 cents of $1 contributed to an FSA to make the contribution financially worthwhile.

"That is a much smaller margin for error," Mr. Salisbury explained.

"To the extent that marginal tax rates fall, FSAs become less valuable," agrees Deborah Wagner, a consultant in the Chicago office of Towers, Perrin, Forster & Crosby.

Under the old plan, a $100 pair of glasses paid for with pretax dollars contributed to an FSA would cost a person with a 50% tax rate $50, she explained. With the lowering of the employee's tax rate to 33%, those same $100 glasses now cost $77 on a pretax basis.

"The cost of glasses went from $50 to $77, but the employee is still better off than having to pay $100 for them," Ms. Wagner explained.

Fred Hamacher, vp of compensation and benefits for Minneapolis-based Dayton-Hudson Corp., which offers employees an FSA program, said there will be less need for FSAs with lower tax rates.

"There will be fewer employees enrolling and fewer companies starting up," Mr. Hamacher said. Employers will ask themselves, "Why get involved with the mechanism of setting up the system when at lower tax rates they (employees) can take the money and take care of those issues themselves?"

However, Zelda Lipton, second vp for flexible benefits at Union Mutual Life Insurance Co. in Portland, Maine, said most employees in FSA plans that her company administers already are in the 28% bracket, so the new tax rates will not have any significant effect on the way employees use the account.

The impact of the tax rate on an individual employee's willingness to participate in an FSA can depend upon several variables, including income level, marital status and, for those with dependent care FSAs, the number of children, Ms. Wagner said.

In coping with the impact of the tax rate changes, all employers probably will have to modify their benefit communications materials so that employees know the impact of the tax changes on their individual situation, Mr. Salisbury said. In addition, it will be necessary to re-emphasize the importance of careful budgeting, he pointed out.

Most consultants add that the benefit provisions contained in the tax measure give FSAs a "green light."

Congress has explicitly affirmed the concept of FSAs, Ms. Wagner pointed out.

In addition, Ms. Wagner notes that the tax reform measure will shift $120 billion in taxes from individuals to companies over the next five years. Some companies, hit with a bigger tax bite, will be looking for ways to control benefit costs, which is one of the advantages of FSAs, she explained (see story, page 40).

However, the new benefit discrimination tests contained in the tax measure that apply to FSAs will mean employers must monitor employee contributions more carefully and may be forced to put new limits on contributions by higher-paid employees, said Lance Tane, chairman of The Wyatt Co.'s national flexible compensation practice based in Washington.

For example, consultants expect tax guidelines will include a rule that higher-paid employees cannot defer an amount greater than, for example, 125% of the amount deferred by lower-paid employees (*BI*, Aug. 25).

So, if lower-paid employees typically defer an average of $200 to FSAs, higher-paid employees cannot individually defer more than an average of $250, Mr. Tane explained.

Employers and consultants are waiting to see how variables like the number of dependents are factored into the regulations when they are applied to dependent care FSAs, he added.

Union Mutual, a major administrator of FSA programs for employers with fewer than 500 employees, already is working on reducing the maximum amounts employees can allocate to FSAs, Ms. Lipton said.

"We want to make certain we can pass the discrimination tests," she explained, noting that Union Mutual already has reduced to $1,500 from $3,000 the maximum amount employees can contribute annually to medical FSAs the insurer administers.

"We don't think the tax law has unreasonable tests," she said. ■

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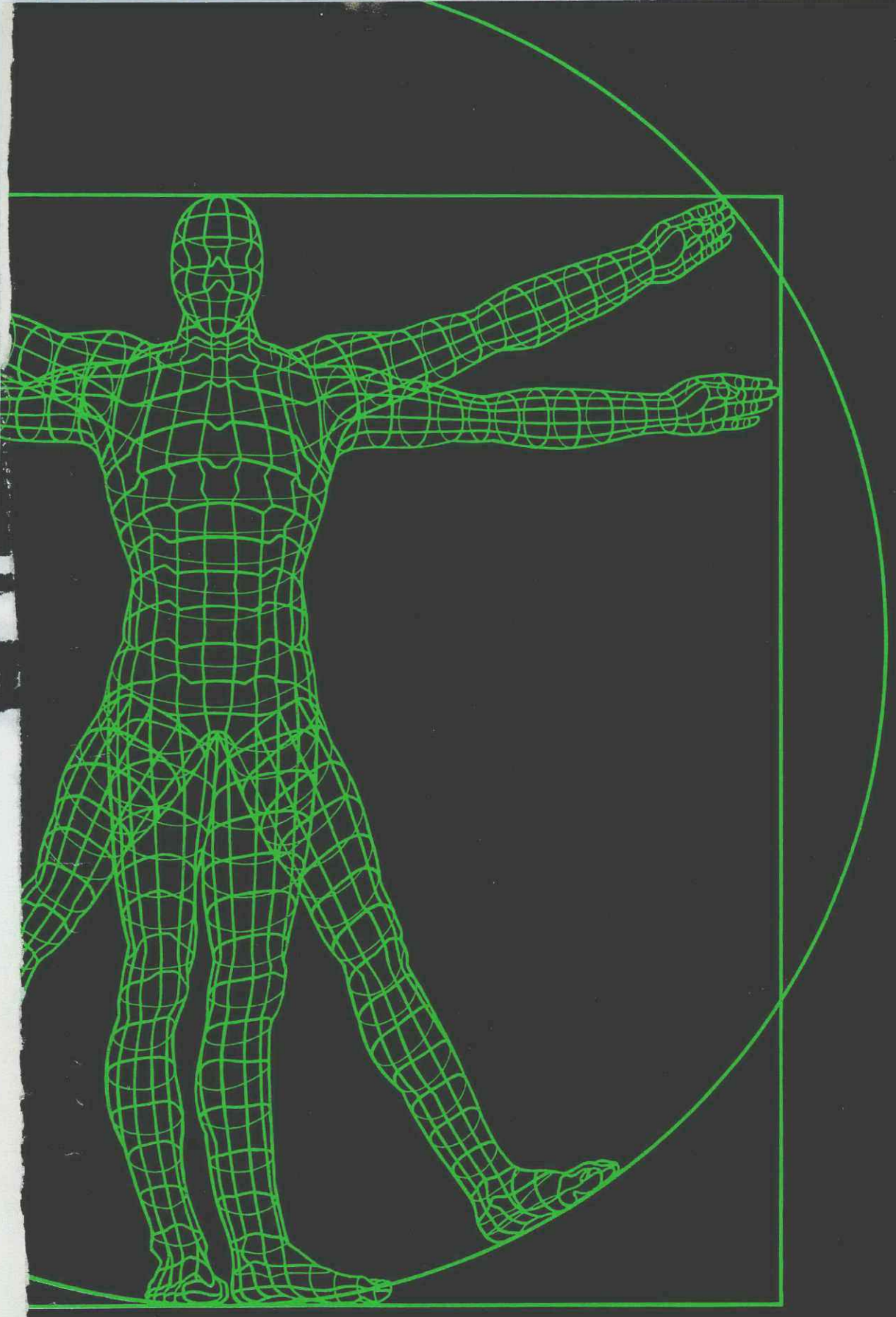
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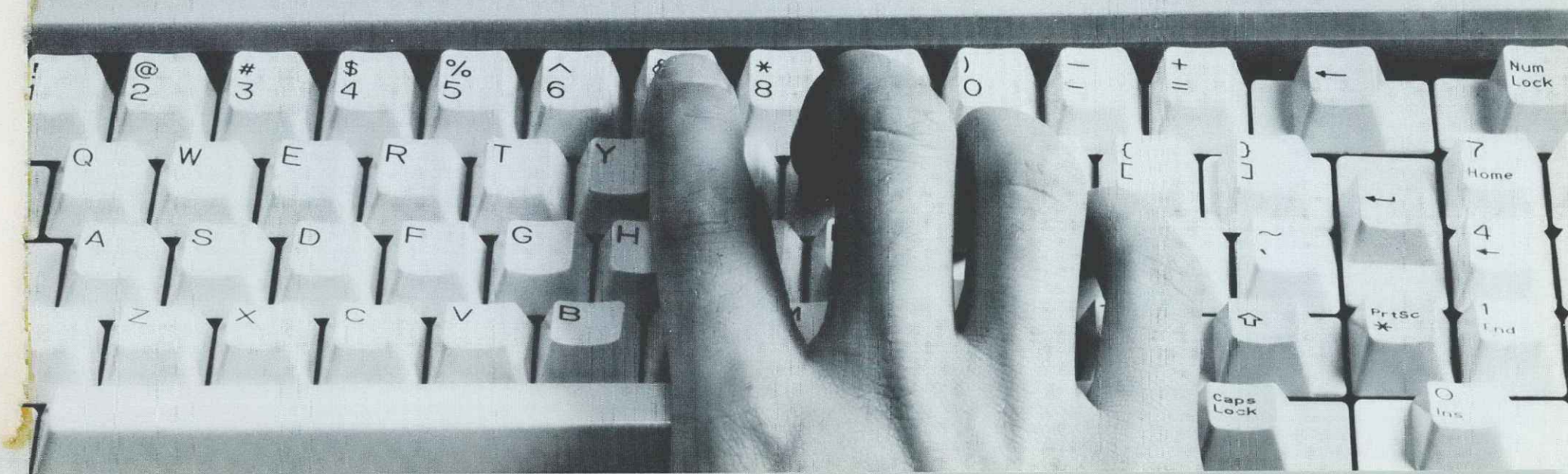
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Employers turn to alternative care for AIDS

By STEVE TARAVELLA

'By allowing some flexibility in a benefit plan, they're able to accommodate the individual in a much better fashion and save costs as well' in dealing with AIDS cases, says Dana Ferrell, director of health resources at the South Florida Health Action Coalition.

Spurred by the success of San Francisco-area employers, benefit managers nationwide increasingly are turning to case management, home health care and hospice programs to care for employees with acquired immune deficiency syndrome.

Increased experience with treating AIDS patients has led medical professionals, group health insurers and employers to recognize the cost-effectiveness of both outpatient treatment and assistance from community service organizations.

To treat AIDS patients, several health care coalitions and hospitals rely on networks of community support groups like counseling centers, volunteer care groups and Meals on Wheels programs, which bring food to invalids.

The employers that have taken the lead in coping with AIDS cases —and with finding the most cost-effective and humane forms of treatment under group health plans—generally are major companies in San Francisco, a city with one of the highest incidences of AIDS diagnoses, according to those involved in AIDS patient care.

In fact, because of their favorable experience in utilizing case management, home health care and extended care benefits in treating AIDS patients, many benefit managers who previously had not used these techniques now have incorporated them into their plan design for all major catastrophic illnesses.

And, when extended care or hospice benefits are not part of the employer's health plan, some benefit managers even have made exceptions to the plan design to accommodate an AIDS patient.

Working closely with their health insurers, benefit managers frequently arrange for AIDS patients to receive home health care, which generally is less costly and more appropriate for AIDS cases than hospitalization, even when that type of care is not otherwise covered under the group health plan.

In a case management program, a covered employer's insurer or the self-insured employer assigns a health care professional to monitor a patient's care to determine the most appropriate treatment for that person, with an eye on alternatives to hospitalization. This could mean outpatient treatment, home health care, a hospice stay or any combination of these and other forms of care.

Employers that do not provide a full case management program as part of their group health care plans incorporate certain elements of a case management program, such as home health care and hospice care, into their plans.

"By allowing some flexibility in a benefit plan, they're able to accommodate the individual in a much better fashion and save costs as well," pointed out Dana Ferrell, director of health resources at the South Florida Health Action Coalition.

Employers' current handling of AIDS cases is in marked contrast to the hysteria with which the business community originally confronted AIDS, health care coalition leaders say. Benefit managers attribute this to educational efforts and greater experience in dealing with the disease.

"We're finding the medium-to-large companies handling it just as they would any other problem," noted Dr. Leon Warshaw, executive director of the New York Business Group on Health. "Most of the companies are doing an awfully fine job, but just don't want the publicity."

AIDS is an incurable disease that destroys the body's immune system, leaving it vulnerable to attack by cancers and other illnesses.

As of Sept. 8, 24,576 people have been diagnosed with AIDS, according to the national Centers for Disease Control in Atlanta. Of those, 13,574 have died.

The real cost of treating AIDS patients has been difficult to determine because the disease is still relatively new. Cases first were reported to the CDC in 1981, and few companies have seen enough cases to prepare a credible claims study.

Nonetheless, curbing the cost of AIDS claims has become such a hot issue that insurers sometimes use their ability to manage these claims as leverage when bidding for an employer's account, observed Linda Havlin, a consultant with Hewitt Associates in Lincolnshire, Ill.

The AIDS treatment cost figure that has been bandied about most often by medical professionals, benefit managers and the media is $147,000, an early-1985 CDC

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AIDS care

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estimate of the average cost of inpatient care from diagnosis to death.

But the CDC, acknowledging that changes in AIDS care practices have outdated its original estimate, now suspects that the average AIDS patient incurs bills of $60,000 to $100,000, according to Dr. Ann Hardy, the CDC epidemiologist who made the original cost estimate.

"That's about half now and, in San Francisco, about half of that," noted Dr. Mervyn Silverman, a private health care consultant who also serves as president of the American Foundation for Aids Research (AmFAR), the national AIDS research fund established by actress Elizabeth Taylor. Dr. Silverman also is the former director of health for the city and county of San Francisco.

Turning to community organizations for help so the AIDS patient can remain at home instead of being hospitalized demonstrates 'that corporations are showing some respect and sensitivity to the situation,' says Reese Smith of Levi Strauss & Co.

Dr. Silverman's assessment echoes that made about four months ago by Anne A. Scitovsky, chief of the health economics department at the Palo Alto, Calif., Medical Foundation. Based on available 1984 data culled from about 20 sources, mostly hospitals, Ms. Scitovsky estimated that AIDS patients incur an average of $60,000 to $75,000 in medical bills from diagnosis to death.

Benefit managers who initially feared AIDS patients would run up exorbitant medical bills are relieved by these new figures. They now say that their biggest challenge in dealing with AIDS is not its cost but providing proper treatment for an additional, new disease.

"The difference is not one of magnitude, but one of change," noted Donald Hoy, employee benefits manager at First National Bank of Chicago.

But many health and benefit professionals point out that costs associated with AIDS vary as greatly as the different types of diseases that afflict AIDS patients as a result of the destruction of their immune systems.

The health and benefit professional also pointed out that the costs involved in treating an AIDS patient also will vary depending on how much experience an employer's medical community has had in treating the disease.

Employers located in medical communities inexperienced in treating the disease are likely to face higher bills than those in the large cities hardest hit, such as San Francisco and New York.

San Francisco offers what one benefit manager describes as "the ultimate treatment for AIDS." Its approach to AIDS care has become a model for other cities to follow, health professionals say. Minimal reliance on hospitals has put the per-patient cost of AIDS in that city far below what it is in other metropolitan areas.

For example, Pacific Bell Telephone Co. attributes its comparatively low per-patient AIDS costs to heavy use of extended care and hospice facilities and the level of experience the city's medical personnel have developed with the disease.

Emphasizing outpatient treatment, the company spent, on average, less than $40,000 for care for each of 12 employees who succumbed to AIDS in the first eight months of last year, reported Michael Garcia, staff director of benefit administration for Pacific Bell.

That figure, based on Pacific Bell's utilization data and extracted by Affordable Health Care Concepts in Sacramento, reflects total medical bills incurred by these employees over a three-year period.

Mr. Garcia is confident the figure is a sound indication of Pacific Bell's experience. He also noted that none of the costs in the 12 cases reviewed was aberrantly high or low.

Pacific Bell began covering both extended care and hospice care treatment for salaried employees this year. Next January the same benefits will be available for non-salaried employees. Both benefits entail less costly and more humane treatment of AIDS patients than hospital settings can provide, Mr. Garcia stressed.

Likewise, another San Francisco benefit manager—who asked that his company, a manufacturer, not be identified—says the typical AIDS case at his company generates bills "in the $30,000 ballpark."

Levi Strauss & Co., also based in San Francisco, has found the network of volunteer organizations and support groups in that city's homosexual community an integral part of the company's approach to controlling medical costs associated with AIDS, according to Reese Smith, the company's director of employee benefits.

Turning to these organizations for help with needs like housekeeping, feeding and errand-running so the AIDS patient can remain at home instead of being treated in a hospital demonstrates "that corporations are showing some respect and sensitivity to the situation," Mr. Smith said.

AIDS hospital wards generally are "really negative places to be," he added.

Levi Strauss, which self-insures its group health plan to a maximum of $1 million per person per lifetime, covers home health care and is considering covering hospice care, he noted.

These approaches to AIDS, which San Francisco employers discovered several years ago, are being put to use now by employers and insurers in other cities now.

Businesses in the South Florida Health Action Coalition have kept their AIDS claims costs under control largely by utilizing a network of various local community organizations, health care providers and James M. Jackson Memorial Hospital, a public hospital in Miami known for its expertise in treating AIDS cases.

Greater use of outpatient procedures and community resources has helped the hospital reduce the average length of stay for AIDS patients to 14.5 days per admission from almost 25 days per admission a year ago, according to Woody Davis, vp-operations for the hospital.

Jackson Memorial hopes to reduce the average stay an additional three to four days by this time next year, Mr. Davis noted.

In addition, the average patient charge over the past 12 to 18 months has dropped to $850 per day from $1,000 per day.

These numbers are "very encouraging," said the coalition's Ms. Ferrell. "We are reaping the benefit of an aware community."

Continued on next page



Continued from previous page

Benefit managers and insurers in all parts of the country must become aware of how non-hospital care for AIDS patients can work to their advantage, consultants and health professionals say.

For example, consider the case of one employer that decided last April to provide case management services to employees that contract AIDS—just prior to the fourth hospital admission of an employee with the disease.

The case management company—a division of the employer's group health insurer, The Equitable Life Assurance Society of the United States—instituted home care for the AIDS patient that month. The employee died 36 days later.

The home care costs totaled $5,772, a savings of more than $36,000 over what hospital care would have cost for the same period of time, according to Jan Roughan, Equitable's product manager of medical case management in Brea, Calif.

And, in another example, Ms. Roughan said that one New Mexico employer and Equitable were paying the hospital bills of an employee with AIDS who was admitted only so he could receive a special drug therapy that had to be prepared daily.

'The answer, of course, is managed care' for AIDS patients, says Dr. Leon Warshaw.

The employee was able to return home when the case management division found a local pharmacist that was willing to prepare the drug and deliver it to the patient's home. The employee was taught to administer the drug himself, Ms. Roughan noted.

"The answer, of course, is managed care," Dr. Warshaw said.

"There's no question that you can provide services outside the hospital and provide them properly," observed AmFAR's Dr. Silverman.

"Everything that can be done to move the patient from the hospital should be. There are a lot of people sitting in hospitals that don't need to be there."

According to a 154-company survey about AIDS that was conducted last November by consultant Towers, Perrin, Forster & Crosby, only five of the 34 companies reporting employees with AIDS always assign a case manager; 20 said they never did.

But, many employers over the past year apparently began to change their approach to treating AIDS patients. For instance, Caremark/Home Health Care of America, which markets to employers a comprehensive home health care program for AIDS patients, has managed about 615 such cases, according to Gail Gallagher, marketing director in Newport Beach, Calif.

At this time last year, the 3-year-old company had treated only about 70 AIDS patients—less than the number of new cases it has taken on in the past 45 days alone.

In some benefit plans, case management is initiated when the affected employee reveals his diagnosis to the benefit manager.

In other plans, it kicks in when the claims administrator or insurer suspects an employee is suffering from the disease. The insurer then might approach the employee's physician to discuss alternative forms of treatment.

In other plans, case management begins only when the employee's medical bills reach a certain dollar amount.

Honeywell Inc. of Minneapolis turns its catastrophic disease claims over to an outside case management company, Chesterbrook, Pa.-based Intracorp, a CIGNA Corp. unit, when its claims administrator detects that an employee's medical bills are topping $10,000, or upon the recommendation of an on-site nurse who has consulted with the employee, according to Dr. John Burns, vp-health and environmental resources.

Honeywell has found case management invaluable when seeking the most humane, medically appropriate alternative to traditional hospital treatment, he said.

But, regardless of what the trigger is, case management is most effective when it is used early in a person's illness.

"You shouldn't wait until the bills become astronomical," advised Lawrence Lenahan, a ben-

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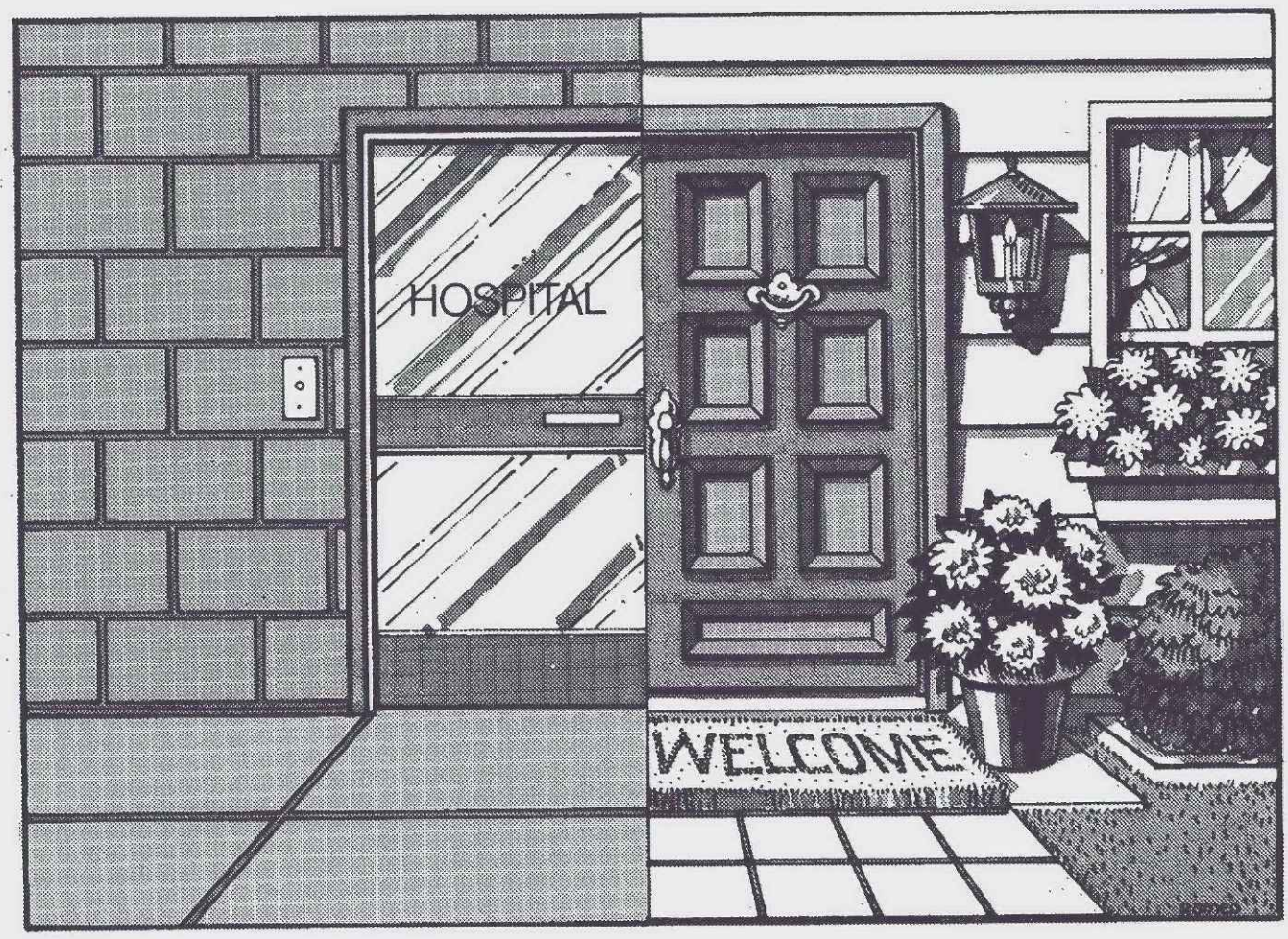
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AIDS care

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efit consultant at Buck Consultants Inc. in Harmon Meadow, N.J.

Ironically, the same code of confidentiality designed to protect the employee's privacy occasionally can hinder the employee's timely access to proper care or services.

One self-administered employer in New York has arranged an extensive plan of support services for an employee whose medical claims suggest an AIDS diagnosis but is reluctant to offer the program to the employee until he comes forth, according to Dr. Warshaw.

"Employers should be doing everything they can to encourage employees to identify the fact that they have a terminal illness and need some help," Hewitt's Ms. Havlin emphasized.

Ms. Havlin says the businesses that are the least likely to bear up under AIDS-related claims are small companies, perhaps with fewer than 100 employees, and those that self-administer their group health claims. Because the employer may not be as aggressive in identifying an AIDS claim as a professional claims administrator would be, AIDS claims slip through unnoticed.

'You shouldn't wait until the bills become astronomical,' advises Lawrence Lenahan of Buck Consultants.

The employer either buys a group health policy or self-insures without stop-loss coverage. The business does not offer case management, extended care or hospice provisions in its benefits plan. ■

Some insurers helping fund organizations to battle AIDS

By STEVE TARAVELLA

Some group health insurers—as concerned as self-insurers about AIDS treatment costs—are putting their money where their anxiety is.

Insurer donations to AIDS organizations have ranged from funds to find a cure for the disease to public education videotapes to office equipment and furniture.

One of those insurers is Los Angeles-based Transamerica Life Cos., which last January donated $100,000 to the American Foundation for AIDS Research (AmFAR), the national foundation established by actress Elizabeth Taylor to award funds to promising AIDS research projects.

In June, the insurer awarded a $75,000 grant to AIDS Project Los Angeles (APLA) to evaluate that city's health care and counseling service needs.

Transamerica also co-underwrote a 12-minute video on AIDS in the workplace. After showing it to local chief executive officers at a Los Angeles breakfast seminar, it gave APLA the rights to sell the video as a fund-raising project.

Transamerica also has given numerous gifts in-kind to APLA, Minority AIDS Project and Shanti Foundation, a non-profit organization benefiting AIDS patients and their families. These have included printing services, a photocopying machine and numerous pieces of used office furniture.

'Not only is (AIDS) devastating for society, but potentially for our industry as well,' says Ms. Nash.

In addition, the company provided APLA with an educational brochure called "Fear Is in the Air. AIDS is Not," which is being distributed to local schools, churches and community groups.

Transamerica, which produced 750,000 of the brochures, also distributed copies to its own employees and to life and health insurance policyholders, noted Jill Nash, second vp-corporate marketing.

"Until we stop this disease, not only is it devastating for society, but potentially for our industry as well," Ms. Nash said.

"We were uniquely positioned to help because of the business we're in and our geographic location—this is happening right in our backyard. When you see how devastating this is, you just can't walk away from it," she explained.

Another insurer that has made contributions to AIDS organizations is Pacific Mutual Life Insurance Co. of Newport Beach, Calif.

The insurer funds the Pacific Mutual Foundation, which awarded $25,000 last April to the National AIDS Network in Washington, D.C., a non-profit information and resource center for more than 200 AIDS education and service providers nationwide.

The donation is being used to establish a computer system for the network.

Pacific Mutual Life Insurance Co., which writes group life and health insurance as well as individual life policies, also contributed $2,500 last year to the AIDS Services Foundation in Orange County, Calif. That foundation provides support services, such as housing and transportation, to persons suffering from the disease.

Two Washington, D.C.-based trade associations, the American Council of Life Insurance, whose 635 member companies write about 94% of the total life insurance in the U.S., and the Health Insurance Assn. of America, whose 380 members write about 80% of the nation's commercial health insurance, have made several joint contributions to AIDS organizations.

Last month, the two groups gave $100,000 to the National AIDS Network. And, last April, the groups doled out $1 million, with AmFAR receiving $100,000 and the American Red Cross $900,000. The Red Cross is using the funds to establish a public education program about AIDS. The program will include a videotape that community groups and employers can present to audiences, and posters aimed at adolescents.

And, the Life & Health Insurance Medical Research Fund, which is financed by voluntary contributions from HIAA and ACLI member companies, awarded a $160,000 grant last April to two research facilities that are studying the effects of the AIDS virus on the brain.

The research is being conducted jointly by Memorial Sloan Kettering Cancer Center in New York and the University of Alabama at Birmingham. ■

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US HEALTHCARE

EAPs cope with growing cocaine use

By STEVE TARAVELLA

As the number of cocaine and drug abuse cases handled by corporate employee assistance programs grows, many employers are stepping up their drug awareness programs.

However, employers report few other changes in their EAPs to meet the growing use of cocaine and other drugs.

Until about two years ago, when EAPs began to notice a shift to cocaine and other drug problems, EAPs treated alcohol abuse cases far more often than any other form of substance abuse.

But, although more employees are seeking help for cocaine problems, cocaine may be just the drug of the day in the eyes of EAPs.

For example, while cocaine use has soared, heroin use has leveled off over the past six years. Now there are about 500,000 heroin addicts, about the same as in 1980, according to the National Institute on Drug Abuse in Rockville, Md.

"Whether it's scotch instead of gin, vodka instead of beer or coke instead of heroin, it doesn't change the focus of the program," explained Charles Tilkington, manager of special health services at United Technologies Corp. in Hartford, Conn.

"Cocaine to us is simply another drug," said Rick Vesper, acting manager of employee assistance at United Airlines in Chicago.

The wave of cocaine addiction has flooded EAPs relatively quickly.

For example, at Chicago-based IC Industries Inc., only about 5% of the employees who sought treatment for substance abuse three years ago were abusing chemicals other than alcohol.

But today, cocaine and other drug problems account for 30% to 40% of substance-abuse EAP visits, said Joe DeRosa, director of employee assistance.

Mr. DeRosa also noted that, while the typical cocaine user in the past was likely to be a white-collar worker, he or she now is just as likely to be a lower-paid laborer.

This is due in part to a gradual drop in street drug costs, he said. For example, crack, a form of cocaine, sells for about $10 per 3-granule vial, while paste sells for about $1 per granule, Mr. DeRosa noted.

Both narcotics, which are smoked, are addictive.

Some employers, like United, have found that the treatment centers they have long used to help employees addicted to mood-altering drugs are equally capable in handling cocaine problems.

But some businesses have sought out clinics and treatment centers specially equipped to deal with addiction to the drug.

"Standard alcohol-treatment counselors are not always well-equipped to handle cocaine," said Mark Houts, Western marketing representative for Brownlee Dolan Stein Associates in Cupertino, Calif.

Several California employers, including the Los Angeles Unified School District and Hewlett-Packard Co., contract with Brownlee Dolan Stein for EAP referrals.

Meanwhile, some EAPs are communicating to employees how to detect, identify and treat addiction to cocaine.

Others are channeling their energies into educating employees on the legal, professional, social and health implications of the drug.

For example, Capital Cities/ABC Inc. has an ambitious program to combat cocaine abuse among its 18,300 workers nationwide.

"Our principal problem was drugs, not balancing people's checkbooks and curing their loneliness," observed John C. Peterson, executive editor of Shore Line Newspapers in Guilford, Conn., a Cap Cities/ABC subsidiary.

Mr. Peterson was chairman of an employee advisory committee for the program.

Cap Cities rejected some traditional approaches to stress education and communication, he said.

The company's seven-month-old attack on drugs has included:

- Producing a film called "White Lady" on the legal and health ramifications of using cocaine and other narcotics, which is shown to employees.
- Enclosing educational leaflets in employees' paychecks.
- Offering drug awareness training for supervisors and creating a manager training manual.
- Displaying posters emphasizing the perils of drug dependency.

Projects like these encourage the employee to call a 24-hour, toll-free number for referrals to agencies or centers. The hot line number is administered by the Fair Oaks Hospital in Summit, N.J.

The project also includes sending drug-help brochures to employees' homes. Mr. Peterson said 17% of the hot line's calls so far have been from employees' family members.

More than 130 employees have received help through the substance-abuse program.

Of those helped, about 50% sought help for alcohol-related problems, about 40% for cocaine abuse and about 10% for other drugs, he said.

To encourage more outpatient care for substance abuse, Cap Cities/ABC is working with its group health insurers to increase outpatient benefits to $3,500 or $4,000 annually per person. Employees now are reimbursed for 50% of outpatient costs up to $1,000 annually, he said.

The company also is negotiating preferred provider arrangements with hospitals and treatment centers in several parts of the country, he pointed out.

As one example of how this type of arrangement might work, Mr. Peterson said the hospital may agree to accept whatever health insurance the employee has as full payment for treatment in exchange for being the first of several referral centers offered to the employee.

The company spent about $10 per employee in start-up costs, but Mr. Peterson expects the program's annual operating costs to drop to about $5 per worker by January.

Most employers say EAPs cost them no more than they did before the wave of cocaine use. Most EAP firms charge an annual rate based on the number of covered employees. And, experts note that people who seek treatment for cocaine addiction through an EAP have a better chance of receiving timely care than unemployed, uninsured individuals who seek similar treatment, because some publicly funded treatment centers in major cities now have waiting lists. ■

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Now, however, the character of an individual risk is becoming important again. Insurers are staunchly hewing to basic underwriting principles underlying the specific risks they handle best. Loss experience, level of protection, quality of construction, loss control programs—as well as class of risk—are subjects worth bringing to the table.

Reviews of property insurance programs are, therefore, timely. Judgment and negotiation again are becoming factors in risk acceptance.

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Insurer designs plan to prefund retiree costs

By DAVE LENCKUS

MINNEAPOLIS—A Minneapolis-based life insurer is developing a flexible savings plan to prefund acute and long-term health care costs for employees' retirement.

The insurer hopes the plan will induce employers to prefund their retiree health care liabilities—despite the current tax disincentives to do so—and reduce some of the strain on the Medicare and Medicaid programs.

The plan, as envisioned, also may allow employers to reduce their retiree health care liabilities by trimming retiree health care benefits—despite recent court rulings that prohibit this—and provide an attractive vehicle through which employees can fund future health care expenses themselves.

LifeScope would be a supplement for retirees to Medicare and Medicaid. But, unlike Medicare, LifeScope would provide long-term managed care for retirees. And, unlike Medicaid, the retiree need not be indigent to receive benefits.

The plan was conceived by NWNL Group, a division of Minneapolis-based Northwestern National Life Insurance Co.

The broad-based model program, called LifeScope, would be a supplement for retirees to Medicare and Medicaid.

But, unlike Medicare, LifeScope would provide long-term managed care for retirees. And, unlike Medicaid, the retiree need not be indigent to receive health care benefits.

Several benefit consultants say NWNL Group's plan is "intriguing" and applaud the insurer for its efforts, but they are skeptical about whether the plan can succeed under current tax and case law.

Consultants note that tax laws do not give employers or employees any incentive to prefund for retiree health care liabilities, and several courts recently have ruled that employers may not alter, reduce or eliminate retiree benefits once the employer has provided them (*BI*, Oct. 28, 1985).

NWNL acknowledges that for the program to gain widespread popularity, Congress must amend applicable laws so employers and employees have an incentive to prefund retiree health care costs.

But, NWNL officials say the retiree health care liability problem employers face must be addressed, whether or not Congress considers the related tax and legal issues.

NWNL is developing the program to assist employers that offer retiree health care benefits that soon may find themselves caught in the middle of a tug-of-war between tax laws and accounting requirements, says Don D. Henyan, executive vp of NWNL Group.

A recent U.S. Labor Department report noted that the value of the accrued liability for private-sector retiree insurance was approximately $98 billion in 1983, the last year for which figures are available (*BI*, Sept. 8).

But, under the Deficit Reduction Act of 1984, while employer contributions to fund future retiree health care benefits are tax-deductible, the employer must pay taxes on the interest earned on those contributions.

And, while employer contributions to a qualified pension or annuity plan for health insurance benefits and the interest earnings on those contributions are tax-deductible under Section 401(h) of the Internal Revenue Code, the employer may contribute an amount equal to only 25% of the pension benefits provided to employees.

Compounding this problem, the Financial Accounting Standards Board is considering requiring employers to reflect their retiree health benefit liabilities on their balance sheets. Currently, employers must only footnote these liabilities on balance sheets.

LifeScope, as envisioned by the insurer, would consist of three key elements:

- Fund accumulation. An account—funded by contributions from the employee, the employer or both—would build from year to year for an active employee enrolled in the program. At retirement, the retiree could utilize the fund to pay health care costs or buy long-term health care coverage from NWNL Group.
- Portability. The accumulated fund and other elements of the LifeScope program would follow the employee to different employers as the employee changes jobs or careers. Once enrolled in LifeScope, the employee would be a lifetime member.
- Managed care for retirees. NWNL or another contractor would authorize appropriate treatment for retirees, using hospitalization alternatives like outpatient care, home health care, nursing home care or hospice care.

LifeScope currently is being developed by NWNL Group with assistance from a group of about a half-dozen employers and health care providers in Minnesota. The insurer hopes the group can design LifeScope by year-end and develop a two-year business plan that select employers in Minnesota can follow to test the product.

NWNL Group would like to start up its Minnesota model program by the second quarter of next year, offering the product to three or four employers, including NWNL itself.

The employers that offer the benefit to their employees during the model program probably would enroll only a certain segment of their employee populations in the program, says Mr. Henyan.

Mr. Henyan estimated that a total of 5,000 employees will be enrolled in the model program next year.

Although the modeling effort is in its early stages and virtually no element of LifeScope is fully developed, NWNL Group has a general concept of how the program would operate.

The plan would be sold through traditional employee benefit channels as a flexible benefit program.

Continued on next page

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Employees would participate as they would under most current flexible benefit plans, choosing various income protection and health care options that would cover their needs during their working years and into retirement.

Examples of LifeScope products include:

- Life, health and disability insurance.
- Wellness and fitness programs.
- Retirement counseling.
- Financial services programs.
- Automobile and homeowners insurance.
- Buyer discount services.

The insurer would encourage the employer or employee to contribute an amount to the health care savings plan based on a health risk assessment of the employee and his or her participation in wellness and fitness programs.

NWNL Group would provide employees with regular fund accumulation and benefit reports and updated health assessments during their working years.

As the employee's retirement approaches, NWNL Group would counsel the employee about the benefits available to him or her and how the accumulated fund can be paid to the employee.

Among the payout options is a lump-sum disbursement. Then, when the retiree requires acute or long-term health care, the insurer could direct him or her to a preferred provider that offers LifeScope members discounts.

NWNL announced last spring that it and two other insurers—John Hancock Mutual Life Insurance Co. in Boston and Hartford Insurance Group in Hartford, Conn.—are planning to invest nearly $100 million over the next three years in a joint venture to develop, own and manage alternative health care systems nationwide (*BI*, May 19).

Although that venture and LifeScope are two separate business dealings, NWNL Group possibly could utilize its share of the health care system to provide care to LifeScope members, according to Mr. Henyan.

Another option a retiree could select is to give up any claim to the money in the fund in exchange for lifetime health care coverage from NWNL.

Or, a retiree also could choose to use money in the fund to purchase health insurance from NWNL.

Whichever fund disbursement option a retiree selects, retirees would have access to a broad range of health care services, according to the insurer. Those services would include long-term nursing home care and home health care.

NWNL Group envisions that such ancillary needs as physician costs, vision and dental care, prescription drugs and home custodial expenses would be covered under the program.

And, Mr. Henyan says that he would like to see a certain percentage of the investment earnings from the savings plans in LifeScope "go to the public pot" to help health care providers pay for care provided in charity cases.

"That's the part of the thing we need to strategically develop," he said.

Among the half-dozen employers and health care providers assisting NWNL Group in designing LifeScope are Minneapolis-based Honeywell Inc. and St. Paul, Minn.-based Deluxe Check Printers Inc.

However, while representatives from both companies say they think highly of the LifeScope concept, neither company has committed to using LifeScope after it is developed.

"We think they're going in a very good direction," noted Merlyn Scroggins, vp for administrative services at Deluxe.

'On balance, the nation has to come to grips with portability with the type of workforce we have,' because employees move from employer to employer more often than in the past, says Merlyn Scroggins of Deluxe Check Printers Inc.

"It has a lot of merit as far as meeting needs," agreed Laird Miller, director of health systems for Honeywell.

But, because Deluxe assumed an "exceptional liability" this summer when it implemented a new health care program for its employees, the additional cost to the company that LifeScope could entail if Deluxe contributed to the program's savings plan for employees would be financially burdensome, Mr. Scroggins noted.

"I think it would be a very large additional cost without employee participation," he observed.

Neither Mr. Scroggins nor Mr. Miller saw any problem with the portability of the benefit.

Mr. Scroggins likened a portable benefit that consists of funds contributed by the employer to a profit-sharing program, which Deluxe offers its employees.

"On balance, the nation has to come to grips with portability with the type of workforce we have," he observed, referring to the mobility of the nation's workforce.

The key to the program's success will be coordinating managed care, including wellness and early detection programs, and channeling care through quality providers, according to Mr. Miller.

The program also must address a couple of other important points, Mr. Miller noted.

"For example, if LifeScope is predicated on people with appropriate lifestyles and you're bringing in people that don't have them, that is a problem."

On the tax side, Mr. Miller questioned how investment earnings on funds accumulated in the LifeScope savings plans would be treated. He questioned whether employees would be required to pay the tax on those investment earnings.

Meanwhile, benefit consultants,

Continued on next page



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LifeScope

Continued from previous page
many of whom were unfamiliar with NWNL's undertaking when contacted by *Business Insurance*, expressed mixed opinions about the program.

All applauded the insurer for tackling the weighty subject of how to finance long-term health care for the aged in general and the dilemma of unfunded post-retirement health care liabilities for employers in particular.

But the consultants, who also posed questions about LifeScope, were somewhat skeptical about the likelihood of employers embracing the program, because current tax law does not provide employers or employees an incentive to prefund retiree health care benefit liabilities.

"It sounds intriguing to me," commented John Hickey, a partner at consultant Kwasha Lipton of Fort Lee, N.J.

Mr. Hickey said it is interesting that the idea is coming out of the Minneapolis-St. Paul area, where many employers utilize health maintenance organizations.

"That's one of the things that sounds like a nice fit," he observed.

"What's exciting to me is that they're addressing the accumulation of funds," noted Jody Dietel, a consultant with The Wyatt Co. in Minneapolis.

"I'm definitely glad to see them addressing the issue."

But the consultants had several questions about the plan, primarily about the associated tax ramifications.

"What I'm most anxious to find out is about the portability. . . .What are the tax ramifications?" Mr. Hickey wondered.

"Are they (NWNL) paying the taxes on the earnings that are accumulating in participants' names?" Ms. Dietel asked.

'A young, mobile workforce would be more inclined to like this,' says Kwasha Lipton's John Hickey.

That question is one of several that will be answered by the business plan being developed, pointed out Ginny Patrick, director of group marketing communications for NWNL Group.

"The business plan will tell us what else we need to focus on, given everyone's perspective," Ms. Patrick said. "A lot of questions yet to be answered will be developed out of the business plan."

Those questions include the cost of the plan, how the plan will be administered and the best method of accumulating funds.

And, the insurer in its promotional material for LifeScope emphasizes that Congress must modify tax laws to encourage employers and employees to prefund retiree health care liabilities.

Meanwhile, Stuart Brahs, executive director of the Assn. of Private Pension & Welfare Plans, expects Congress will face increasing pressure to modify such tax laws, but he says it is too early to predict what action, if any, Congress will take.

"It's much too premature to speculate on any changes in the tax code when the current one hasn't been signed off yet," Mr. Brahs noted. "Certainly, I think in the next Congress, a lot of people, including us, will be looking at post-employment funding, not just post-retirement."

"It's going to be a long haul" before Congress revises tax laws regarding prefunding of retiree health care benefits, predicted Edward J. Davey, vp-manager of the national benefits research department at New York-based Johnson & Higgins.

However, Mr. Davey sees "some ray of hope" because the Senate this year attempted to amend a provision of the 1984 Deficit Reduction Act that pertains to prefunding retiree health care benefits.

Under the act, employer contributions to fund those benefits are tax-deductible, but the employer must pay taxes on the interest earnings on those contributions. In addition, computation of those contributions must be based on the assumption that future benefits will cost the same as benefits currently provided—without considering inflation.

Mr. Davey noted that although the amendment was killed by the House-Senate conference committee, the Senate at least attempted to allow employers to take inflation into account when figuring contributions to retiree health care benefit plans.

Mr. Hickey speculated that the current tax disincentive for a plan like LifeScope may be less important to some employee segments than others in cases when the plan's savings account would be funded in part or whole by employee contributions.

"A young, mobile workforce would be more inclined to like this," he said.

In addition, higher-income employees may be attracted to the plan, speculated Geraldine Alpert, a principal with William M. Mercer-Meidinger Inc. in New York.

"I think the new tax bill may make it easier to save for those medical costs for those people in higher tax brackets," she noted.

But, on the employer side, "if there's no tax incentive, employers won't prefund," Mr. Davey predicted.

In addition, even if employees capitalized their own health care fund under LifeScope, employers still would face the same unfunded retiree health care liability problems, unless they reduce or eliminate promised retiree health care benefits, consultants noted. And, courts increasingly are ruling that those benefits cannot be altered, the consultants pointed out.

Ms. Dietel also observed that the portability of the plan would be limited. "It would only be portable if another employer had LifeScope," she said.

She encouraged NWNL Group to "go one step farther" in its efforts to assist employers and employees in prefunding retiree health care liabilities by allowing employers and employees to transfer LifeScope to other insurers that may develop similar plans.

"I think the concept is really intriguing, but I think it's obvious, at least to me, it's futuristic," Ms. Dietel noted.

Overall, the insurer's efforts at least are worth examination, Mr. Hickey said. "Any new concept like that is exciting and worth looking at."

Despite the tax and other case law questions surrounding LifeScope, the program is at least a springboard for addressing prefunding of retiree health care liabilities, Mr Henyan noted.

"Whether it has a tax advantage or not, I think the American working population has to start saving for old age, or they won't receive the care they hope to receive," Mr. Henyan observed.

"We're going public with the Minnesota model. If it's successful, the logic of legislative changes will become apparent," he said.

But, he added, "Whether logic is something that should be considered in terms of legislation, I don't know." ■



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Employer offers program for latchkey kids

By MARGARET LeROUX

WORCESTER, Mass.—It's 3 p.m. Do you know where your children are?

What kids are doing—or not doing—when they are home alone after school is a daily worry for millions of working parents.

Busy signals tying up telephone lines in late afternoons at companies nationwide attest to the concern of parents calling home to check up on their offspring.

And, concentration on work wavers when a parent must frequently reassure or referee children at home by telephone.

An accountant for a Massachusetts insurer recounts an all-too-familiar scenario: "A frantic phone call from a co-worker's child soon has everyone in the office discussing sibling rivalry instead of the work at hand."

That company, State Mutual Life Assurance Co. of America in Worcester, is teaching employees' children how to handle being home alone after school without frequent calls to Mom or Dad.

The five-session "Survival Skills" course for latchkey children aged 9 through 12 was adapted from the "I'm in Charge" program of the Kansas Committee for the Prevention of Child Abuse.

The insurer conducts the program semiannually—in the spring, to prepare children for being at home during the summer, and in the fall, before school starts.

The program "may be a way for us to increase productivity, but that's not the primary goal," said Joseph E. Tancrell, assistant vp of human resources and media development for State Mutual.

"We see it as a way of alleviating some of the stress and anxiety felt by employees who are parents," he said.

The classes benefit both employee and employer, agreed Jill Hamilton, a consultant with the human resources and media development department who teaches the course with Mr. Tancrell.

Children in the program, who meet at the company's offices, enjoy snacks while discussing how to handle such emergencies as fire, gas leaks or burst water pipes.

For example, to initiate discussion, the instructor presents situations like the following that the children may encounter while at home alone: "You smell smoke coming from the kitchen and your little sister is playing in her bedroom. . . .What do you do?"

"They really get into it," Ms. Hamilton said. "If one of the kids gives an answer the others consider wrong, they are quick to point out what should be done instead."

And, homework is assigned to both the children and their parents, including conducting a home safety survey, designing a fire escape plan and drawing up a parent-child agreement on rules and privileges for after school.

The class also discusses minor problems, like persuading a younger sibling to do homework instead of watching television.

"What impresses me most about the classes is that the kids are treated as responsible people," noted an accountant with the insurance company, who spoke on the condition that he not be identified.

The accountant also noted that his son "was not at all enthusiastic about taking the course. We made a deal. He'd go to the first class and if he really hated it, he wouldn't have to return."

But the snacks and audiovisual equipment used for the class captivated the child.

The program opened up a line of communication between an information consultant and her "headstrong" 10-year-old daughter.

"She resists what I tell her," said the consultant, who also requested anonymity. "The classes gave her quality advice, and I didn't have to be in the role of giving it."

Now, when problems arise after school, the consultant says she tells her daughter: "Remember, we talked about this in your class."

Her daughter is enthusiastic about what she has learned. "The teachers make it fun," the consultant said.

The consultant pointed out another benefit from the class: "It gave me a chance to spend some time with my daughter. If there's one thing I don't have enough of, it's time. The class was a relief for my sense of guilt."

But few State Mutual employees apparently are taking advantage of the program, which was launched in September 1985.

Employees have enrolled only five to 10 children in the programs conducted since last year, Ms. Hamilton says. The insurer employs 2,400 in the Worcester area, but Ms. Hamilton does not know how many are parents.

Meanwhile, some child development experts, who do not think children should be left alone at home, say latchkey training programs are not the only alternative.

"Parents shouldn't feel it's their only option," noted Ellen Gannett, coordinator of the School Age Child Care Project at Wellesley College in Wellesley, Mass.

"In many communities, there are after-school programs supervised by adults, where children can pursue lots of different activities."

One employer tried to set up an after-school program at pizza restaurants in Oklahoma, Louisiana and Alabama, but it failed due to a lack of enrollment.

Dallas-based Brock Hotel Corp. assigned one of its managers and invested $70,000 for personnel to staff after-school clubs at 11 of its Chuck E. Cheese Pizza Time Theatre and Showbiz Pizza restaurants. Membership was open to the entire community, and there was a $5 daily charge for food and video games.

But the company was forced to discontinue the after-school clubs after just three months.

"We weren't having enough kids to make it worthwhile," explained Mary Hellen Cook, who was the latchkey corporate administrator.

A logical location for the after-school programs is in the schools, noted Ms. Gannett at Wellesley College. "Schools have the space, and if there is enough support from the community, after-school programs can be self-supporting."

"Employers are in an ideal position to exert their influence to promote after-school programs," noted Rich Scofield, editor of "School Age Notes," a newsletter on programs for latchkey children.

"An employer could focus on one school district that serves a majority of the employees' children or support programs at several schools in an area," he said. ■



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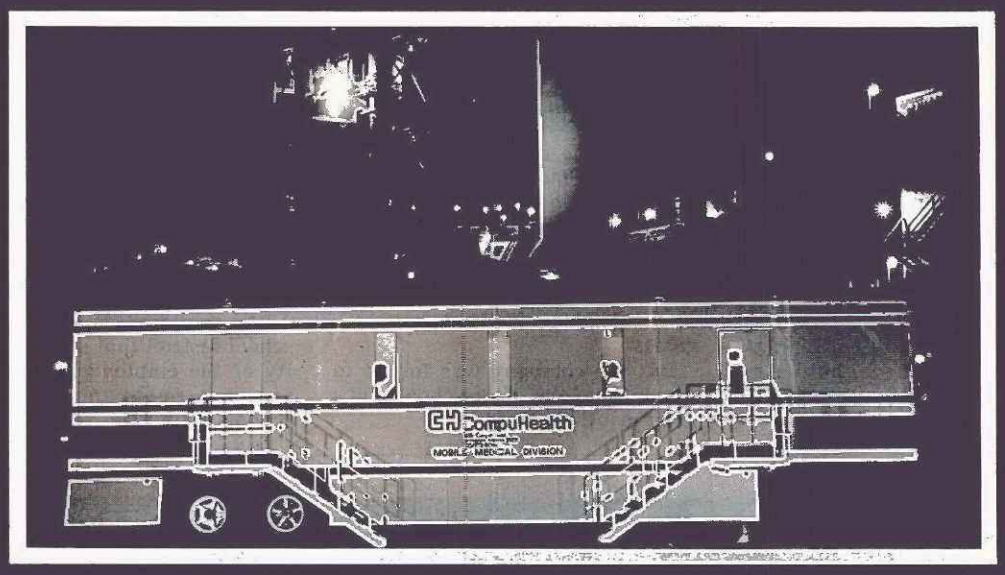
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Companies aiding smokers who want to 'kick the habit'

By MARGARET LeROUX

Employee benefit managers increasingly are discovering that where there's smoke, there must be fire.

Employers are finding that employees who smoke on the job increase benefit costs, are absent more often, are less productive and increase a variety of other costs.

In light of these higher costs and increasingly vocal complaints from non-smoking employees, many companies are taking steps to put out the fire, including offering smoking cessation classes and banning smoking at work.

In fact, a recent study by the Bureau of National Affairs, a private research firm in Washington, and the American Society for Personnel Administration shows that 36% of 660 responding companies currently have some kind of no-smoking policy. In addition, 2% will implement such a policy by the end of 1986, and 21% are considering banning smoking at work.

Companies that ban smoking in the workplace include:

- The Stride Rite Corp. in Cambridge, Mass., a manufacturer of children's shoes that employs 4,000 people in the United States and Puerto Rico. Stride-Rite, which instituted its ban in April 1985, claims it is the first company listed on the New York Stock Exchange to implement a comprehensive no-smoking policy, touting its "concern about the health and welfare of its employees."
- Pacific Northwest Bell Telephone Co., a Seattle-based telephone company that employs 15,000 people in three states, which prohibits smoking "in any company facility."

The ban took effect 18 months ago "to protect the health of Pacific Northwest Bell employees," according to a company memo announcing the policy.

- Texas Instruments Inc., which six months ago prohibited its 20,000 employees in the United States and Canada from smoking in the workplace. But, each Texas Instruments facility provides a separately ventilated smokers lounge for employees to use during their breaks.
- CIGNA Health Plan of Arizona, a Phoenix-based health maintenance organization employing 2,000 people, which banned smoking at all of its facilities in April 1985.

"For us to be an HMO and not do something so basic to maintain our own employees' health was a contradiction," said Michael Larson, executive assistant to CIGNA's medical director.

But, many companies are not abandoning smoking employees, forcing them to quit "cold turkey" or sneak a puff in the parking lot.

Instead, they are offering programs to help their employees quit, both on the job and at home.

Pacific Northwest Bell offers free smoking-cessation classes, and 1,591 employees and spouses signed up during the first 18 months of the smoking ban.

In comparison, only 331 people had taken advantage of the free classes during the two-year period before the ban.

At Texas Instruments, there was a tenfold increase in the number of people who signed up for the smoking-cessation classes after the company's no-smoking policy began six months ago.

Other companies are offering employees incentives to quit:

- At Bonne Bell Inc. in Lakewood, Ohio, smokers who want to quit can sign up for the company's stop-smoking plan at the first of the year. If the employee does not smoke for six months, the company awards him or her $250.

But, if the employee resumes smoking after that, he or she must pay the company $500, which is donated to a local association that supports no-smoking efforts.

- At City Federal Savings & Loan in Birmingham, Ala., smokers who quit for at least 30 days are eligible for a $20 monthly bonus for as long as they do not smoke.

The program has been in effect for more than 20 years, and "the vast majority" of the company's 280 employees get the bonus, says Elizabeth Mengel, training manager-human resources.

Neither Bonne Bell nor City Federal Savings prohibits smoking in the workplace.

Consultants suggest employers offer employees more than one approach to stop smoking.

"Because people smoke for a variety of reasons, there is no single way to help them quit. We recommend employers offer a range of programs," said Robert Rosner, executive director of Smoking Policy Institute, a Seattle consulting firm that worked with Pacific Northwest Bell to develop its stop-smoking program.

Pacific Northwest Bell offers several techniques, including acupuncture, hypnosis, behavior modification, aversion therapy, nicotine gum, motivational training and vitamin therapy.

"Acupuncture is the most-popular because it requires the least from the smoker," noted Kerry Roland, an administrator of the stop-smoking program.

"But, it's not as successful. People who take behavior modification classes are less likely to start smoking again," she said.

Continued on next page

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Ms. Roland emphasized that Pacific Northwest Bell sought the cooperation of its unions in establishing the no-smoking program.

"The unions were in on it from the beginning," she said.

And, she added, "We didn't tell anyone they have to quit smoking," only that they cannot smoke at work.

Boston-based consultant Clean Air Associates helped Stride Rite set up its no-smoking program.

"My programs, aimed at the non-smokers—who represent about 80% of the workforce—create pressure for smokers to conform," explained Rita Addison, president of the consultant.

"Clean-air policies eliminate the environmental cues for smokers. If you don't see the person at the next desk lighting up, you're not as likely to either," she said.

The cost of smoking cessation classes ranges from $70 to $100 for in-house sessions, such as those taught by the American Lung Assn., to $300 per person for specialized classes outside work.

Pacific Northwest Bell reports its average per-employee cost for smoking cessation classes is $140. As of the end of August, the company had spent about $224,373 for smoking cessation classes since its smoking ban took effect.

"Compared to our annual health care costs, the amount is peanuts," noted Len Beil, director of human resources planning. The company self-insures its group health care benefits at an annual cost of more than $50 million, Mr. Beil said.

The company has not collected data on the savings resulting from the smoking ban, but Mr. Beil notes: "It has had an impact on our health costs when you consider that smoking is the No. 1 cause of preventable disease."

Like Pacific Northwest Bell, most companies rely on common sense rather than hard data to show stopping smoking saves money. Few track the cost savings from banning or discouraging smoking among employees.

In fact, "employers are reluctant to equate a clean-air policy with dollar savings," Ms. Addison pointed out. "They don't want employees to think, 'You're trying to save money, so you're making me stop smoking.'"

And, most employers do not want to commit the time and expense to gather data on health care claims and absenteeism, as well as other smoking-related costs such as depreciation of equipment and furniture, Ms. Addison added.

However, William Weis, a director of the Smoking Policy Institute, estimates that each smoking employee costs an employer an average of $4,500 per year, based on increased health insurance costs, absenteeism, reduced productivity, early mortality, damage to and depreciation of equipment and maintenance costs.

The U.S. Office of Technology Assessment estimates that smoking-caused illnesses cost U.S. businesses $22 billion in health care costs and $43 billion in lost productivity each year.

And, the office reports that a non-smoker's risk of developing lung cancer can increase 1½ times when he or she is exposed to a smoke-filled environment.

"There are several different studies that show, for certain people, exposure to smoke may present a long-term risk for cancer and other diseases," said Dr. Dale Sandler, an epidemiologist at the National Institute for Environmental Health Science at Research Triangle Park, N.C. "Taken individually, the studies are inconclusive. But taken together, they suggest the cancer risks are real."

And, some employers are beginning to be concerned about future liabilities they may face if non-smokers develop illnesses because they were exposed to smoke in the workplace. This concern is another impetus for employers to formulate policies on smoking, experts say.

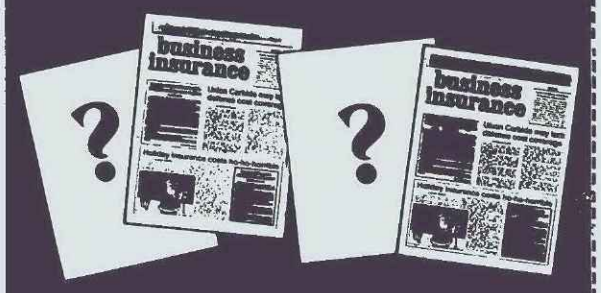
"Employers can't afford to sit back and ignore the issue any more," said Ruth Behrens, senior consultant for the Washington Business Group on Health.

Meanwhile, some employers hope to receive discounts on their group health care costs for non-smokers, similar to the discounts already offered by many personal lines insurers.

Blue Cross & Blue Shield of Minnesota plans to offer reduced-premium health coverage for non-smokers starting the first or second quarter of 1987, says Kit Tomasi, manager-health promotion.

"We'll be offering discounts to groups of 50 or fewer non-smoking employees to start," she noted, adding the discount eventually will be extended to all groups. ■

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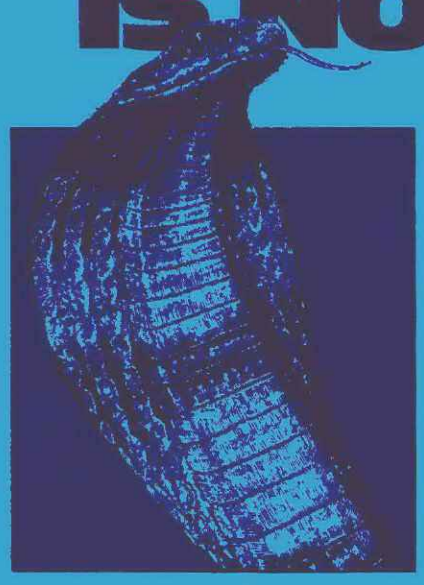
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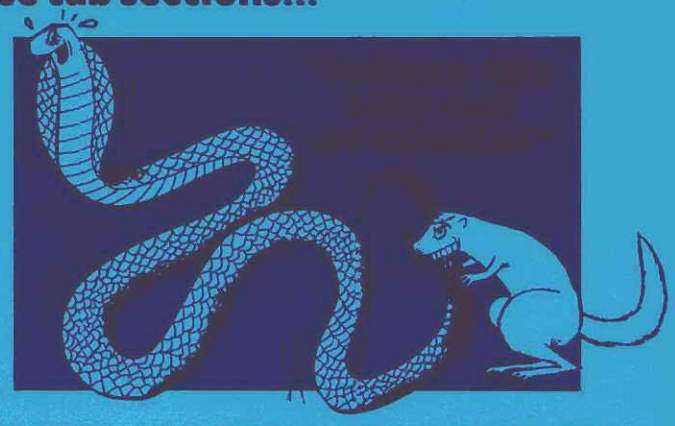
The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") will have a far-reaching impact on every employer with 20 or more full or part-time employees.

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Small group health plan offers many options

American Administrators Inc./ The Blaine Agency has introduced MesaCare, a fully insured health plan for small groups in which each plan participant can select his or her own deductibles and other plan options.

The coverage is underwritten by Pennsylvania Life Insurance Co. of Philadelphia.

The MesaCare plan provides such features as a prepaid prescription card benefit through Paid Prescriptions Inc.; coverage for organ transplants; mental and nervous disorder coverage; and coverage for drug-abuse treatment. Skilled nursing home and home health care benefits are also included in the plan.

Optional features of MesaCare include dental benefits; accidental death and dismemberment benefits; vision care coverage; and group life and dependent life insurance benefits.

MesaCare is currently available in Western states, though the coverage will eventually be offered in other areas.

For more information contact American Administrators Inc./The Blaine Agency, 3931 McArthur Blvd., Newport Beach, Calif. 92660; 714-752-5665 or, in California, 800-848-2266.

products & services

Drug testing

Equifax Services of Atlanta has introduced a drug testing program to help employers crack down on employee drug abuse, which costs American businesses more than $40 billion annually.

With Drug Abuse Management Services, an employer can find out in 24 to 72 hours whether an employee is using drugs and in what amount, according to June O'Kelly, assistant vp of Equifax's security and resource management group.

The test can discern which drugs are in the bloodstream and in what amount, and the contracting employer can decide what action to take.

Specimens are collected by medically trained personnel from Equifax's Physical Measurements Information Division and sent overnight for analysis to Pharm-Chem Laboratories Inc. in Menlo Park, Calif., the largest independent laboratory specializing exclusively in drug/urine toxicology.

Specimens that test positive undergo further examination to ensure accuracy, and the entire process is documented for security, Ms. O'Kelly stressed.

But before Equifax will conduct its drug testing service, the contracting employer is required to have a written drug policy, she noted. For an additional fee, Equifax will provide consultants to help draft such policies.

Consultants also are available to assist in the design and implementation of corporate drug rehabilitation programs.

Equifax's fee for the drug testing service varies based on the amount of consulting and testing it provides, according to Ms. O'Kelly.

For more information, contact Security and Resource Management Services, Equifax Services Inc., P.O. Box 4081, Atlanta, Ga. 30302; 800-241-1896.

Pollution prevention

Reducing hazardous wastes through recycling and substitution of safe alternatives is as good for business as it is for public health, according to a new book from the Institute for Local Self-Reliance.

"Proven Profits from Pollution Prevention: Case Studies in Resource Conservation and Waste Reduction" features 46 case studies that show waste minimization is both economically viable and environmentally sound, says Jan Simpson, outreach coordinator for the institute.

"Industrial profitability and environmental quality have traditionally been adversaries. But that does not have to be the case," Ms. Simpson asserts.

"A new concept of pollution prevention through waste minimization can not only improve environmental quality, but increase profits for businesses," she explains.

The 46 case studies, which constitute the bulk of the book, examine the transferability of the cited technology or strategy, so that much of the information presented can be directly applied in other industrial settings.

Among the issues covered in the accompanying text are waste reduction strategies, waste minimization program implementation on the company scale and the conditions necessary nationally for redefining and redirecting industries' and communities' responses to hazardous wastes, according to Ms. Simpson.

The book also includes recommendations for a national waste reduction policy.

"Proven Profits" is available for $26.50 postpaid from the Institute for Local Self-Reliance, 2425 19th St. N.W., Washington, D.C. 20009; 202-232-4108. Quantity discounts are available.

Cleaning agent video

A new audiovisual program from the Industrial Training Systems Corp. informs employees about the hazards of cleaning agents.

"Cleaning Agents,' a 12-minute

Continued on next page

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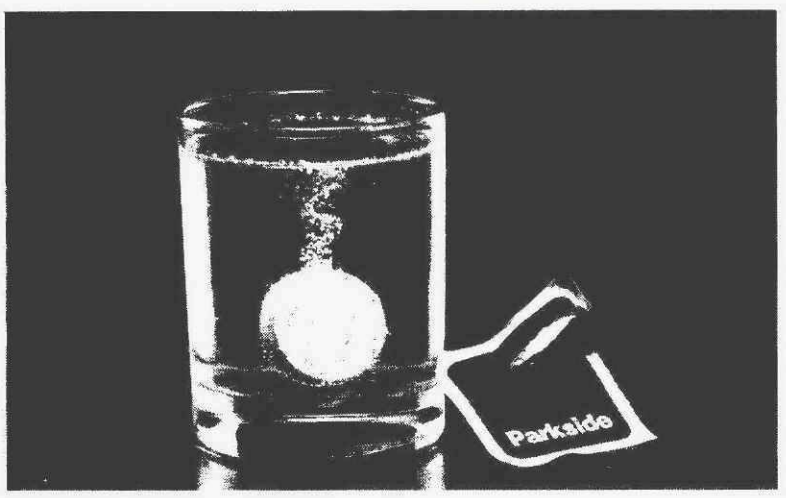
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info

• State legislatures enacted more than 235 laws in 1985 covering almost every aspect of workers compensation benefits, and a new record number of U.S. workers were covered for such benefits, according to the **1986 Analysis of Workers' Compensation Laws** published by the U.S. Chamber of Commerce. The annual analysis tracks statutory provisions of workers compensation laws in all 50 states, the District of Columbia, Guam, Puerto Rico, American Samoa and the U.S. Virgin Islands, as well as the federal, provincial and territorial laws of Canada. Copies are available at a single-copy cost of $12 postpaid with reduced costs for bulk orders. Orders should specify both the title and publication No. 6893. Contact the U.S. Chamber of Commerce, 1615 H. St. N.W., Washington D.C. 20062; 301-468-5128.

• "Measuring the Value of Health Services" is the title of a book containing dialogue on the **price, utilization and quality of health care services.** Produced by the Hospital Research and Educational Trust, an affiliate of the American Hospital Assn., the book is based on a forum that brought together leaders from major purchaser and provider organizations to discuss such issues as evolution of the purchaser/provider relationship, how purchasers gather and apply data on price, utilization and quality of health care, innovative approaches to resolving conflicts in providing information to purchasers, an agenda for the future and more. The book is available for $15 from AHA Services Inc., 4444 W. Ferdinand, Chicago, Ill. 60624; 312-280-6030.

• In a new brochure, The Hartford Steam Boiler Inspection & Insurance Co. describes **insurance based on technical evaluation of alternate energy products.** The coverage, System Performance Insurance, is designed for the alternative energy market. The booklet focuses on two key benefits for potential investors: First, Hartford Steam Boiler determines the technological feasibility of energy-related products; then, the company backs its evaluation with insurance to help protect policyholders against default in repayment of the loan in the event of technological failure or underperformance. The brochure also lists typical energy ventures the product is designed to insure and details qualifications and the risk review process. For free copy, write to Lloyd M. Harrington, Manager, Technological Risks, The Hartford Steam Boiler Inspection & Insurance Co., 1 State St., Hartford, Conn. 06102.

• Legislative updates, health promotion and cost containment, new health care systems, ethical considerations in health care decisions and quality control are among the subjects discussed in **"Health Care Cost Management-1986,"** recently published by the International Foundation of Employee Benefit Plans. Other topics covered in the 105-page book include drug and alcohol abuse programs, development and use of health care data, new approaches to the finance and delivery of health care to the elderly and others. The book is a collection of edited texts presented at the IFEBP's 1986 Health Care Cost Management Conference held last April. Cost of the book is $12 for IFEBP members and $20 for non-members. Send payment to Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008; 414-786-6700.

• **"Catastrophe: A Natural Catastrophe Planning and Management Guide"** is the title of a new publication from American Re-Insurance Co. The 28-page brochure details the causes of natural catastrophes, underwriting against catastrophes, developing and implementing a plan of action and recent developments in catastrophe handling. In addition, a pamphlet, "Preparing for a Hurricane," is included. For a free copy contact Terese Rosenthal, Corporate Communications, American Re-Insurance Co., One Liberty Plaza, 91 Liberty St., New York, N.Y. 10006; 212-618-7000.

• **"Comfortable Retirement: Your Guide to Achieving a Financially Secure Future"** is the title of a new 16-page booklet from Fax Communications Inc. that details basics of financial planning, including investments, what to expect from Social Security and where to go for more information. For a free sample copy write Fax Communications Inc., Department BI, 3279 20th St., San Francisco, Calif. 94110.

• "Quiet Times" is the title of Industrial Noise Control Inc.'s noise control bulletin, which offers detailed **solutions to noise problems in the industrial workplace.** The bulletin provides case history information along with material performance data and basic product specifications. Published eight times per year, Quiet Times is available for no charge to all those interested in noise control by contacting Industrial Noise Control Inc., 1411 Jeffrey Drive, Addison, Ill. 60101; 312-620-1998.

• The first edition of DIGEST, a quarterly review of **workers compensation issues** published by the National Council on Compensation Insurance, discusses such topics as workers compensation in the age of Gramm-Rudman, video display terminals and workers health and safety. The book is distributed, without charge, to insurance professionals, regulators, legislators, academics and libraries. A copy may be obtained from the National Council on Compensation Insurance, Kathy Spicer, Public Affairs, 1 Penn Plaza, New York, N.Y. 10119; 212-560-1014.

• For **employee benefits communication and administration on an IBM PC**, Benchmark Communications Group has produced a brochure that describes software for producing any type of personal benefits statement. In addition, Benchmark offers a diskette containing a demonstration of the above, as well as interactive software designed for employee use. There is no cost for the brochure and the diskette can be obtained for $10 from Benchmark Communications Group, 1238 Jefferson Davis Drive, Brentwood, Tenn. 37027; 615-373-3780.

• Jury Verdict Research has published a recent review of electrical work cases, finding that plaintiffs/employees injured while performing electrical work are receiving favorable verdicts. Copies of **"Employees Injured While Performing Electrical Work"** are available for $19.50 each from Jury Verdict Research Inc., 5325 Naiman Parkway, Suite B, Solon, Ohio 44139-1065.

• "Stop Bleeding" is the title of a **first-aid poster** from C.A.B. Consultants. The 8½-by-11-inch poster illustrates first-aid for the extremities, mentions the use of tourniquets and how to transport severed body parts. Cost of the poster is $3. In addition, a brochure is available that describes **wellness programs** the occupational health and welfare consultant offers. For a copy of the free brochure, a ‡10 self-addressed stamped envelope must be provided. Contact C.A.B. Consultants, 503 N. Clayton, Hillside, Ill. 60162; 312-544-2087.

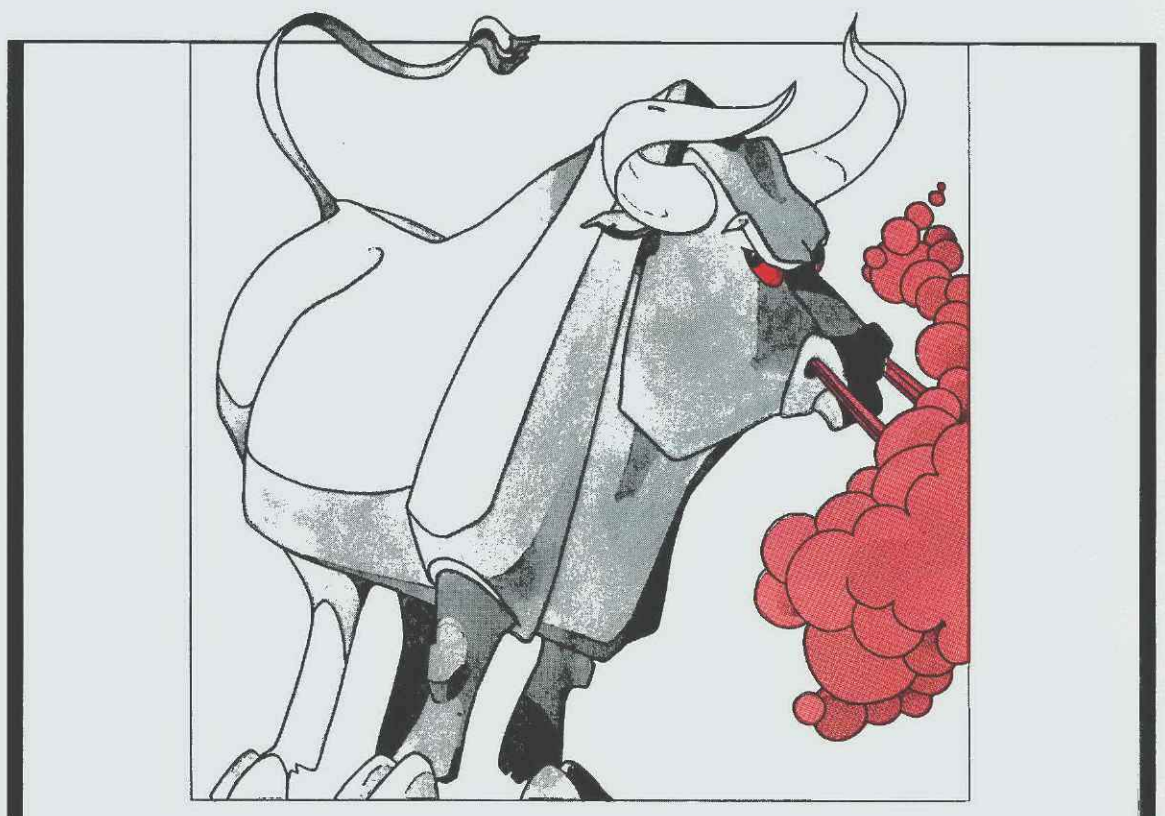
• Krames Communications has published a new eight-page motivational resource, **"Fitness at the Terminal—Comfort Tips for Computer Users."** The colorfully illustrated pamphlet shows simple exercises to relieve fatigue and discomfort that may result from sitting in front of a computer terminal for a long period of time. For a free sample copy write to Krames Communications. Department FAT17, 312 90th St., Daly City, Calif. 94015-1898.

• Want to know what industry leaders are saying about **civil justice problems**? The Insurance Information Institute and Fordham University have published a comprehensive bibliography entitled "Civil Justice Information Resources." Among the subjects covered in the bibliography are alternative dispute resolution, automobile accident compensation, civil justice and litigation issues, frivolous lawsuits, jury trials, statutes of limitations, statues of repose and tort law and reform. Types of insurance covered in the book include liquor liability, medical malpractice, product liability, professional liability and workers compensation. Single copies of the bibliography are available for $20 from Insurance Information Institute, Civil Justice Information Resources, 110 William St., New York, N.Y. 10038.

• **"Health Care Cost Management—A Basic Guide"** is the title of a new book published by the International Foundation of Employee Benefit Plans. The book discusses plan redesign, working with insurers and health care providers, increases in deductibles and/or coinsurance, self-funding, HMOs and more. Emphasis is on assisting you in selecting and utilizing the options best suited to your plan's framework. Cost of the 132-page book is $15 for IFEBP members and $20 for non-members. It's available from Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069.

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International Union of Marine Insurance conference

Hull, inland marine rates increasing

By STACY SHAPIRO

HAMBURG, West Germany—Hull and inland marine rates are finally increasing because of the tightening property/casualty market and reduced capacity for marine hull reinsurance, marine underwriters say.

However, underwriters keep offering cheap rates for cargo and offshore oil rig coverage because the oil industry and international trade continue to slump and underwriting profits can still be made.

"Marine is following the same trend as property/casualty, but is not increasing rates as much because the rate cuts were never as drastic," said George Zacharkow, chairman of the Marine Office of America Corp., a subsidiary of Continental Corp. in New York.

'Marine is following the same trend as property/casualty, but is not increasing rates as much because the rate cuts were never as drastic,' says George Zacharkow, chairman of the Marine Office of America Corp.

"Hull rates have stabilized to get an increase in premiums. But, cargo is still under attack," he said.

"And, inland marine has come through with strong rate increases."

Mr. Zacharkow echoes the conclusions of the more than 500 marine underwriters who attended the annual International Union of Marine Insurance conference in Hamburg Sept. 14-18.

The conference, hosted this year by the Federal Republic of Germany Insurance Assn., provides a forum for marine underwriters from all over the world to discuss marine insurance and reinsurance trends.

This year, the marine underwriters agreed that hull insurers are just about maintaining the level of rate increases that they began last year.

According to the British Marine Underwriters' Assn., hull underwriters, led by insurers in London, began increasing hull rates by 10% to 50% and increasing deductibles, also by 10% to 50%, late last year. Underwriters agree these kind of increases will continue in 1987.

"I expect the hull rates to go up further, but not much," noted Christian Kluge, director of Munich Reinsurance Co. in Munich, West Germany. "Maybe they will go up an average of 10%. But we need more than that."

About 25 years ago, hull rates averaged between 0.5% and 0.75% of the insured value of a vessel, he said. But it is common today for hull rates to average between 0.2% and 0.4% of the insured value, he said. Also, deductibles are one-tenth what they were 25 years ago, now ranging between $10,000 and $30,000, he said.

"Certainly there have been technical risk improvements with regard to the objects insured, but they can hardly explain a decline in the percentage rates for hull risks to some 25% of what was once required," he said.

And, Mr. Kluge pointed out that few reinsurers are currently supporting hull insurers because the rates are not high enough.

For example, Munich Re has reduced the amount of hull reinsurance it will write to less than 1% of its total premium volume, Mr. Kluge.

"There is absolutely no money in marine hull reinsurance," he said.

On the positive side, IUMI members heard there were fewer hull losses in 1985 than there were in 1984. The Institute of London Underwriters showed that 189 ships were declared total losses last year, a reduction of 25 over the 1984 total of 214.

"The shipping market is depressed, but the casualty figures have actually lowered," said David Lowen, chairman of the ILU.

IUMI members heard, too, that the number of ships that have been laid up during the shipping slump has been reduced by 200, according to Tony Nunn, chairman of the IUMI hull committee.

Only the hull war risk market has seen serious casualties, with 40 vessels hit in the Persian Gulf in 1985 and 40 vessels hit between January and June this year, noted Mr. Nunn.

But, the 1986 hull losses will

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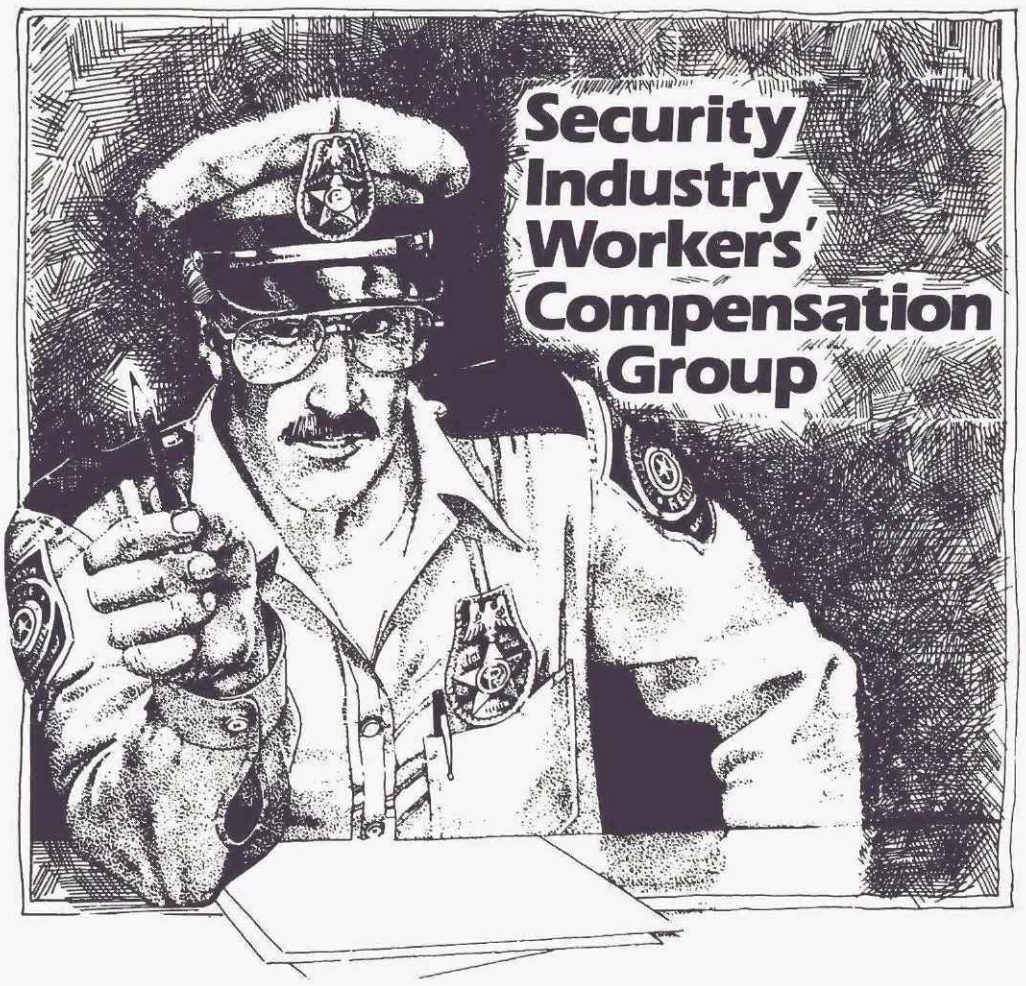
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Industrial explosions

A 30-minute audiovisual presentation that shows how to prevent industrial explosions is available from the American Society of Safety Engineers.

Suitable for both hourly employees and supervisors, the program defines and categorizes types of explosions; identifies major sources of industrial processing explosions; details prevention methods; and explores techniques to mitigate the effects of explosions.

Produced by ASSE and Fenwell Inc., a fire protection systems manufacturer, the program is available in slide/cassette tape format or any videotape format at a cost of $120 for ASSE members and $145 for non-members.

Send prepaid orders to the American Society of Safety Engineers, Department F, 1800 E. Oakton St., Des Plaines, Ill. 60018-2187, or phone 312-692-4121 to place VISA or MasterCard orders.

Periodicals index

The latest edition of the Insurance Periodicals Index has rolled off the presses and is available from NILS Publishing Co. of Chatsworth, Calif.

The reference book, at $90 per copy, indexes more than 10,000 articles from 36 periodicals spanning all lines of insurance. The IPI indexing was performed by specialists from the nation's largest insurers, brokerages, universities and financial institutions.

In addition to a complete thesaurus of cross-references and a subject index, the index also features an author index, according to NILS, which is an operating unit of ABC Publishing, a division of Capital Cities/ABC Inc.

To order or to obtain more information, call NILS Telemarketing at 800-423-5910; 818-998-8830 in California.

Flexible benefit book

The Employers Council on Flexible Compensation has recently released a comprehensive guide to flexible benefits.

"The Flexible Compensation Sourcebook," a 599-page handbook, contains information on cafeteria plans, 401(k) and 403(b) arrangements, spending accounts and other forms of employee choice benefit plans.

The sourcebook also covers the legislative and regulatory history of flexible compensation.

Copies are available at a discounted price of $108 until Oct. 15. After that date, copies of the sourcebook will be available for $135 for ECFC members and $250 for non-members.

To order, send a check or money order to: Employers Council on Flexible Compensation, 1660 L. St. N.W., Suite 715, Washington, D.C. 10036.

PPO 'Blue Book'

The first issue of the "Blue Book Digest of PPOs" is available from the National Assn. of Employers on Health Care Alternatives.

The digest includes information on 200 preferred provider organizations in 35 states as of Jan. 1, 1986.

The first annual "Blue Book Digest of PPOs" is available for $49.50 from NAEHCA offices. For further information, contact the National Assn. of Employers on Health Care Alternatives, Suite 304, 104 Crandon Blvd., Key Biscayne, Fla. 33149; 305-361-2810.

Tort reform profiles

A comprehensive set of profiles detailing the structure and status of tort reform in all 50 states is now available from the American Insurance Assn.

"Tort Reform Reporter," a new publication presented in looseleaf form, is composed of individual fact sheets for each state. The pages describe the status of legislation, current law, recent developments and the outlook for tort reform.

Names and addresses of the organizations and participants active in tort reform efforts also are provided.

The information is updated periodically and profiles are revised and distributed whenever there is significant change in the tort reform status in any particular state.

"Action Updates" are sent to subscribers when any late-breaking development occurs, and the looseleaf binder includes a section to accommodate these supplementary informational mailings.

A one-year subscription to both "Tort Reform Reporter" and "Action Update" is $395.

For more information, contact Ronald Krauss, vp-communications, American Insurance Assn., 85 John St., New York, N.Y. 10038; 212-669-0419. ■

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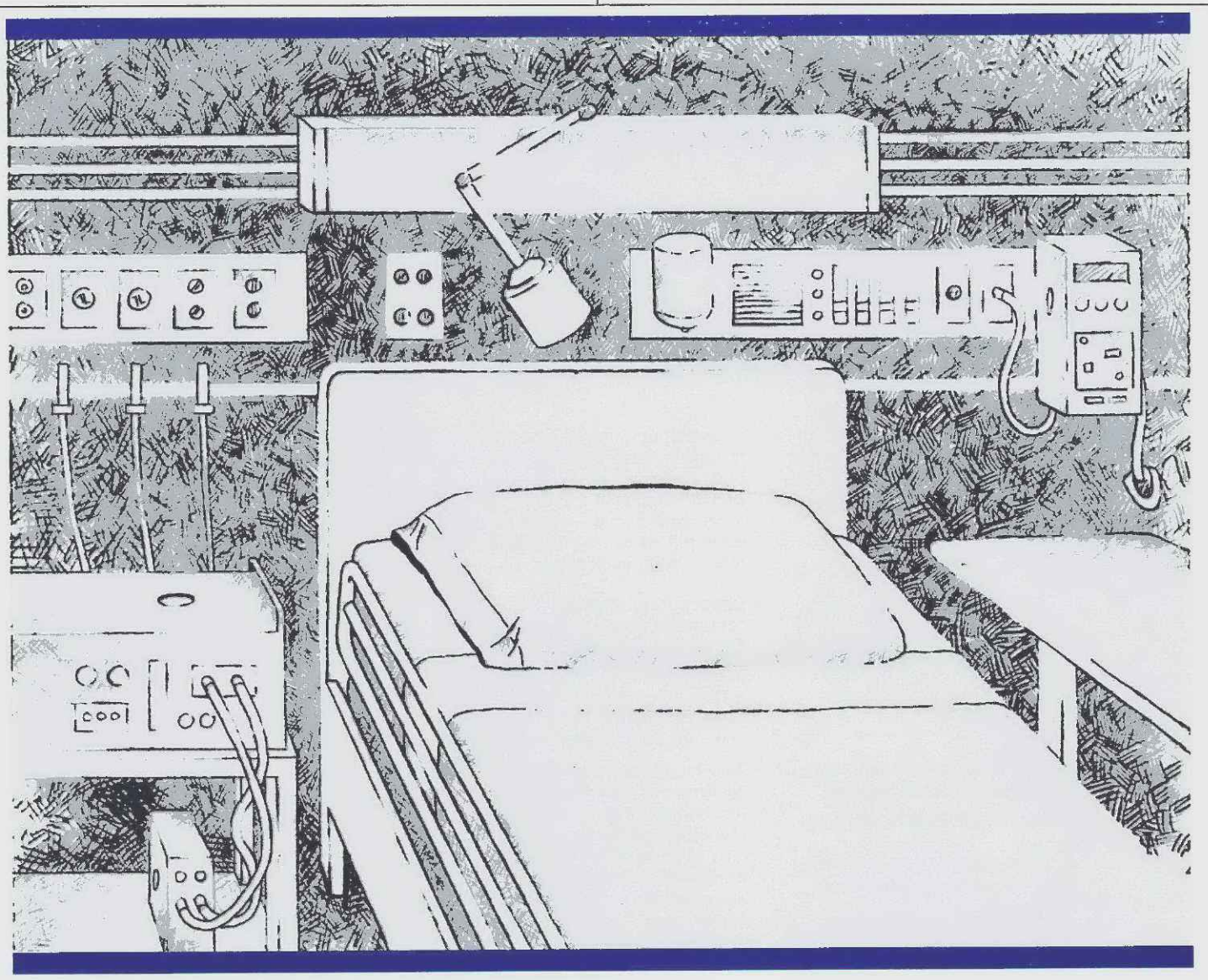
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Second Opinion
AMBULATORY SURGERY PROGRAM

Malpractice costs rapidly rising: GAO

By JERRY GEISEL

washington

WASHINGTON—Medical malpractice costs are soaring, according to the General Accounting Office.

The GAO, in a report released last week, found that the nation's hospitals in 1985 paid more than $1.3 billion in malpractice costs, which are defined as insurance premiums, contributions to self-insured trusts and claims payments made from general revenues. That's up from $800 million in 1983.

During the same period, medical malpractice insurance costs for physicians doubled to $3.4 billion from $1.7 billion, the GAO reported.

Of hospitals' $1.336 billion in malpractice insurance costs in 1985, $866.8 million went to pay for insurance premiums, up from $562.4 million in 1983, a 54% increase.

In addition, contributions to self-insurance funds climbed to $350.6 million from $255.8 million, a 37% increase, while uninsured losses jumped to $118.6 million from $31.1 million, up 281%.

In 1985, 56% of hospitals had annual medical malpractice insurance costs of less than $100,000, down from 65% in 1983. On the other hand, hospitals whose insurance costs exceeded $500,000 increased to 12% in 1985 from 7% in 1983.

Other GAO findings on malpractice costs include:

- The average annual malpractice cost per hospital bed rose to $1,784 in 1985, up from $1,000 in 1983, a 78% increase.
- Last year, the average malpractice cost per inpatient day increased 85% to $5.60 from $3.02 in 1983.
- Among various practice categories, obstetricians and gynecologists paid the highest malpractice insurance premiums in 1984: an average of $18,800, up from $10,900 in 1982, a 72% increase. Peciatricians paid the lowest premiums: an average of $3,500 up from $2,900 in 1982, a 21% increase.

Other average premiums and the percent they rose between 1982 and 1984 by physician speciality include: surgery, $13,400, up from $9,900, a 35% increase; internal medicine, $4,900, up from $3,700, a 32% increase; and general/family practice, $4,600, up from $3,500, a 31% increase.

The GAO report, requested by Rep. John Porter, R-Ill., was based on questionnaires sent to 1,782 hospitals and an analysis of data compiled by the American Medical Assn., as well as independent research.

Health coverage

The number of workers covered by employer-provided health insurance plans is slipping, according to a benefits research organization.

The Washington-based Employee Benefit Research Institute says that 130.3 million persons were provided with health care coverage through employer plans in 1984, down from 131.2 million in 1982.

Some 65.1% of the non-elderly population had employer-sponsored health insurance coverage in 1984, compared with 67.1% in 1982.

While the number of people with employer-sponsored coverage declined, the number of individuals without any health insurance in 1984 increased to 34.7 million, or 17.4% of the non-elderly population, up from 30.3 million or 15.5% of the non-elderly population.

In both 1982 and 1984, about 50 million people either purchased individual policies or were covered under public programs, like Medicaid, EBRI said.

Reasons cited by EBRI for the decline in employer-sponsored health insurance coverage include:

- The economic recession hit hardest in industries—like manufacturing and mining—where health insurance coverage is most likely to be offered, resulting in layoffs and the cancellation of coverage. At the same time, employment grew in service industries, where employers are least likely to provide health care coverage.
- Rising health insurance costs may have deterred employers from starting new health insurance plans.

"Because of the expense, some employers, particularly smaller firms, in which one-half of recent new job opportunities arose, may have been reluctant to establish health plans for their employees," EBRI said.

Employer spending for group health insurance, as a percent of wages of wages and salaries, climbed to 5.3% in 1984, up from 1.2% in 1960.

EBRI found that higher-income workers were far more likely to be covered under employer health care plans than low-income employees.

For example, in 1984, 54.6% of workers earning less than $10,000 were covered under employer plans, compared with 85.8% of those earning between $10,000 and $19,999 and 93.9% of employees earning more than $20,000.

However, the percentage of working men and women covered under employer plans was virtually even: Some 75.6% of men were covered by employer plans in 1984, compared with 75.4% of women workers.

Tort reform targets

The American Tort Reform Assn., a Washington-based lobbying organization, says it has targeted 19 states and the District of Columbia in which it will concentrate its efforts next year to overhaul the civil justice system.

Those states are Arizona, California, Georgia, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Mississippi, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Texas, Virginia and Wisconsin.

At the same time, ATRA has prepared for use by state business lobbyists its major recommendations and justifications for specific changes to tort laws.

For example, in its recommendation to eliminate joint and several liability, ATRA says the theory is inequitable because a defendant only slightly at fault can be fully liable for a plaintiff's damages.

"Joint and several liability leads to a search for a 'deep pocket' and has made governments, large corporations and other insured entities bear the greatest burdens of liability when their involvement in an injury is minimal," the ATRA recommendation says.

In another area, ATRA's recommendations for changes to state punitive damages statutes include:

- A second trial, after a defendant is found liable, should be required to determine whether punitive damages should be awarded.
- While juries should decide whether punitive damages should be awarded, judges should set the amount.
- A "meaningful limit," which ATRA does not define, should be placed on the amount of punitive damages that can be awarded to the plaintiff.
- Clear and convincing evidence of actual malice or actual fraud should be required before punitive damages could be awarded by a court.

Tax simplification?

The original goal of tax reform may have been tax simplification, but the final product—The Tax Reform Act of 1986—is anything but simple.

The two-volume act—which includes the actual bill and the accompanying conference report written in thick, dense prose—weighs in at four pounds and totals 1,811 pages.

Despite its $37 price tag, hundreds of people waited in line last week in front of the Government Printing Office's main book store in Washington to obtain the first copies of the tax proposal as passed by a congressional conference committee.

For those who want to order by mail, copies of the measure are available through the U.S. Government Printing Office, Main Book Store, North Capitol and H Streets, Washington, D.C. 20401. Specify Report 99-841, Volumes I and II. ■

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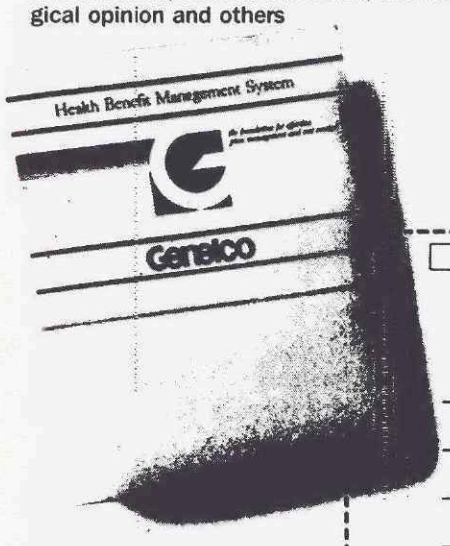
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Wisconsin to continue hot line

MADISON, Wis.—Funding for the Wisconsin Commercial Insurance Hotline will continue for an additional period of time, state Insurance Commissioner Thomas P. Fox says.

The hot line was established in May to assist commercial insurance buyers and agents and brokers attempting to find hard-to-find commercial insurance coverages.

The hot line is operated as a cooperative effort between the Wisconsin Office of the Commissioner of Insurance and the property/casualty insurance industry.

The service was recommended by the Special Task Force on Property and Casualty Insurance, which was formed by the state in November 1985 to assess and make recommendations concerning the commercial insurance crisis in Wisconsin.

While the service had been scheduled to expire at the end of this month, several insurers are now showing a willingness to write tough lines of business in Wisconsin and the hot line will be extended, the commissioner says.

"With expanded sources, the hot line will be in a better position to help consumers obtain insurance coverage," Mr. Fox explained.

The hot line can be reached by calling 414-453-0123 between 8 a.m. to 4:45 p.m. Monday through Friday. ■

Benefits for New Yorkers better than average: Survey

LINCOLNSHIRE, Ill.—Salaried employees in New York have retirement and hospitalization benefits that are slightly better than the national average, but those benefits are slightly below average for salaried employees in Chicago, according to a survey conducted earlier this year.

To make this comparison, Lincolnshire-based Hewitt Associates broke out data on the individual cities from the information contained in its nationwide survey of employee benefits, "Salaried Employee Benefits Provided by Major U.S. Employers in 1985."

That survey studied a variety of benefits provided to salaried employees by 812 employers nationwide (*BI*, June 2).

Hewitt found that 96% of the New York companies offered a pension plan, compared with 91% of the employers nationwide. But, only 89% of the Chicago employers offered pension plans to their salaried employees.

Also, 67% of the New York employers offered a savings or thrift plan with an employer match and with a 401(k) option, compared with only 59% of the Chicago employers and 65% of the employers nationwide.

Eleven percent of the New York employers offered such a plan without a 401(k) option, compared with 9% of the Chicago employers and 10% of the employers nationwide.

The majority of employers in New York paid 100% of the reasonable and customary fees for hospital room and board charges, while the majority of employers in Chicago paid only 80%.

In New York, 71% paid 100% of reasonable and customary charges, and 13% paid 80%. In Chicago, only 15% paid 100% of reasonable and customary charges, and 53% paid 80%.

Nationwide, 45% paid the full bill for reasonable and customary hospital room and board charges, while 34% paid 80%.

In Chicago, 83% of employers had a front-end deductible that was applied to hospital room and board charges as well as to other expenses. Only 34% of the employers in New York and 54% of the employers nationwide had such a deductible.

Eighty-three percent of the Chicago employers and 87% of the New York employers extended medical coverage to retirees after age 65, compared with 93% of the employers nationwide.

Second surgical opinions were mandatory for certain procedures for 44% of the Chicago employers and 42% of the New York employers, compared with 41% of the employers nationwide.

Half of the Chicago employers offered the same coverage for the surgical procedures, whether or not the second opinion was obtained, compared with 54% of the New York employers and 52% of the employers nationwide.

And, 6% of the Chicago employers offered an incentive, in the form of higher coverage, for obtaining a second surgical opinion, compared with 4% of the New York employers and 7% of the employers nationwide.

Eight percent of the New York employers and 6% of the Chicago employers made outpatient surgery mandatory for certain procedures, compared with 10% of the employers nationwide.

And, 54% of the Chicago employers offered an incentive in the form of higher coverage for outpatient surgery, compared with only 40% of the employers in New York and nationwide.

But, 62% of the New York employers provided coverage for hospice care, compared with only 47% of the Chicago employers and 58% of the employers nationwide.

Finally, 83% of the New York employers offered dental coverage to their salaried employees, compared with 89% of the employers in Chicago and nationwide.

And, 24% of the Chicago employers offered a vision care plan, compared with 13% of the employers in New York and 20% of the employers nationwide.

•

Copies of the survey, "Salaried Employee Benefits Provided by Major U.S. Employers in 1985," are available for $25 each from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

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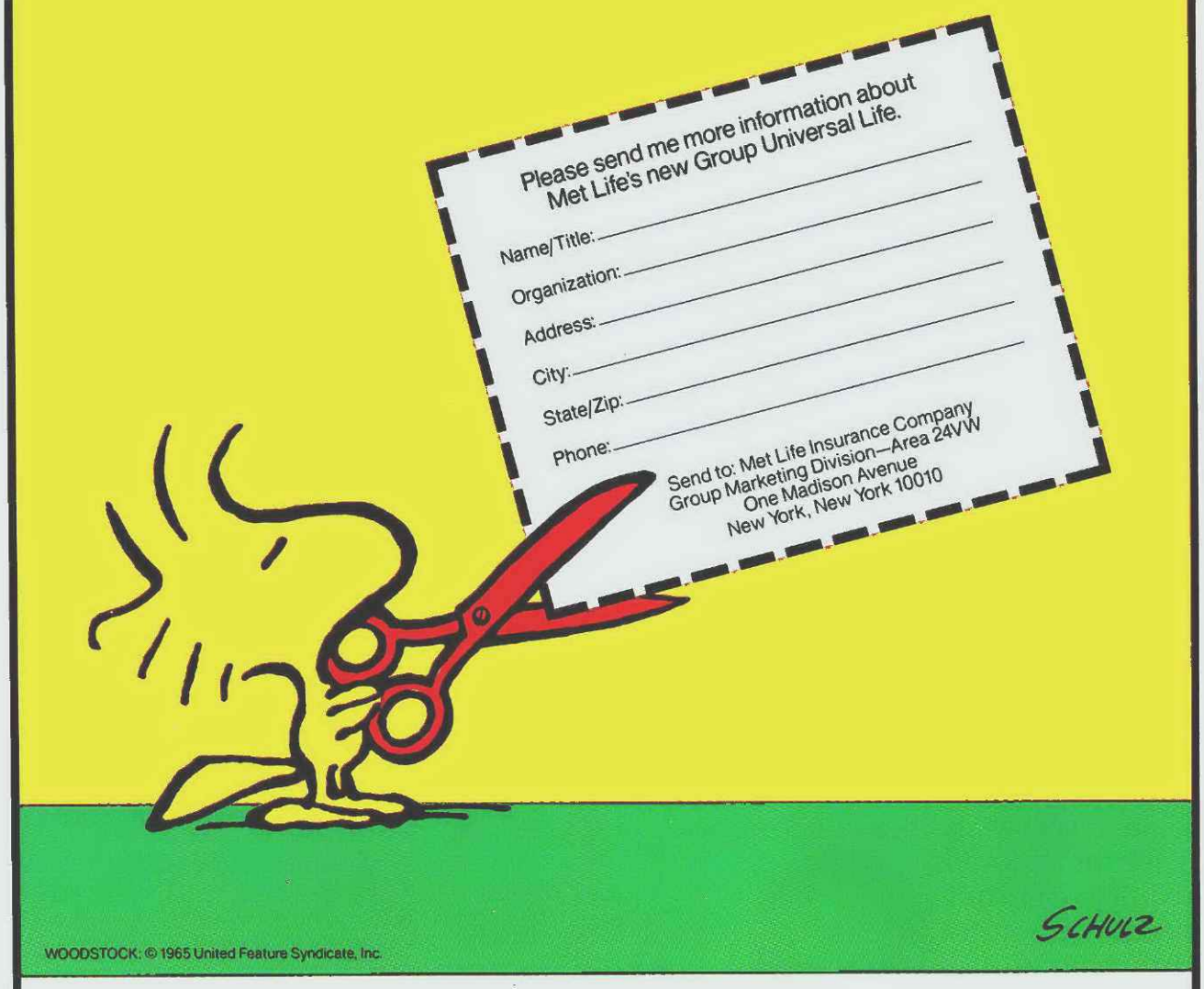
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Companies using benefits to attract directors: Study

LINCOLNSHIRE, Ill.—Increasingly, companies are offering some benefits as well as cash compensation to those people who serve as outside directors, according to a recent survey.

In the survey, "Compensation and Benefits for Outside Directors in the Fortune 100 Industrials, August 1986," consultant Hewitt Associates examined both the cash and the non-cash compensation given by 97 of the top 100 industrials to their outside, or non-employee, directors.

Providing employee benefits and allowing outside directors to defer their cash compensation are becoming increasingly important tools as companies try to lure talented people to their boards of directors, according to Hewitt.

"More large corporations are using deferred compensation opportunities and employee benefits to attract and retain 'good' directors in today's environment of increased accountability and public scrutiny," explained Peter S. Egan, a Hewitt consultant.

"In fact, retirement benefits—with their promise of future payments—currently may be more attractive to directors than additional taxable cash," Mr. Egan said.

Specifically, the survey, which was based on proxy statements filed by the companies with the Securities and Exchange Commission, noted:

- Some 35% of the companies provided a pension plan for outside directors, up from 28% in the 1985 survey.

Most of the companies had eligibility requirements for the pension plan, based on age and years of service.

- Directors at 71% of the companies were allowed to defer all or part of their cash compensation until a later date, usually upon retirement or when a director terminates his or her relationship with a company.

'Retirement benefits—with their promise of future payments—currently may be more attractive to directors than additional taxable cash,' Mr. Egan says.

- Twenty percent of the companies provided life insurance coverage for outside directors, up from 17% last year. The typical amounts of coverage provided were $50,000 or $100,000.
- Fourteen percent of the companies provided an accidental death benefit, up from 9% last year.

The amount of the benefit provided ranged from $100,000 to $1 million, although some companies limited coverage to business travel only.

- Only 4% of the surveyed companies provided medical and dental coverage for their outside directors.

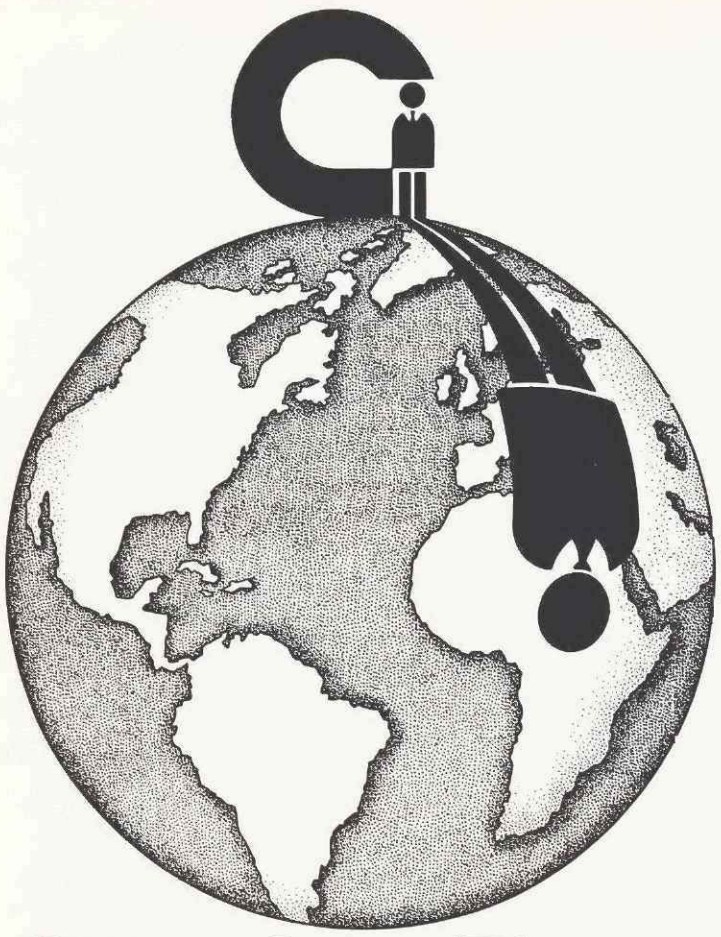
In addition, the survey found that 98% of the companies paid their outside directors an annual retainer. The retainers ranged from $10,000 to $46,500, with an average of $20,485.

And, 81% of the companies paid additional amounts for each meeting the director attended.

The total amount of cash compensation reported ranged from $18,500 to $50,000, with an average of $31,160.

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Copies of "Compensation and Benefits for Outside Directors" are available for $45 each from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.



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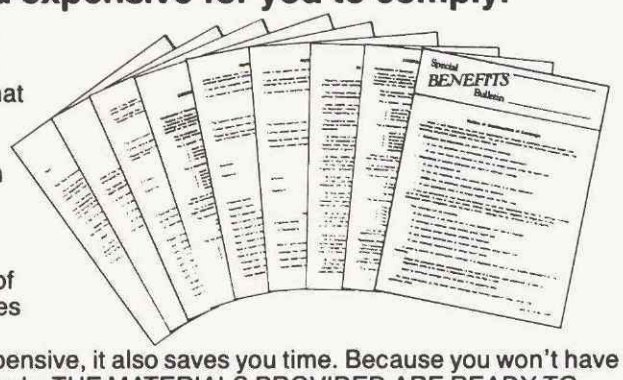
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New consulting firm serves self-insurers

Companies that are self-insured or are considering self-insurance now have a clearinghouse of experts to which to turn for advice.

The Self Insurance Exchange Inc., with headquarters in Irving, Texas, is a national network of independent companies that provide consulting services to employers in both property/casualty and group health benefits, said Andrew J. Cmiel, president of the company and an officer of the Self Insurance Institute of America.

The network includes "pre-qualified, pre-screened vendors that can provide assistance or products to a client that is self-insured or that is looking at alternatives to the traditional insurance market," he said.

Mr. Cmiel said the companies provide information on a variety of self-insurance issues, including:

- Risk management.
- Third-party administration.
- Risk management information systems.
- Medical cost management programs.
- Loss control.
- Structured settlements.

The exchange has divided the country into six regions, Mr. Cmiel said. SIEX has consultants in the Northeast, the Southeast, the Central states, the South Central states, the Western states and the Northwest, Mr. Cmiel said.

Clients pay a $125 annual registration fee for unlimited use of the exchange, he said. All clients also complete a detailed questionnaire, which the exchange then uses to refer the client to particular companies in the network that meet their insurance and geographic needs, he said.

SIEX is now finalizing its board of directors, which includes specialists in law, financial aspects of self-insurance, underwriting, benefits, and self-insurance for associations and municipalities.

"We make professional referrals. However, there is no obligation on the client's part to use the companies once they have consulted them. This is not a franchise—everyone's an independent," he explained. "The whole intent is to offer alternatives to traditional insurance to the insurance-buying public."

SIEX is located at 414 Santa Fe Trail, Suite 93, Irving, Texas 75063; 214-556-0869.

New insurer

A notice of intent to incorporate a new stock casualty insurance company has been filed with the New York Insurance Department.

The company, HANYS Insurance Co., will be capitalized at $11 million and will write only excess personal injury liability coverage for physicians, said Joel Glass, a partner with the New York-based law firm of Ackerman, Salwen & Glass, and counsel for the 15 incorporators of the insurer.

Coverage limits to be provided have not yet been determined.

Hospitals will be the stockholders of the new company and representatives of the hospitals probably will be the principal officers of the insurer, Mr. Glass said. He could not say when a stock offering will take place.

The company will be affiliated with the Hospital Assn. of New York, he said.

"This is a very limited-purpose company. Because it will write only this specific coverage, it really will not provide any extra capacity to the casualty industry," he said.

The insurer probably will begin underwriting on Jan. 1 and will be located in Albany, New York, he said.

markets

Health management

A new company, National Health Management, intends to help benefit managers increase their clout when shopping for health care services.

NHM is being started by Iris Masotti, its president and the former project director of the Midwest Business Group on Health in Chicago. The company will help benefit managers negotiate collectively when shopping for health care providers, like preferred provider organizations and health maintenance organizations, and to better extract and understand data on the utilization of their health care plans.

It will market these services by community, beginning in Chicago in the coming weeks. Local participating employers would become members of a non-profit purchasing group.

The one-community-at-a-time approach will work well because the company's services depend partly on obtaining existing data from area HMOs and PPOs, Ms. Masotti explains. She expects the company to start up in six or seven cities over the next 12 to 18 months.

The company will work with Katten, Muchin, Zarvis, Pearl, Greenberger & Galler, a Chicago law firm with health law specialists, and with The Wyatt Co., a benefit consulting firm.

For more information, contact Ms. Masotti at NHM, 525 W. Monroe St., Suite 1600; Chicago, Ill. 60606.

New offices

The office of Michael P. Dangelo, director of risk consulting for **Minet/Osborne Post & Kurtz** has moved to 11 Broadway, New York, N.Y. 10004; 212-425-5771.

CIGNA Corp. has consolidated its subsidiary companies in San Francisco into a new office located at 101 California St., San Francisco, Calif. 94111; 415-954-1300.

In addition, CIGNA has opened a new office in the St. Louis area: Five CIGNA Corp. subsidiaries have been consolidated into one office located at 8182 Maryland Ave., Clayton, Mo. 63105; 314-726-7700.

Rollins Burdick Hunter, the insurance brokerage division of Combined International Corp., has relocated its headquarters to 123 N. Wacker Drive, Chicago, Ill. 60606; 312-701-4000.

Mergers/acquisitions

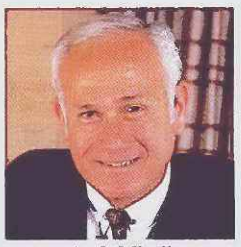
Morency, Weible & Sapa Inc., a Hinsdale, Ill.-based insurance agency has acquired **The Solin Insurance Agency** of LaGrange, Ill., and **Bower Yeisley Agency** of Lombard, Ill. The agencies have been merged into Morency, Weible & Sapa's location at 950 York Road, Hinsdale, Ill. 60521; 312-887-0910. ■



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People and Performance

General Dynamics begins drug-abuse counseling

St. Louis-based General Dynamics Corp. has hired a substance-abuse consultant to assess the company's abuse-related problems and educate and counsel employees.

Quatro Associates of Annapolis, Md., will visit all of the company's locations to meet with management and employees, said a spokesman for General Dynamics.

Quatro will interview employees, evaluate the degree of abuse problems and direct troubled employees to rehabilitation, he said.

The program includes drug screening—which is mandatory when employees are hired—counseling, rehabilitation and training.

General Dynamics has some 105,000 employees. Of those employees, about 40,000 belong to unions, including the United Auto Workers, which support the program, the spokesman said.

Outside drug testing firms will be used to evaluate samples collected from employees at all locations, he said.

Then, he said, "If the test is positive, the firm will refer the employee to the appropriate outside counselor for rehabilitation."

The company hopes that the program will help employees who have substance abuse problems as well as ensure the safety and productivity of the company operations, he explained.

benefit beat

FSA program

One benefit consultant that specializes in designing, implementing and administering flexible benefits plans for small employers practices what it preaches.

Devon, Pa.-based Consulting Group Inc., which establishes flexible plans for employers with between 20 and 1,000 employees, also offers its own 25 employees a flexible benefits plan, said Harriet Hankin, executive vp.

Under its plan, Consulting Group provides employees with a core of benefits including long-term disability, short-term disability, life insurance, profit-sharing and vacation time, said Ms. Hankin.

The company's LTD coverage is underwritten by Reliance Life Insurance Co. of Philadelphia. The plan provides employees with 60% of their salary, up to a maximum of $2,500 a month, said Vp Julie Mith.

The company self-insures its short-term disability, and the coverage provides employees with 70% of their pay, up to a maximum of $250 a week, she said.

Employees also are provided with $25,000 of life insurance, also insured by Reliance Life, she said.

Each employee also receives a "budget" of $200 plus 3.5% of their salary. They can elect to use the money to buy other benefits, defer the money to a 401(k) savings plan or receive it as taxable income, said Ms. Hankin.

With the budget, employees can elect a medical benefit plan, under which they do not pay a copayment or contribute to the premium, she said. However, employees do pay $250 per person per hospital admission. The plan, which has a $1 million lifetime limit on coverage, is underwritten by Blue Cross of Greater Philadelphia.

"Their budget covers their medical plan," said Ms. Hankin.

The flexible plan also includes a 401(k) plan, to which employees can defer the maximum amount allowable under Internal Revenue Service rules. The company matches employees' contributions at a rate of 50% of the first 3% of pay deferred.

Employees also are offered a health care reimbursement account and a dependent care reimbursement account.

They can place up to $250 on a pretax basis in the account to fund their deductible under the medical plan, she said. And, they can place up to $1,000 in the dependent care account.

Employees also can buy up to five extra vacation days to supplement the five days included in the core of benefits, Ms. Hankin said.

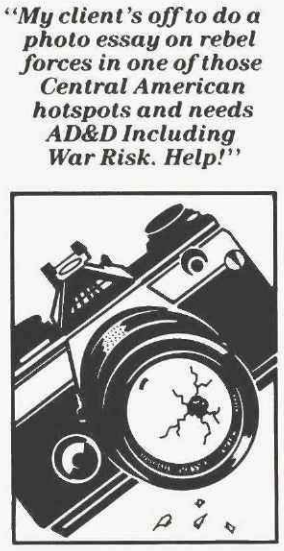
Consulting Group provides a full range of services when helping other employers introduce their own flexible benefits plans, Ms. Hankin noted.

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Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Donna DiBlase, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

Challenge #117

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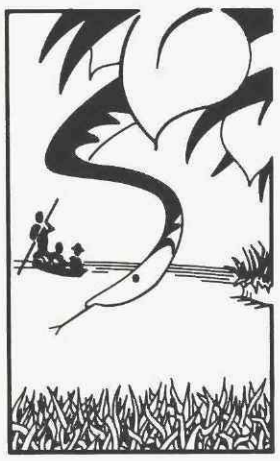
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Insurers say hurricanes a threat to many oil rigs in Gulf of Mexico

By STACY SHAPIRO

HAMBURG, West Germany—The more than 3,550 offshore and onshore oil rigs in and around the Gulf of Mexico are a potential nightmare for marine insurers.

One hurricane in the Gulf could wipe out those rigs, creating hundreds of millions of dollars in insured losses, according to underwriters attending the International Union of Marine Insurance conference in Hamburg.

And, the fact that so many offshore rigs are not in use—or are "laid up"—in the Gulf also adds to the potential liability, the underwriters say.

"There is a problem of accumulation of oil rigs in the Gulf," said Ed Cave, president of the All American Marine Slip in New York, managed by Marine Office of America Corp.

The places where the rigs are laid up "are right in the middle of the hurricane area," he said.

A lot of underwriters are especially nervous about the exposure during the current hurricane season, he added.

Also, some of the areas for lay-up "are not satisfactory from a safety point of view," he said. "The trouble with laying up by stacking is that it is a hazard."

Altogether, about $800 million to $900 million in worldwide premiums is generated annually from the oil and gas industry, he noted.

But, never before have so many drilling units been out of commission and laid up, IUMI conference members agreed. The slump in world oil trade caused by the reduction in the price of oil has forced oil companies to cut back or cease drilling operations altogether.

The British Marine Underwriters' Assn. estimated in a written IUMI report that as of May, only 56% of the world's offshore rigs were being used and the rest were stacked up.

American oil companies, in particular, have cut back drastically on oil and gas drilling, the report notes. Only 37% of U.S. offshore rigs are being used, and a total of 156 units are not in operation, the British report said.

In addition, only 600 out of 4,000 land rigs in the United States are operating, said the British Marine Underwriters' Assn.

"The stacking points of these will be variously spread over a number of states," said the report. "However, it will be remembered that the principal activity in the oil industry is concentrated in the southern states, most of which, again, are exposed to hurricanes.

"A favorite area for stacking has become the Sabine Pass in Louisiana (in the Gulf of Mexico), where it is reported that currently 34 rigs are laid up," the British report said. And, about 31 additional rigs are laid up on the fringes of the Gulf of Mexico, according to the report.

These rigs are "exposed to hurricane losses, and underwriters will realize that there is a distinct possibility of an accumulation risk there," the report said.

The unused rigs are only worth about 15% to 20% of what they were two years ago when they were operating, said Mr. Cave.

However, the rigs are insured for their full operating value to cover the cost of loans used to finance them, he said.

"So you can't reduce the (insured) value of the rigs," he said.

Therefore, each laid-up offshore drillship could be insured for $35 million to $45 million, each semi-submersible rig could be insured for between $35 million and $100 million and each jackup rig could be insured for between $15 million and $90 million, he said.

The major oil and gas industry insurance markets in London, the United States and Scandinavia are considering ways to address the problem of accumulation risk related to laid-up rigs in specific areas such as the Gulf, IUMI members were told.

The American Institute of Marine Underwriters, for example, said in a written report that "the American market is making inquiries of surveyors and owners to determine what increases in exposure result from these practices (of stacking and lay-up) with a view to determining what changes, if any, should be made in policy conditions."

Some policy changes might include the definition of the role of the surveyor, which currently is required to approve the lay-up location.

And, underwriters are seeking more consistency in policy wording. For example, some policies require a watchman to be on board the laid-up vessel, while others do not. ■

Hull rates to rise

Continued from previous page

receive a severe hit from the recent loss of the $159 million Dutch submarine Walrus, which could be one of the most expensive construction losses ever, noted Mr. Nunn.

The Walrus, which was about 70% reinsured by Lloyd's underwriters, caught fire at a Dutch shipyard last month, underwriters said. And, saltwater that was used to put out the fire ruined the technical equipment on the Walrus, which was being built for the Dutch Navy.

Marine underwriters also are concerned about a potential $90 million loss caused by fraudulent bills of lading on a cargo of coffee from Brazil, IUMI underwriters said.

IUMI underwriters also agree that inland marine rates will continue to harden.

Inland marine risks are most closely related to property/casualty risks, for which rates have doubled or tripled in the last year, noted Samuel T. Byron Jr., senior vp of Marine Office of America Corp. in New York.

Echoing the views of other underwriters, he said that although rates won't double or triple, "inland marine rates are doing well now because of the association with the rest of the property/casualty business."

Inland marine includes coverages for contractors equipment, truck cargo, legal liabilities, bridges, tunnels, dams and television towers, he said.

IUMI underwriters also say that:

- Insurers are concerned about the number of inactive oil rigs currently stored—or laid up—in the hurricane-prone Gulf of Mexico. Most of those rigs currently are insured for their full value (see related story.)
- Cargo rates continue to be cut by as much as 30% because there are relatively few losses and underwriting profit for insurers (see story, page 76).
- The marine underwriters' share of the world's total premium volume has dropped drastically.

John Hickey, deputy manager of the American Hull Insurance Syndicate in New York, noted that, whereas in 1800 marine insurance made up 30% of the world's premiums, today it only accounts for 3%.

"The marine influence among (insurance) companies has become so diminished over the past decade that we now find that our contribution to premiums in the U.S.A. is a minuscule 1.8% of the overall," he said.

"Our once influential loud voice has turned into a whisper at best."

Roughly 60% of the world's marine insurance and reinsurance is written in London through underwriters at Lloyd's of London and the Institute of London Underwriters, IUMI members agree.

The second and third-largest marine insurance markets are the United States, where the Marine Office of America Corp. is the largest marine insurer, and Norway.

Marine underwriters generally cover ships, cargo, onshore and offshore oil rigs, marine-related risks such as oil terminals, war risks and liabilities. ■



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Cargo insurance rates remain cheap

By STACY SHAPIRO

HAMBURG, West Germany—Cargo insurance remains reasonably priced worldwide, even though most other marine, property and casualty coverages are more expensive, marine underwriters say.

But, underwriters meeting at the recent International Union of Marine Insurance conference in Hamburg were cautioned about the danger of under-pricing their product.

Competition and continued profitability with few major losses have kept cargo rates depressed for many years, the underwriters agreed.

Although hull rates are marginally increasing and property/casualty rates remain high, cargo insurance rates may be reduced by as much as 30% over last year, the underwriters pointed out.

"The cargo (insurance) business is marginally profitable," said Samuel T. Byron, Jr., senior vp of Marine Office of America Corp.

But, he cautioned, "Cargo insurance is the most freely traded item. The rate is down while world trade is down, so there is a deterioration of premium."

Cargo premiums in Japan, for example, have decreased 30% in the last year, said Kazutomo Kokubu, general manager of the cargo department of the Sumitomo Marine & Fire Insurance Co. Ltd. in Tokyo.

Cargo insurance is among the few lines in which premium discounts are still offered freely. For example, cargo insurers will give discounts up to 20% if the cargo is shipped in large trailer-size containers, which tend to reduce risks, noted George Jones, senior vp-marine of The Atlantic Cos. in New York.

Although there is no estimate of the premium volume written by cargo underwriters during the last 10 years, a review of the American cargo underwriters reveals that from 1975 to 1985 the U.S. underwriters suffered a total of $102 million in losses that were in excess of $500,000, Mr. Jones noted.

The largest single loss was $7 million, and about $44 million of the total was from cargo washed overboard, he said.

But, despite the absence of major losses, cargo underwriters should exercise caution in setting rates, the experts say.

Geoffrey Merriman, chairman of IUMI's cargo loss prevention committee, said, "It is clear that there is no easing up of loss or damage to cargo. . . .Serious shortage losses continue to arise. . . .And, there continues to be a noticeable amount of fraud. Insurers should be on their guard."

Marine underwriters warn that rates should be increased in anticipation of future major losses, such as those that might occur if fire, flood or theft wipes out millions of dollars of cargo stored in containers.

"It is a difficult transition for cargo underwriters," noted Mr. Jones. "Rates have fallen, but there is a failure to take into account the major exposures involved in containerization. I hope that the risks will be rated more realistically.

"Underwriters should be able to develop adequate rates and make at least a small profit," he said.

Today, nearly all cargo is shipped in large containers that can be transported by ship, rail, truck and aircraft. Containerization, which is was begun 30 years ago, revolutionized cargo shipping and handling, noted Mr. Jones.

There are now almost 400 ports around the world that handle containers, added Bo Wahllof, senior vp and chief executive of the marine department of Skandia Insurance Co. Ltd. in Stockholm, Sweden.

Proper stowing of the goods in the containers is the key to preventing loss, Mr. Wahllof said. Cargo must be packed tightly to avoid any movement as it pitches and rolls on the seas, he said.

"There are many directions on how to stow goods," he said.

But, Mr. Byron noted, "The largest single cause of loss is losing containers overboard."

Underwriters may be able to reduce these losses by hiring surveyors to spot-check the fastening of these containers onto decks, said Mr. Byron.

"People do not do what you expect. But people do what you inspect," he said.

Security also can be a major problem, noted Mr. Byron. "Just tracing a cargo is a task of awesome proportion," he said.

"Ingenious criminals are stealing cargo. . . .Railroads are known to have a great deal of problem with security."

Other major causes of loss include condensation, holes in the containers and inadequate bills of lading, underwriters noted.

In addition, underwriters were told they should ask questions about the way cargo will be packed and handled during the journey and about security for the cargo, Mr. Wahllof said.

But, he added, "When so much of world trade is shipped in containers, it is difficult to ask these questions in advance. Underwriters are left out of many decisions." ■

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Soviet, British underwriters share Soviet cruise ship loss

By STACY SHAPIRO

HAMBURG, West Germany—Soviet and British underwriters will pay some of the liability claims resulting from the sinking of a Soviet cruise ship in August that killed about 390 people, according to a Soviet marine underwriter.

However, the amount the underwriters will pay for oil pollution cleanup costs and personal injury claims will depend on the outcome of a current Soviet government investigation into the collision of two Soviet ships that caused the sinking, said Michael Safronov, deputy director of the state-owned Soviet insurer Ingosstrakh—Insurance Co. of the U.S.S.R. Ltd.—in Moscow.

"The night was clear and the sea was calm" on Aug. 31 when the 5-year-old cargo carrier Petr Vasev collided with the 61-year-old cruise ship Admiral Nakhimov nine miles out of port in the Black Sea, Mr. Safronov said at a International Union of Marine Insurance meeting. About 390 people drowned or were missing from the Admiral Nakhimov, he said, and 10 people remain hospitalized. There were no injuries on the Petr Vasev, although the ship suffered severe damage to the bow.

The Petr Vasev was carrying Canadian grain, though substantial oil pollution resulted from the accident and is still being cleaned up, he said.

The Soviet government, which currently is investigating the collision, will determine which ship was at fault, he said.

Both ships are owned by Black Sea Shipping Co. in the Soviet Union, he said. Neither ship is insured for hull damage, Mr. Safronov added, noting that few ships in the Soviet Union are insured for hull losses. However, each ship has third-party collision coverage that will pay one-quarter of the other's hull loss.

Forty percent of the liability coverage for both ships is written by Ingosstrakh, while the other 60% was written by London-managed protection and indemnity club United Kingdom Mutual Steamship Assurance (Bermuda) Ltd., Mr. Safronov said. The Admiral Nakhimov is insured only for oil pollution cleanup costs, while the Petr Vasev is insured for pollution and third-party liability claims, he said.

If the Petr Vasev is found to be responsible for the collision, "which is probable," its insurers will have to pay Admiral Nakhimov's pollution cleanup costs and compensation to the survivors of the victims, he noted. If the Admiral Nakhimov's crew is found to be negligent, then pollution costs will be paid by insurers, but compensation to survivors will be paid by Black Sea Shipping.

Travel companies that issued the cruise tickets also may have some liability, depending on the wording of the tickets, he said.

Under Soviet law, the maximum liability for which the vessels are responsible is limited to 20 rubles ($29.40) per gross registered ton, which totals 372,080 rubles ($546,958) for the Petr Vasev and 341,060 rubles ($501,358) for the Admiral Nakhimov.

Oil pollution claims are limited to 120 rubles ($176.40) per gross registered ton, or 2.23 million rubles ($3.3 million) for the cargo carrier and 2 million rubles ($2.94 million) for the cruise ship, Mr. Safronov said.

However, claims for personal injury losses are unlimited, and the Soviet government will not set a limit on the losses from the Admiral Nakhimov, he said.

In a private interview, Mr. Safronov detailed the hull and liability insurance for most vessels in the Soviet Union, noting that the Mikhail Lermontov, which sank off New Zealand earlier this year, was only insured through Ingosstrakh for oil pollution cleanup. Normally, the Soviet fleet is not insured for hull damage because the ships are owned by the state, although Ingosstrakh provides protection and indemnity coverage for the vessels.

In most cases Ingosstrakh writes 25% of liability coverage for tankers with 75% written by British P&I clubs. Liability coverage for passenger ships are 40% insured with Ingosstrakh and 60% nsured with the P&I clubs, he said. Those ships that sail only in Soviet waters are insured just for oil pollution claims, while Soviet ships that sail outside Soviet waters are also covered for third-party liability claims, he said. Ingosstrakh participates in international insurance and reinsurance programs through its London subsidiary, Black Sea & Baltic General Insurance Co. Ltd. ■

Oil well blowout fuels premium hikes

By STACY SHAPIRO

HAMBURG, West Germany—Several leading London marine underwriters are enforcing tighter policy wording and charging higher premiums for energy exploration and development insurance.

The action follows the most-expensive oil-well blowout in history on Sept. 20, 1984, at Sable Island, 320 miles off Nova Scotia.

The blowout cost $143 million to control, 94% of which was covered by insurance, attendees at the recent International Union of Marine Insurance conference in Hamburg were told.

"It is the largest well-control claim and the largest offshore oil claim in oil exploration," noted Ed Cave, president of the All American Marine Slip in New York, which led most of the coverage.

The new wording for energy development and exploration insurance, which was developed by London insurers, including Lloyd's of London underwriters last year and reissued Sept. 1 for 1987 renewals, includes coverage for control-of-well costs, redrilling and extra expenses, and seepage and pollution cleanup costs.

However, it excludes for the first time coverage for punitive or exemplary damages, and it limits the coverage for liabilities arising from seepage and pollution from a blowout.

In addition, policyholders must pay additional premiums for five endorsements to the policy to cover costs related to salvage of a damaged well, controlling well problems underground, steps taken to avoid a loss, extended redrilling and restoration and evacuation of people and property.

"This year will probably see a reduction in the overall number of blowout claims," said Peter Portman, deputy underwriter for Lloyd's of London's B.G. Adams syndicate.

"However, there is now nowhere near the premium volume to support any sort of major loss."

And, he told members of the IUMI, "I feel it is true to say that the wording has been widely accepted."

Mr. Portman explained to the conference attendees why underwriters feel a new wording is necessary.

A group of five London underwriters began to consider a new policy wording five years ago, after losses under operators extra-expense policies totaled $400 million in 1980 and 1981, Mr. Portman said.

He noted that estimated premiums worldwide had never exceeded $100 million in any year and had averaged around $70 million, he said. But, despite this, policies were still being issued for $100 million to $300 million in per-occurrence limits, he said.

A working party was set up and "a tremendous amount of work" went into drafting a wording, Mr. Portman said. But, although premium rates increased, the wording was never issued, he said.

"This was because by late 1982 there still existed quite unrealistic competition for this class of business both internationally and within the London market," he said.

"It was felt that London brokers would not cooperate in selling a new, more restrictive wording to their clients while also being asked to sell substantial rate increases.

"Regrettably, it was decided to abandon the standard wording concept for the time being," he said.

By late 1983, the claims situation had improved, but underwriters still were showing an overall deficit for the class of business, he said.

As a result, the chairman of the London Drilling Rig Committee—composed of representatives of Lloyd's and the Institute of London Underwriters—asked Lloyd's and ILU underwriters to look again at ways to improve the underwriting of well-control coverage, Mr. Portman said.

Mr. Portman, along with other underwriters, formed a working party to draft a new wording. After 18 months of work, the wording was issued in September 1985, and then was revised and reissued on Sept. 1 of this year, he said.

The current energy exploration and development insurance policy is divided into three sections:

- Control of well insurance. To make the wording more specific, underwriters have avoided using the word "blowout" and now use "well out of control" and "well brought under control."
- Redrilling/extra expense insurance. Redrilling claims have accounted for about 50% of all control-of-well-related claims since 1977, Mr. Portman said, adding that the new wording allows underwriters to charge more premium for this risk.
- Seepage and pollution, cleanup and contamination insurance. The underwriters "engaged in long discussion with London liability underwriters in order to draft this section," said Mr. Portman.

"These discussions resulted in the limitation of coverage to liability arising out of an above-surface blowout following a claim recoverable under (control of well insurance) of the policy."

Although this coverage is still written on an occurrence rather than a claims-made basis, the new wording creates "considerable restriction" of coverage, he said.

More underwriters and brokers are supporting the new wording now than they might have a few years ago because of the Sable Island accident.

Because of its proximity to the Labrador current and the Gulf Stream, Sable Island has treacherous currents and extensive fog, and it has been the site of many shipwrecks, said Mr. Cave.

The first shipwreck was recorded in 1583, but Mr. Cave noted, "I believe that the accumulative value of all these wrecks did not reach the cost of controlling the blowout which occurred Sept. 20, 1984."

Controlling the well involved two different procedures: controlling the surface explosion and drilling relief wells to ease the pressure on the damaged well.

The cost to control the well above the surface, including evacuation, totaled $103 million, Mr. Cave said. And, drilling relief holes in October 1984 and January 1985 cost an additional $40 million, he said.

It took a total of nine months to bring the well under control, he said.

And, he noted that "Although one year has passed since the control operations were completed, the claim itself has not been absolutely finalized." ■

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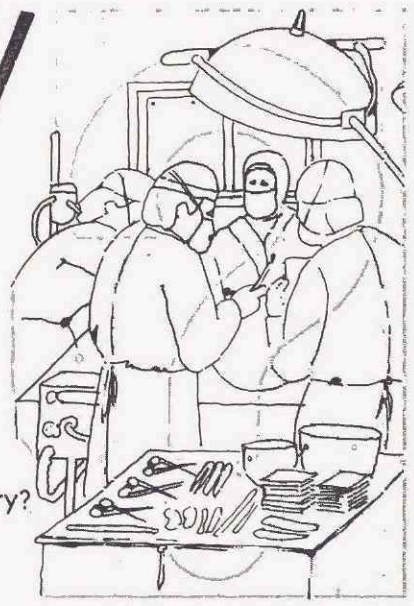
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OCT. 6-8. Annual Government Risk Management Seminar in Washington, sponsored by the Public Risk & Insurance Management Assn.; $390 for PRIMA members; $350 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 6-8. Seventh Annual Governor's Safety and Health Conference in Anchorage, Alaska, sponsored by the Alaska Safety Advisory Council $200. Nancy Cannington, Alaska Department of Labor, P.O. Box 7-018, Anchorage, Alaska 99510.

OCT. 6-10. Management and Administrative Skills for the Occupational Health Professional course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $700. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 7. Automating Risk Management for Profit and Survival seminar in Livonia, Mich., sponsored by SOFTEC Inc.; free. **Also Oct. 7** in Dallas; **Oct. 9** in Houston; **Oct. 14** in Chicago; **Oct. 16** in Minneapolis; **Oct. 21** Washington, D.C.; **Oct. 23** in Baltimore; **Oct. 28** in New York; **Oct. 30** in Boston; **Nov. 4** Kansas City, Mo.; **Nov. 6** in St. Louis; **Nov. 11** in Cincinnati; **Nov. 13** in Cleveland; **Nov. 18** in Los Angeles; and **Nov. 20** in San Francisco. Jack Bergers, SOFTEC Inc., 33063 Schoolcraft Road, Livonia, Mich 48150; 313-261-4440.

OCT. 7-8. The Bermuda Insurance Marketplace seminar in Hamilton, Bermuda, sponsored by Malcolm Butterfield Associates; $155. **Also Oct. 14-15, Oct. 16-17, Oct. 30-31, Nov. 4-5.** Malcolm Butterfield Associates, P.O. Box HM 2100, Hamilton 5; 809-295-5472.

OCT. 8. Workers Compensation for the Day-to-day User in Corono-Norco, Calif., sponsored by Xorcium; $95. **Also Oct. 15** in Los Angeles; **Nov. 5** in San Fernando Valley, Calif. Karen Gillett, Xordium, P.O. Box 8422, Newport Beach, Calif. 92658-8422. 714-759-1707.

OCT. 8-10. Risk Management Information Systems course in New York, sponsored by the Risk & Insurance Management Society; $600 for RIMS members; $700 for non-members. Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 9. The 1986 Tax Act-How it Affects Insurance Companies seminar in Chicago, sponsored by Ernst & Whinney; $275; $125 for each additional registrant from the same organization. **Also Oct. 16** in New York, **Oct. 23** in Los Angeles. Kathy Stewart, Ernst & Whinney, 18th Floor, 1285 Avenue of the Americas, New York, N.Y. 10019; 212-554-8289.

OCT. 9. Protecting Directors and Officers: Risk Management Alternatives seminar in New York, sponsored by the Risk & Insurance Management Society; $125 for RIMS members; $175 for non-members. **Also Oct. 24** in Anaheim, Calif.; **Nov. 7** in New Orleans. Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 9-10. Quality Control in Alternative Health Care Settings conference in Dallas, sponsored by the American Hospital Assn.; $325 for AHA members; $400 for non-members; $275 for each additional registrant from the same organization. American Hospital Assn., P.O. Box 98946, Chicago, Ill. 60693; 312-280-6083.

OCT. 9-10. National Institute on Workers Compensation: A Review of Remedies, Emerging Developments and Costs in New York, sponsored by the American Bar Assn. Tort & Insurance Practice Section; $350 for ABA members; $325 for TIPS members; $375 for non-members; $300 for young lawyers; $75 for law students. American Bar Assn., Division for Professional Education, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

OCT. 9-10. Risk Management: A Step Into the Future seminar in New York, sponsored by J. Mattman Security Inc.; $550. J. Mattman Security Inc., 645 S. State College, Suite E. Fullerton, Calif. 92631; 714-870-4110.

OCT. 9-10. Coping with Employee Benefits Reform seminar in New York, sponsored by the Practising Law Institute; $390; $40 for course handbook only. **Also Oct. 23-24** in San Francisco. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

OCT. 12-15. International Assn. of Industrial Accident Boards & Commissions 72nd Annual Convention in Louisville, Ky.; $175 for active member or associate member; $240 for non-member; $100 for spouse or guest. IAIABC 72nd Annual Convention, P.O. Box 10103, Bowling Green, Ky. 42101; 502-223-4018 or 502-564-5575.

OCT. 14. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance workshop in New Orleans, sponsored by the Society of Chartered Property Casualty Underwriters; $125 for CPCU members; $140 for non-members. **Also Nov. 17** in Washington, **Nov. 19** in Los Angeles, **Nov. 21** in Seattle. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB ‡9, Malvern, Pa. 19355; 215-251-2741.

OCT. 14. Insurance Industry Day: Tort Reform—Is It the Answer? seminar in Little Rock, Ark., sponsored by the Arkansas Chapter of Chartered Property Casualty Underwriters; $25. Kevin O'Donnell, Arkansas Chapter of CPCU, Danville Building, Suite 400, 10810 Executive Center Drive, Little Rock, Ark. 72211; 501-223-6700.

OCT. 15. Cost Containment and Quality Assurance: The Impact on Today's Dental Profession symposium in East Rutherford, N.J., sponsored by Delta Dental Plan of New Jersey Inc.; $60. Delta Dental Plan of New Jersey Inc., 299 Cherry Hill Road, P.O. Box 222, Parsippany, N.J. 07054; 201-334-6300. Ext. 342.

OCT. 15-16. Business Interruption Basics course in San Francisco, sponsored by Property Claim Services division of American Insurance Services Group Inc.; $95 for PCS subscribers; $145 for non-subscribers. Property Claim Services, Education and Training Department, 700 New Brunswick Ave., Rathway, N.J. 07065; 201-388-5700.

OCT. 15-17. Fortieth Annual Fall Conference Council on Employee Benefits in Boston, sponsored by the Council on Employee Benefits; $300 for CEB member company or association (for each individual); $350 for non-me2bers. C.S. Lazaroff, Goodyear Relief Assn., 1144 E. Market St., Akron, Ohio 44316; 216-796-4008.

OCT. 15-17. Meeting Your Responsibility for Worker Training and Right to Know course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $400. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 15-17. Retirement Advisors Workshop in Chicago, sponsored by Retirement Advisors Inc.; $495. **Also Nov. 5-7.** Retirement Advisors Inc., 919 Third Ave., New York, N.Y. 10022; 212-421-2400.

OCT. 16. Risk Management: Challenges of Changing Times workshop in Northbrook, Ill., sponsored by Chicago, Wisconsin and Northeastern Illinois chapters of the Risk & Insurance Management Society; $75 for members of RIMS and prospective members. Patricia Benedick, Ameritech Corp., 30 S. Wacker Drive, Chicago, Ill. 60606; 312-750-5196.

OCT. 16-17. Buying Reinsurance in 1987 conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for other registrants from organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 in New York.

OCT. 16-17. Risk Financing Alternatives: Coping With the Crisis in Coverage course in New York, sponsored by the American Management Assn.; $695 for AMA members; $800 for non-members. **Also Nov. 6-7** in San Francisco; **Nov. 24-25** in Chicago. AMA, P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 17. Managing the Health Care System symposium in Chicago, sponsored by Blue Cross and Blue Shield of Illinois; $95. Rosemary Longo, Blue Cross/Blue Shield of Illinois, 233 N. Michigan Ave., Chicago, Ill. 60601; 312-938-6155.

OCT. 17-18. Alternative Delivery Systems: Strategies for Physician Control conference in Washington, sponsored by the American Society of Internal Medicine; $350 for ASIM members; $425 for non-members. Teresa Crumpler, American Society of Internal Medicine, 1101 Vermont Ave., N.W., Washington, D.C. 20005-3457; 202-289-1700.

OCT. 18. Burns: Emergency Management for Occupational Health Nurses course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $125. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 19-22. Asia/Pacific Conference in Singapore, sponsored by the Risk & Insurance Management Society; $500. Risk & Insurance Management Society, Conference Department, 205 E. 42nd St., New York, 10017; 212-286-9292.

OCT. 20. Keeping Pace With Employee Benefits conference in Philadelphia, sponsored by Penjerdel Employee Benefits Assn.; $75 for member full day, $50 for member half day; $90 for non-member full day, $65 for non-member half day. Penjerdel Employee Benefits Assn., 1346 Chestnut St., Suite 800, Philadelphia, Pa. 19107; 215-545-1234.

OCT. 20-21. How to Audit and Check Insurance Policy Costs and Coverage course in St. Louis, sponsored by the American Management Assn.; $675 for AMA members; $775 for non-members. **Also Oct. 27-28** in Philadelphia; **Nov. 6-7** in St. Petersburg, Fla.; **Nov. 13-14** in Dallas; **Nov. 17-18** in Bloomington, Minn.; **Nov. 20-21** in Boston; **Nov. 24-25** in Parsippany, N.J. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 20-21. The Third Annual Hazardous Waste Litigation Symposium in Garden City, N.Y., co-sponsored by Rivkin, Radler, Dunne & Bayh and the Hofstra University School of Law; $375. Hazardous Waste Litigation Symposium, P.O. Box 5009, Garden City, N.Y. 11530; 800-522-5351; 800-225-7155 in N.Y.

OCT. 22-23. Strategic Planning for Raising Capital for the Insurance Industry conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 in New York.

OCT. 22-25. Eighth Annual Educational Conference and Professional Trade Exhibition of the American Society for Hospital Risk Management of the American Hospital Assn. in Washington, sponsored by the ASHRM, Maryland Society for Healthcare Risk Management and the Risk Management Division, Hospital Council of the National Capital Area; $390 for ASHRM/MSHRM or RMD, Hospital Council of the National Capital Area members; $450 for non-members; $325 for each additional registrant from the same organization; $125 for full-time students. American Hospital Assn., P.O. Box 98946, Chicago, Ill. 60693; 312-280-6083.

OCT. 23. Employee Benefits workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for members; $180 for non-members. **Also Nov. 7** in Binghamton, N.Y.; **Dec. 11** in Dallas. PRIMA., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 24. Managing Police Liability workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

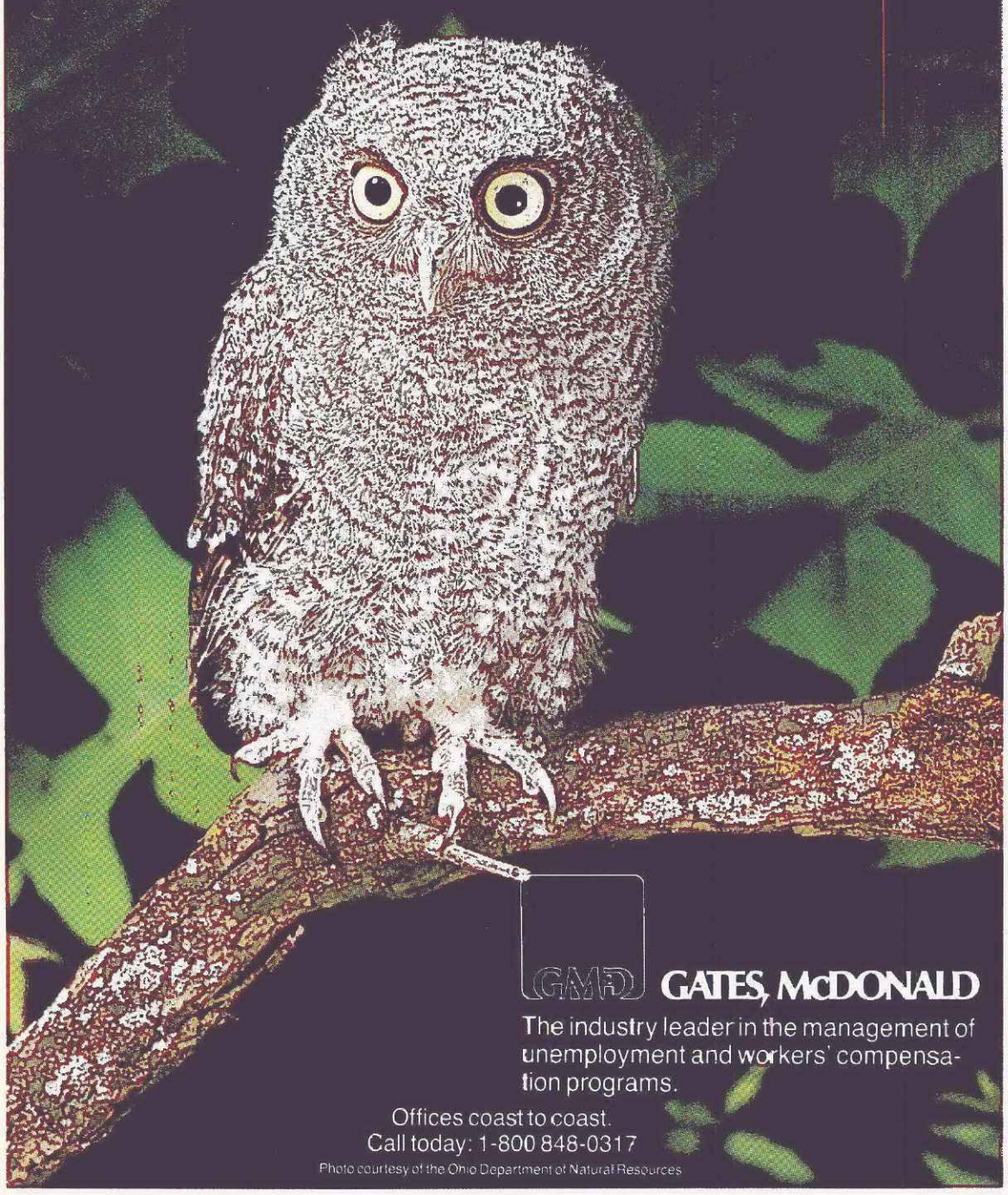
OCT. 27-31. Self-Insurance Institute of America Inc.'s Sixth Annual National Educational Conference in Denver. Registration options are: section A (property/casualty and workers compensation issues) $425 for SIIA members, $525 for non-members, $75 for spouses; section B (employee benefits issues) $425 for SIIA members, $525 for non-members, $75 for spouses; and Section C (encompasses both A and B) $525 for SIIA members, $625 for non-members, $95 for spouses. Conference Registrar, SIIA 1986 National Conference, P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

OCT. 28. ISO Commercial General Liability Rating workshop in Dover, Del., sponsored by the Insurance Society of Philadelphia; $65 for ISP members; $75 for non-members. **Also Nov. 13** in Philadelphia. Delaware Tech, Office of Continuing Education, 1832 N. DuPont Parkway, Dover, Del. 19901. For Philadelphia location: Insurance Society of Philadelphia, Public Ledger Building, Philadelphia, Pa. 19106.

OCT. 29-30. Insurance Industry Mergers and Acquisitions conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

Continued on next page

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Continued from previous page

OCT. 29-31. Liability Insurance Alternatives: From Crisis to Innovation conference in Washington, sponsored by the National Health Lawyers Assn.; $375 for NHLA members; $425 for non-members. Limited discounts available to students, academicians or government employees. National Health Lawyers Assn., 522 21st St. N.W., Suite 120, Washington, D.C. 20006; 202-833-1100.

OCT. 30-31. Techniques of Self-Insurance course in New York, sponsored by the Practising Law Institute; $390; $40 for handbook only. PLI, Dept. 105-Z7, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700. Ext. 286.

OCT. 30-31. Public Agency Risk Pooling seminar in New Orleans, sponsored by the Public Risk & Insurance Management Assn.; $150 for PRIMA members; $250 for non-members. **Also March 5-6** in Clearwater Beach, Fla. PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 31. Managing and Controlling Asbestos Contamination/Exposure course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $150. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

NOV. 3. Hedging with Financial Futures in the Insurance Industry seminar in New York, sponsored by Peat, Marwick, Mitchell & Co.; $400. Peat, Marwick, Mitchell & Co. Executive Education, 810 Seventh Ave., New York, N.Y. 10019; 212-603-3811.

NOV. 3-7. Sampling and Evaluating Airborne Asbestos Dust course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; $710. University of Southern California, Institute of Safety and Systems Management, Office of Extensions and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

NOV. 5-7. Marine Cargo Insurance and Ocean Cargo Claims seminars in New York, sponsored by the World Trade Institute; one day: $410, $365 for additional registrant from the same organization; two days: $640, $575 for additional registrant; three days: $815; $730 for additional registrant. (Marine Cargo Insurance seminar is Nov. 5-6. Ocean Cargo Insurance seminar is Nov. 7.) Registrar, The World Trade Institute, One World Trade Center, Floor 55 West, New York, N.Y. 10048; 212-466-4044.

NOV. 5-7. Claims Management course in New York, sponsored by the Risk & Insurance Management Society Inc.; $490 for RIMS members; $590 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

NOV. 6. Loss Control & Safety workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. **Also Nov. 14** in Tampa, Fla. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 6-7. National Employee Benefits Institute's West Coast Employee Benefits Meeting in Costa Mesa, Calif.; free for members; $395 for non-members; $100 for each additional registrant. National Employee Benefits Institute, 2550 M St. N.W., Suite 785, Washington, D.C. 20037; 800-558-7258 (ask for Sandy Sparacino).

NOV. 6-7. Utilization Management Issues and Innovations: An Emerging Discipline symposium in Orlando, Fla., sponsored by the American Hospital Assn. and the Florida Utilization Review Assn. of the Florida Hospital Assn.; $300 for AHA/FHA/FURA members; $350 for non-members; $50 discount for additional registrants from same organization. American Hospital Assn., P.O. Box 98946, Chicago, Ill. 60693; 312-280-6083.

NOV. 7-8. Municipal Liability: The Search for Deep Pocket course in Orlando, Fla., sponsored by the American Bar Assn. Tort & Insurance Practice Section; $350 for ABA members; $325 for TIPS members; $375 for non-members; $300 for young lawyers; $75 for law students. American Bar Assn., Division for Professional Education, Department NI 438, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

NOV. 9-13. National Assn. of Independent Insurers' 41st Annual Meeting in Atlanta; $250 for members; $350 for non-members and subscribers; $100 for spouses. National Assn. of Independent Insurers Convention Office, 333 N. Michigan Ave., Suite 1632, Chicago, Ill. 60601

NOV. 10. Insurance Representation, Specifications and Negotiations seminar in Dallas, sponsored by the International Risk Management Institute Inc.; $235. International Risk Management Institute Inc., 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231-3390; 214-363-9596.

NOV. 10-11. Ergonomics Building Efficiency and Safety in the Workplace course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extensions and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

NOV. 10-13. Sixth Annual Construction Insurance Conference in Dallas, sponsored by the International Risk Management Institute Inc.; $595; $485 for Tuesday through Thursday only; $235 for Monday only. International Risk Management Institute Inc., 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231-3390; 214-363-9596.

NOV. 10-14. Assets Protection Course I—Concepts and Methods course in Dallas, sponsored by the American Society fr Industrial Security; $690 for ASIS members; $750 for non-members. American Society for Industrial Security, 1655 N. Fort Meyer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

NOV. 10-14. Modern Safety Management course in Atlanta, sponsored by the International Loss Control Institute; $695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-466-2208.

NOV. 12-14. Back Injury Prevention course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; $275. University of Southern California, Institute of Safety and Systems Management, Office of Extensions and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

NOV. 13. Self-Insurance and Other Risk Financing Techniques workshop in Tampa, Fla., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. **Also Dec. 12** in Dallas. PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

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comings & goings: industry

Haayen named CEO, chairman of Allstate

Richard J. Haayen has been elected chairman of the board and chief executive officer of Allstate Insurance Group in Northbrook, Ill. He succeeds **Donald F. Craib Jr.**, who is retiring.


Mr. Haayen

Mr. Haayen joined Allstate in 1951, and served in several management positions around the country.

In addition, **Wayne E. Hedien** will replace Mr. Haayen as president of Allstate. Mr. Hedien had been the insurer's vice chairman, treasurer and chief financial officer. Mr. Hedien joined Allstate in 1966.


Mr. Hedien

Other insurer changes:

Robert C. Winters will succeed **Robert A. Beck** as chairman and chief executive officer of The Prudential Insurance Co. of America following Mr. Beck's Feb. 5 retirement. Mr. Beck, who will observe his 36th anniversary with the insurer on his retirement date, had been chairman and CEO since 1978.

After his retirement, Mr. Beck will become chairman emeritus of Prudential and will serve as an unpaid consultant.

Also at Prudential, **I. Edward Price** elected senior vp and corporate actuary, succeeding **A. Douglas Murch**, who recently was elected executive vp. Mr. Price had been vp in charge of Prudential's enterprise planning unit.

Donald J. Goaley named senior executive vp and director of affiliates for Mutual of Omaha Cos. in Omaha, Neb. Mr. Goaley has served as senior executive vp and associate coordinator of affiliates since 1982.

William A. Kellstrom appointed vp-group operations for Mutual of Omaha and United of Omaha, Mutual's life insurance affiliate. Mr. Kellstrom joined the companies earlier this year.

Edmund F. Schubert named senior vp-commercial lines of The Atlantic Cos. in New York. Mr. Schubert had been vp-commercial underwriting at the company since 1974.

Robert J. Hytha named senior vp-field operations of Liberty Mutual Insurance Co. in Boston. He succeeds **Joseph M. Gaudreau**, who retired after 39 years with the company. **Daniel P. Heldman** will replace Mr. Hytha as vp and Middle Atlantic Division manager.

Agents/brokers

Ed Horton named vp of McCord Insurance Services in North Hollywood, Calif. Mr. McCord had been an account executive.

Howard Genser Jr. named vp of Cranman Insurance & Financial Services in Savannah, Ga. Mr. Genser was formerly assistant vp at The London Agency in Atlanta.

Kevin Carr elected vp of Lawton-Byrne-Brunner Insurance Agency Co. in St. Louis. Previously, Mr. Carr was assistant manager of property underwriting in the Chicago office of American International Underwriters.

Reinsurers

Nicholas S. Dove named senior vp at Hudson Underwriting Ltd. and Hudson Reinsurance Co. Ltd. in Bermuda. Mr. Dove had been a vp of the units of the New York-based Skandia American Group.

Philip Marcell named chairman of the integrated operations of Continental Reinsurance U.K. and Unionamerica of Continental Reinsurance Cos.

Paul F. Drescher joined Summit Intermediaries Inc. as an insurance and reinsurance consultant in the firm's new Atlanta office.

Other suppliers

Dr. Joan B. Berkowitz named president and chief executive officer of Risk Science International, an environmental risk management consulting firm and a subsidiary of broker Frank B. Hall & Co. Inc. Dr. Berkowitz most recently was vp-hazardous waste consultant services at Arthur D. Little Inc.

Philip Ruggieri named vp of KBC Inc., the benefits consulting subsidiary of The Kornreich Organization in New York. Mr. Ruggieri had been a senior account executive at Connecticut General Life Insurance Co.

Harry S. Temple named vp of Health Risk Management Inc. in Minneapolis. Formerly HRM's director of consulting services, Mr. Temple will continue in that role and take on added responsibilities.

A. Bruce Johnston joined Consulting Associates Inc. in Charlotte, N.C., as vp. Previously, Mr. Johnston was an account executive at Arkwright-Boston Insurance Co. in Charlotte.

Joseph H. Ely named manager of Booke & Co.'s retirement consulting practice in the company's Winston-Salem, N.C., office.

Excess/surplus

Terry Dwyer named vp and manager of the San Francisco office of Stewart Smith West Inc. Previously, Mr. Dwyer was an assistant vp specializing in casualty and directors and officers liability.

In the Los Angeles office of Stewart Smith West, **Lana Miller** promoted to vp and manager of the professional and financial services department and **Fred Anderson** named executive vp. Ms. Miller had been assistant vp and assistant manager of the professional and financial services department and Mr. Anderson was senior vp.

At Stewart Smith Southwest Inc. in Dallas, **Andrew J. Herbert** promoted to senior vp from vp.

Patricia M. Rieger elected vp of Neal, Lloyd & Co. Inc. in Chicago. She had been assistant vp.

James C. Walls promoted to executive vp of Walsh & Walls Inc. in New York. Most recently, Mr. Walls was vp and director of special risks for the Quaker Agency in Sea Girt, N.J.

HMOs

Emanual Sandberg named president and chief executive officer of Heritage Health Plan of Southeastern Pennsylvania, a health maintenance organization serving the Delaware Valley. Mr. Sandberg is president and founding principal of Heritage Health Systems Corp. ■

Product liability

Continued from page 2

ages—excluding punitive damages—at $250,000 if a plaintiff rejected certain settlement offers (*BI*, June 30).

That provision, advanced by Commerce Committee Chairman John Danforth, R-Mo., was aimed at giving plaintiffs and manufacturers incentives to settle cases before they go to trial.

Under that provision, if a plaintiff rejected a manufacturer's offer to pay all economic losses and up to $100,000 for a "serious dignitary loss," the manufacturer's maximum liability for non-economic damages would be $250,000.

And, if the plaintiff made a settlement offer and the defendant rejected it, the defendant would be liable for the plaintiff's attorneys' fees, up to $100,000, if the plaintiff won.

But a number of senators, such Mr. Stevens and Mr. Inouye, denounced the caps as arbitrary and unfair to plaintiffs with serious injuries.

With this new bipartisan support for a substitute bill, Sen. Robert Kasten, R-Wis., the chief Senate proponent of federal product liability legislation, is optimistic that the Senate now will approve a bill before the session ends early next month.

"Because of the widespread support which this bipartisan compromise has already gathered, I am confident that it will be overwhelmingly adopted by the Senate when offered," Mr. Kasten said.

"The element of the bill that generated the strongest opposition will be removed. Now, there is much stronger support," said Liberty Mahshigian, co-counsel for The Product Liability Alliance, a Washington-based coalition of business groups that is lobbying for enactment of a federal product liability bill.

Indeed, product liability legislation last week passed one test, albeit a minor one, as debate began. The Senate rejected on a 96-0 vote a motion to table the measure.

However, a much tougher test was expected late last week when the Senate was to vote on a motion that would block a filibuster. That motion requires a two-thirds majority, and it wasn't clear if backers had sufficient votes.

If the motion fails, a filibuster led by Sen. Ernest Hollings, D-S.C., is certain. And, with so little time left in the session—Congress is scheduled to adjourn between Oct. 3 and Oct. 10—a filibuster would be fatal to the measure's chance of success.

Even if the Senate does approve a bill, the House will not act this year.

But the bill's backers say a Senate vote would give the bill a running start next year and increase the chances of congressional approval during the new session.

"Things would go much faster next year," Ms. Mahshigian predicted.

"It would be likely to be a first priority item next year," said Tom O'Day, associate vp at the Alliance of American Insurers in Washington.

Senate approval also would give a message to the business community that enactment of a federal product liability bill, after so many setbacks during the five years the issue has been debated in Congress, is possible and that they should continue their support, observers say.

Product liability reforms contained in the bill approved by the Commerce Committee and that the Senate is considering would:

- Eliminate joint and several liability for non-economic damages in product liability suits.
- Shield manufacturers from product liability lawsuits stemming from accidents involving capital goods that are more than 25 years old.
- Provide that in the case of consumer goods—except automobile and aircraft parts and other transportation products—products would be presumed not to be defective 10 years after they were manufactured. Suits involving transportation products could be filed regardless of the age of the product.
- Offset product liability awards by workers compensation benefits received by those injured in workplace accidents and eliminate subrogation actions between an injured worker's employer and the manufacturer found liable.
- Require product liability suits to be filed within two years of injury or within two years of the time a plaintiff discovered or should have discovered his or her injury.

Other provisions would impose financial penalties on attorneys who file frivolous lawsuits or delay cases through frivolous defenses; make it more difficult to sue U.S. manufacturers in U.S. courts for accidents that occur abroad; protect drug and aviation manufacturers whose products were approved by the Federal Drug Administration or the Federal Aviation Administration from most punitive damage awards; and give more protection from product liability suits to wholesalers and retailers.

In addition, Sen. Larry Pressler, R-S.D., is expected to introduce an amendment on the Senate floor to eliminate joint and several liability for economic damages in product liability cases.

And, Sens. Kasten, Richard Lugar, R-Ind., and Nancy Kassebaum, R-Kan., are expected to introduce an amendment that would establish a fault-based standard of defense that would protect manufacturers from liability if consumer negligence was responsible for an accident. ■

Insurers leaving reinsurance group

CHERRY VALLEY, Ill.—Four insurance companies that are members of Cherry Valley-based Mutual Reinsurance Bureau will be leaving the reinsurance association on Jan. 1, 1987.

But, two other insurance companies will be joining MRB at that time, according to a spokesman for MRB.

MRB is an association of insurers that assume reinsurance on a direct basis for regional property/casualty insurance companies, the spokesman said.

"We don't have any specialty business, but there are companies or organizations we specialize in, like churches," the spokesman explained.

As a result of these changes, the MRB's combined policyholder surplus will increase $430 million to $1.1 billion, according to the spokesman.

Auto-owners Insurance Co. of Lansing, Mich., and Federated Mutual Insurance Co. of Owatonna, Minn., will join the association.

The association already includes Employers Mutual Cos. and Farmers Mutual Hail Insurance Co. of Des Moines, Iowa; Millers Mutual Insurance Assn. of Alton, Ill.; Motorists Mutual Insurance Co. of Columbus, Ohio; and Shelter Mutual Insurance Co. of Columbia, Mo.

The insurance companies that will be leaving the association are Farmers Mutual Insurance Co. of Lincoln, Neb.; Grain Dealers Mutual Insurance Co. of Indianapolis, Ind.; Michigan Millers Mutual Insurance Co. of Lansing, Mich.; and Pennsylvania Millers Mutual Insurance Co. of Wilkes Barre, Pa. ■

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Lloyd's syndicates

Continued from page 2

($216.3 million), according to a letter to syndicate 799 members from Merrett Managing Director Kenneth Randall.

The syndicate exceeded its premium limit last year for several reasons, Mr. Randall said in the letter. For instance, Merrett did not maintain a central record of estimated premiums on a risk-by-risk basis, as it has this year, he explained.

"The dramatic increases in premium rates since late 1984 and the speed with which they were achieved took us by surprise; it is now clear that we failed fully to recognize the significant changes in the market conditions and therefore underestimated the flow of premium income," he said.

In addition, "many of the American companies which we were reinsuring vastly overwrote their expected premium income, with the result that the syndicate's proportion is greatly in excess of our expectation at the time the reinsurance contract was negotiated."

To avoid overwriting this year, Merrett installed new procedures and monitored premiums on a monthly basis, said Mr. Randall.

As of Sept. 10, total premiums paid in 1986 totaled 94.5 million pounds ($137 million) against the syndicates capacity of 200.8 million pounds ($291.2 million), he told the syndicate members.

And, on Sept. 15, to avoid overwriting, Merrett voluntarily ceased underwriting all new and renewal business for 1986 except policies that are written on a claims-made basis. These policies, if canceled, will trigger additional premium volume if policyholders purchase optional tail coverage that must be offered if the claims-made coverage is canceled, Mr. Jackson said.

'Whatever the syndicates write, there will be a capacity shrinkage and a continuity problem, but the move shows that Lloyd's is protecting the policyholder,' says Terry Mann, managing director of the property division of Price Forbes Ltd.

Nevertheless, Lloyd's issued its decree affecting syndicate 799 three days later.

"Lloyd's thinks not only will we overwrite 85% of our capacity, but 100%, and we do not believe that," said Mr. Jackson. "It is unnecessary (to issue the direction) when we had already voluntarily closed down for the year.

"We did overwrite last year because we were all caught by surprise on the vast increase in premiums" and by the fluctuating exchange rate between the dollar and the British pound, he said. "But Lloyd's thinks this year that we will exceed our premium income and we say we won't."

Lloyd's ban "is futile considering there is very little business to be written between now and the year end. And, it is business as usual for claims-made renewals," he said.

He also pointed out that the ban will not affect his syndicate's 1987 capacity nor Merrett's plans to form a new non-marine syndicate to be underwritten by John Fenn. That syndicate will write U.S. casualty business.

But it appears that Mr. Jackson's syndicate will reduce its volume next year.

Mr. Randall pointed out in his letter to members that Mr. Jackson's syndicate will not write any new business in 1987 and will only renew business for which it is the lead underwriter.

"The (Merrett) board will review the position on new business for the 1987 account when the detailed business plans and 1987 income allocations are available," the letter added.

Mr. Jackson also said syndicate 799 will reduce the amount of medical malpractice and casualty reinsurance treaties that it writes next year, but that the reductions in business will not be as severe as they were this year.

And, he adds, the syndicate will increase its participation on other types of treaties such as professional liability and banks' directors and officers liability, he said.

Mr. Maitland, deputy chairman of Janson Green, also says that his syndicates will not exceed 100% of their total capacity as Lloyd's claims. However, Mr. Maitland thinks the problems between his syndicates and Lloyd's stem from an error he made at the beginning of the year.

Lloyd's requires all underwriters to give a monthly forecast of their estimated premium volume over a 36-month period at the beginning of each year. Lloyd's then checks the syndicates' premium limits against the forecasts monthly.

Mr. Maitland explains he issued a lower estimate than he should have at the beginning of the year, which is why it appears his syndicates may overwrite their limits, when, in reality, they will not.

"There is a difference of opinion between ourselves and the Lloyd's Committee over the overwriting of our accounts," he said. "We gave a lower-figure forecast to the committee at the beginning of the year. It was an inadequate forecast. Our own estimates have been exceeded.

"Over a 36-month period, however, we do not think we will overwrite 100% of our capacity," Mr. Maitland added. "I am quite confident that the syndicates and the premium income is under control."

Janson Green is the last underwriting agency that remains to be sold by a broker to meet requirements in the Lloyd's Act of 1982, though its parent, Hogg Robinson Group P.L.C., recently announced Janson Green would be sold to the agency's management.

As a result, the agency is now in the process of being re-registered by Lloyd's, and some observers said that Lloyd's order against Mr. Maitland's syndicates could imperil the re-registration. But Mr. Maitland says the re-registration will proceed.

Lloyd's brokers fear that the closing of the six syndicates may reduce capacity for U.S. policyholders who need to renew their policies this year and may prompt some U.S. clients to avoid London when looking for coverage.

Lloyd's move "is a big shock," said one Lloyd's broker who asked not to be identified. "It doesn't help our image and it could mean that potential business from the U.S. might not be sent to London.

"The Maitland closure is more significant that the Jackson one for renewals," he added. "Maitland has been writing a broader book of business."

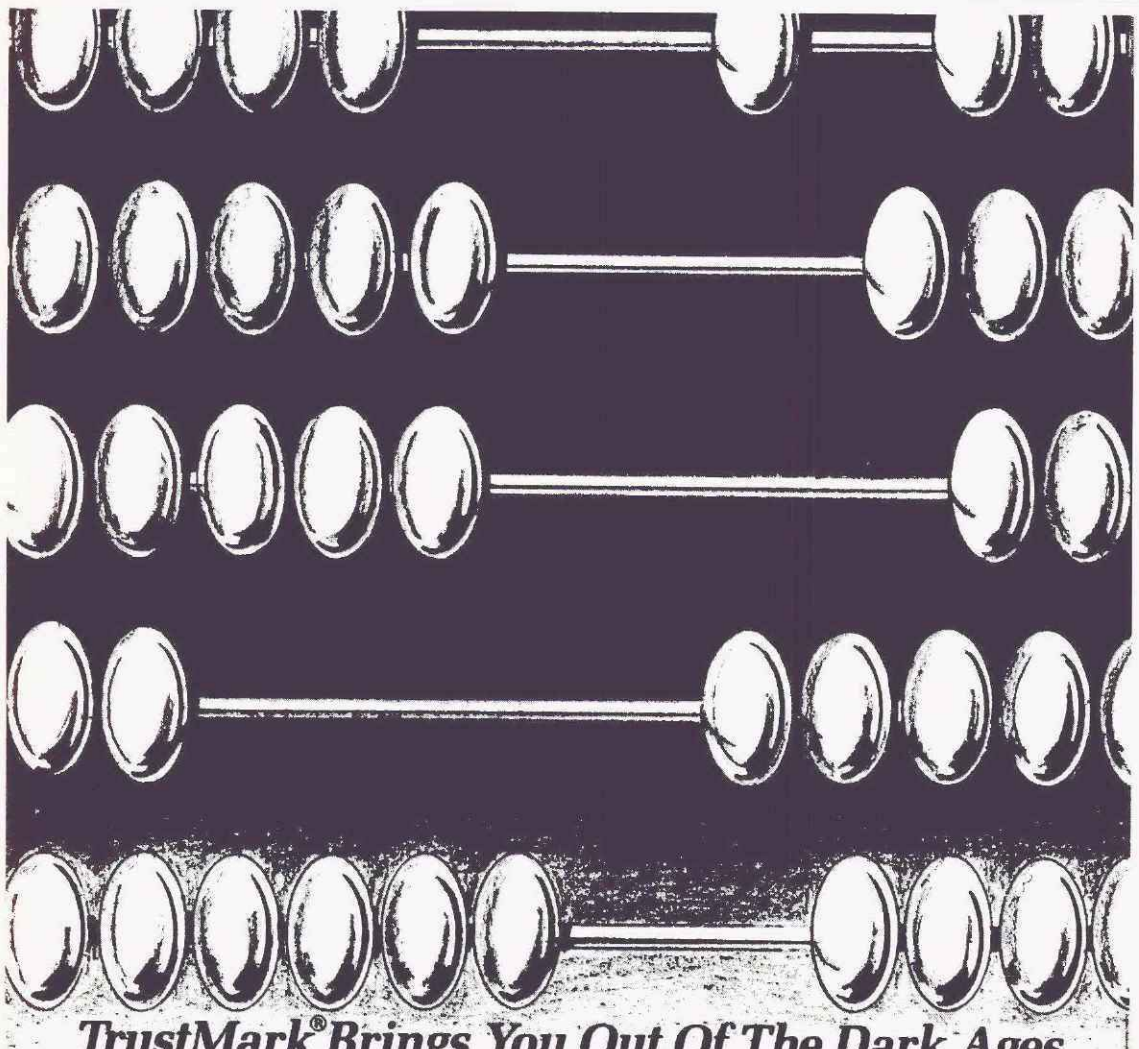
"Whatever the syndicates write, there will be a capacity shrinkage and a continuity problem, but the move shows that Lloyd's is protecting the policyholder," added Terry Mann, managing director of the property division of Price Forbes Ltd., a subsidiary of Lloyd's broker Sedgwick Group P.L.C.

"If that is what it takes to protect the policyholder, then it is a good thing," said Mr. Mann.

While the Lloyd's market was humming last week about Mr. Jackson's overwriting last year, at least one of the members of Mr. Jackson's syndicate is not worried.

"I am not unhappy about that," said the member, who spoke on condition of anonymity. "Technically it is wrong, but it is in a year when profits will be made.

"I have every confidence in Robin Jackson," he added. "And in some ways it is Lloyd's fault because Lloyd's makes syndicates report their results in pounds sterling instead of in dollars. Mr. Jackson seems to have been completely foxed by currency movements." ■



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Proposition 51

Continued from page 2

of 1986," protects defendants from having to pay non-economic damages in excess of their percentage of fault if other defendants cannot pay their share of an award.

The controversy centers on the question of whether California voters intended Proposition 51 to apply immediately to all lawsuits that were being litigated when the law was enacted, or only to subsequently filed lawsuits.

Plaintiffs' attorneys, who opposed the initiative, immediately hailed the appellate court's decision, but defense attorneys say the battle is far from over.

Harry F. Wartnick, a plaintiffs' attorney with Cartwright, Sucherman & Slobodin in San Francisco who argued the Russell case before the appellate court, described the decision as "a major victory."

"The battle is at least 75% won," he asserted.

Mr. Wartnick said the court has upheld the "integrity" of the initiative process.

"If private people are going to put initiatives on the ballot, they have to state in those initiatives what they want to do. They can't put something on the ballot and come back after it passed and say, 'We realize we didn't include language making it retroactive, but, gee, it would have been nice if we had and therefore it should be,'" Mr. Wartnick concluded.

"All this does is make this matter ripe for review by the California Supreme Court," countered Fred Hiestand, counsel to the Assn. for California Tort Reform, one of the groups that spearheaded the campaign for the initiative.

The appellate court agreed with plaintiffs' attorneys, who argued that the initiative does not specifically state that the initiative would be retroactively applied to pending cases, and, therefore, cannot be.

The court said it first studied the language of the proposition itself and found the absence of an express provision for retroactivity was "highly persuasive of a lack of intent."

The court said: "While it clearly applied prospectively to causes of action arising after its passage, the act contains no express provision for retroactive application to pending cases based on causes of action which had already accrued prior to its effective date."

Beyond the language of the initiative itself, accompanying ballot arguments and analysis did not support the argument to apply Proposition 51 retroactively, the court said.

"Nothing in these materials suggests a retroactive application; they are either worded in the future tense, as is the act itself, or are ambiguously worded in the present tense without sufficient indication that the voters understood their passage would impact pending cases based on previously accrued causes of action," the court said.

The court further noted that "retroactive laws are generally disfavored because the parties affected have no notice of the new law affecting past conduct."

Defense attorneys in the Russell case argued that voters wanted Proposition 51 applied to pending cases so the benefit of the new law would not be delayed for several years.

Defense attorneys contended that, by applying the new law prospectively, joint and several liability for non-economic damages actually would not be eliminated for four or five years, the typical amount of time it takes for a third-party legal action works its way through the California courts.

But the court disagreed. "The prospective-only application of Proposition 51 would satisfy an electoral intent for immediate relief of the public entity 'deep-pocket' insurance crisis, and would not delay the curative effect of the act until some 'remote' future time," the court ruled.

It also noted that retroactive application of Proposition 51 would diminish the liability of defendants without any corresponding reduction of insurance premiums, which were paid on the basis of the prior liability system.

"Such a windfall to insurance companies should not be lightly attributed to the California electorate," the court said.

"The very passage of the act has mitigated the insurance crisis by allowing a reduction of premiums," the court stated, noting that defendants—and their insurers—are not joint and severally liable for non-economic damages stemming from lawsuits filed after Proposition 51's effective date.

Defense attorneys also maintained that Proposition 51 is a procedural change, affecting the way in which liability awards are calculated, not a substantive change in legal liability.

But, the court concluded that Proposition 51 does significantly alter the substantive rule of joint and several liability—and therefore could not be given retroactive effect—because under the new law, a tort defendant no longer faces liability to a plaintiff for the totality of a judgment, but for only a fraction of that judgment.

"Given the reduction of the defendant's liability exposure, the substantive effect of Proposition 51 is evident," the court concluded.

The court said that defense attorneys attempted to prevent application of the "substantive" label to Proposition 51 by arguing that it does not totally abrogate a plaintiff's cause of action.

But, the substantive label "may be applied if the measure increases or decreases liability but falls short of total abrogation of a cause of action or a defense," which Proposition 51 does, the court concluded. ■

New study shows strong growth in HMOs

NEW YORK—There is a strong growth in health maintenance organizations nationwide, according to a new study conducted by a New York-based market research firm.

The study by FIND/SVP, called "Health Maintenance Organizations," shows that during 1985 the number of HMOs grew to 480 from 337 in 1984, for an increase of 42%.

During the same period, total HMO enrollment rose 26% to 21.1 million in 1985 from 16.7 million in 1984, according to the survey.

The research firm predicts that the growth of HMOs will continue, fueled by employers' concerns about rising health care costs and by a growing oversupply of physicians.

"We estimate that in 10 to 15 years, one-third of all medical care will be delivered through HMOs," says Peter Allen, manager of market research reports for FIND/SVP.

"Their strategies for reducing hospitalization and length of stay and controlling the use of physician and ancillary services already have been adopted by many medical care providers and insurers," Mr. Allen said.

"In time, their methods may become standard practice for the entire health care delivery system," he concluded. ■

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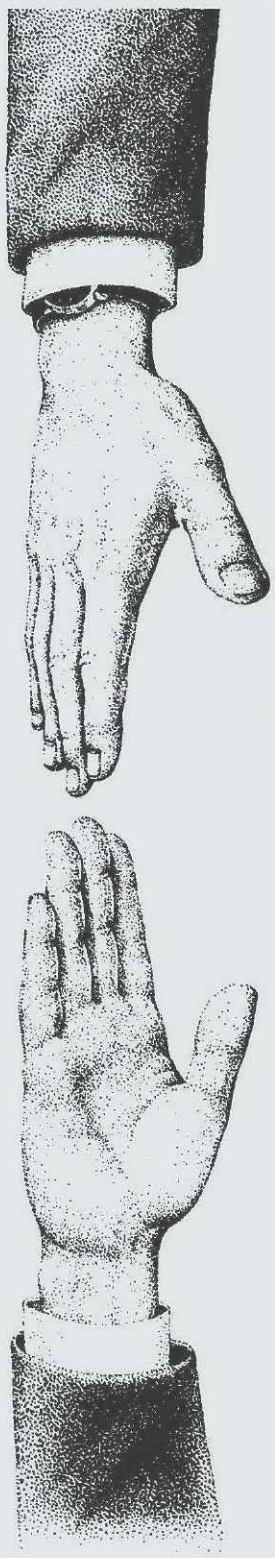
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Secretaries, Treasurers, controllers and other Financial Personnel..6,127

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....7,471

Sub-total 20,892

Associations 477
Government, Unions and Educational institutions 1,357

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Sub-total 22,726

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Insurance Companies.....7,168
Financial Institutions.....897
Actuaries, Attorneys, Adjusters, Appraisers and Consultants.....4,536
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* Source Business/Occupational breakdown of qualified circulation, May 26, 1986 issue, as submitted to BPA for June 1986 BPA Publisher's Statement.

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Grace sues insurers

Continued from page 1

first phase. With the settlement, the new trial is now moot.

The settlement was reached after the plaintiffs and Grace were notified of the granting of the motion, the company said.

Michael B. Keating, Grace's outside counsel, said the judge's order of a new trial was "very, very important to us" in settling the case. "Without that, we would not have settled," he said.

However, a plaintiffs' attorney denied that Judge Skinner's order for a new trial was an important factor in the settlement.

The Grace spokesman declined to reveal the terms of the settlement, but a source familiar with the litigation confirmed the $9 million figure.

Attorneys for plaintiffs and Grace both indicated they were satisfied with the settlement.

"We're very pleased," said Mr. Keating, with the Boston firm of Foley, Hoag & Eliot. "It got a serious problem involving time and effort behind us."

Mr. Keating, who also declined to reveal the amount of the settlement, said that another important factor in settling was the cost in bringing the case to trial.

"It would have been more expensive than settlement," he said.

Negotiations, which had been on and off since before the trial, intensified the last few days, Mr. Keating said.

Mr. Keating said that given the time and money spent by the plaintiffs, he did not regard it as "a substantial settlement" for plaintiffs and indicated it would not encourage similar toxic chemical litigation.

"It's not a very attractive opportunity if I were a plaintiffs' attorney," he said of this type of toxic chemical litigation. "It could very well discourage similar litigation."

Despite settling, Grace emphasized that it was not liable. "We continue to maintain and are now more convinced than ever that we did not pollute the wells and we were in no way responsible for the tragic events that affected our fellow residents in the Woburn community," the company said in a prepared statement.

"Despite this, our concern for the additional strain on the families, litigation costs, complexity of the case and the length of the trial caused us to conclude that a settlement not only made good sense but was virtually mandated by the circumstances."

But plaintiffs' attorneys said the case was very significant and would encourage toxic chemical litigation.

"We're very pleased with the outcome of the case," said Stanley W. Eller, with the Boston firm of Schlichtmann, Conway & Crowley.

"The sums were substantial and our goals were met," he said.

The "message" sent out in this case was that corporations can be held responsible for their disposal activities, Mr. Eller said, adding that it should encourage other plaintiffs who suspect they are injured by the activities of corporations in toxic chemical cases.

'We continue to maintain and are now more convinced than ever that we did not pollute the wells and we were in no way responsible for the tragic events,' Grace says.

Mr. Eller added that a number of factors entered into the settlement including the length of the trial, the strength of the cases and the complexity of the issues that the jury would hear. "All made up parts of the equation," he said.

In the insurance litigation, Grace's suit says Continental Casualty has paid defense costs in the Woburn suit since 1982 under the EIL policy and that Maryland Casualty agreed in March 1983 to participate in Grace's defense of the suit and share one-half of the defense costs with Continental Casualty.

However, the suit adds that Maryland Casualty has made only "insignificant" payments to date.

Continental Casualty paid $3 million in defense costs above a deductible under the EIL policy in which defense costs are charged against the policy's limits of liability, said a source who declined to be identified. Maryland Casualty paid less than $200,000, the source said.

The suit says that in March 1986 Continental Casualty told Grace it exhausted its coverage under the EIL policy and refused to make any more payments, contending that Hartford, as excess insurer over the Continental Casualty coverage, was obligated to defend Grace.

However, in April, Hartford refused to defend under its EIL policies. According to the suit, Hartford said that since the CGL policies written by Maryland Casualty and Continental Casualty had not yet been exhausted, those insurers should pay the defense costs.

Because of the insurers' refusal to pay the defense costs, Grace has had to pay more than $2.8 million, the suit says.

The suit asks that all three insurers be required to defend and pay Grace's liability in the underlying litigation and that the court declare the order in which the insurers should pay.

An attorney for Maryland Casualty disputed Grace's contentions.

"We understand Grace's dispute is primarily with its environmental impairment liability carriers," said Thomas W. Brunner, an attorney for Maryland with the Washington office of Piper & Marbury.

"Maryland Casualty went off Grace's risk in mid-1973 and Grace's own evidence and position is that any causative events of injury, if they occurred at all, postdated the end of Maryland's coverage," Mr. Brunner said.

An attorney for Hartford and a spokesman for Continental Casualty declined comment.

Beatrice is also litigating with its insurers in federal court in Chicago about defense cost coverage in the Woburn case. ■

Risk Retention Act

Continued from page 1

coverage through a risk retention group—would satisfy a financial responsibility requirement.

- Under the House bill, the Commerce Department would be required, among other things, to submit a report to the Congress on the effect, if any, that the Risk Retention Act has on easing the liability insurance crisis.

The Senate bill does not contain such a provision.

These and some other technical differences between the measures can be hammered out before Congress adjourns early next month, observers say.

"We expect that these differences can be resolved in a satisfactory manner," said Michael Mullen, an attorney with Crowell & Moring in Washington. Mr. Mullen represents a coalition of trade groups that favor enactment of the legislation.

"I believe this bill will become law. A conference committee should not be a major hurdle," adds Jon Harkavy, director of governmental affairs and general counsel for RIMS in New York.

While there are differences, the core of the two bills is identical: opening up the advantages of pooling and group purchase of casualty insurance—except workers compensation—to corporations, hospitals, trade associations and municipalities.

Under the bills, a risk retention group that is chartered or licensed in one state could operate nationwide without having to be licensed in other states.

In addition, the legislation would pre-empt state laws that prohibit employers from purchasing casualty insurance on a group basis.

This freedom to establish risk retention groups and to establish purchasing groups now only applies to product liability and completed operations coverage under the 1981 Risk Retention Act.

The legislation to expand the 1981 law would allow such diverse entities as municipalities, day-care centers and nurse-midwives to establish risk retention groups or purchasing groups to obtain liability coverage that may not be available or affordable in the conventional insurance market.

This expansion of the 1981 law could be a major market event and help ease the liability insurance crisis, according to backers of this year's legislation.

"It could have a tremendous impact on how the insurance delivery system works," says Mr. Harkavy. "It has the potential of making the delivery system more efficient, with buyers no longer so dependent on insurers" for coverage.

Since an agreement that was worked out this summer between buyer groups and the National Assn. of Insurance Commissioners to give regulators more control over risk retention and purchasing groups, there has been no opposition to the proposal.

That agreement, among other things, requires a risk retention group to:

- Submit an operating plan to the commissioner in each state in which it intends to do business before beginning operation.

This operating plan would include a rating schedule, coverages to be offered and limits.

- Submit to regulators in every state in which it operates a copy of its annual financial statement that it files in its domicile.

This statement would have to be certified by an independent accountant with a qualified actuary providing an opinion on the group's reserves.

- Exclude coverage for punitive damages or intentional, fraudulent or criminal conduct to the extent such coverage is prohibited by state law.

In addition, federal courts would have the clear authority to issue an injunction to stop a risk retention group from operating in all states if the court finds that a group is operating in a hazardous financial condition. ■

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update

Second-generation DES suit

Continued from page 2

NEW YORK—The first suit involving the granddaughter of a woman who took the antimiscarriage drug DES was filed against seven drug manufacturers in state court last week.

Plaintiffs in the suit are 19-month-old Amy Smith, whose cerebral palsy is alleged to have been caused by DES; her mother and father; and her grandmother who ingested the DES.

Stephanie Kanarek-Smith, Amy's mother, alleges she has reproductive deformities as a result of her mother's ingestion of DES.

Among other allegations are that the manufacturers failed to adequately test the DES, said the plaintiffs' attorney, Leonard Finz, of the firm of the same name.

The suit seeks $100 million in compensatory and punitive damages and takes takes advantage of a recently enacted New York law that gives alleged victims of five toxic substances a one-year grace period in which to file suit if the statute of limitations has already expired (*BI*, June 30).

Named in the suit are Eli Lilly & Co., E.R. Squibb & Sons Inc., Abbott Laboratories, Upjohn Co., Merck & Co., Rexall Drug Co. and Winthrop Laboratories.

Spokesmen for all the defendants declined comment except for Rexall, which could not be reached.

DES, or diethylstilbestrol, is a synthetic estrogen used by millions of women to prevent miscarriages.

Arrest blocks Integrity deal

PHILADELPHIA—Financially troubled Integrity Insurance Co. is still looking for a buyer after the recent arrest on wire fraud and conspiracy charges of two men who had planned to acquire the company.

Clifford Noe—a convicted con man also known as Dr. Noe—and his nephew Paul Noe II were arrested Sept. 18 in the Philadelphia international airport after allegedly buying $10 million in phony certificates of deposit from an undercover FBI agent.

The two men allegedly had planned to use the bogus CDs to support a proposed acquisition of Paramus, N.J.-based Integrity, according to court papers filed in the U.S. District Court for the Eastern District of Pennsylvania.

The Noes—who claimed to have amassed $135 million in assets for the purchase of Integrity—told the FBI agent that the bogus CDs would be used as collateral to obtain a $6 million loan from a bank in Chicago or Dallas, court papers say. The loan proceeds would then be used to obtain additional assets to back up the Integrity purchase, court papers say.

Christian C. Yegen, Integrity's chairman, chief executive officer and president, confirmed that the insurer executed a stock purchase agreement with Paul Noe II earlier this month. Under the agreement, Mr. Noe was to pay $15 million for the insurer and contribute $50 million to its capital and surplus, he said.

The Noes were released on a $100,000 bond and are scheduled to appear at a court hearing next month.

Health pools

Continued from page 1

focused on other provisions that directly affect the federal budget deficit, Mr. Davey said.

"My instincts tell me the pool provisions will be adopted. It is a juggernaut moving on its own steam," said Stuart J. Brahs, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

But employer lobbying groups are launching an 11th-hour campaign to strip the pool provision from the bill.

Last week the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers, sent a letter to each member of Congress urging defeat of the pool provision.

"The task of providing health insurance protection for individuals uninsured or uninsurable under the current system is too important a national question to be addressed through the ill-considered and poorly drafted mechanism now appended to H.R. 5300," Mark Ugoretz, ERIC executive director, wrote in his letter to congressmen.

Indeed, for employers concerned about rising health care costs, the potential consequences of adoption of the pool provision are enormous, observers say.

Under the House bill, states are supposed to set up pools by 1988 for high-risk uninsured individuals.

In theory, the pools are supposed to be self-supporting, with premiums paid by participants covering costs. Pools would be allowed to charge a premium up to 150% of that charged by commercial insurers for a standard individual policy.

The maximum annual deductible could not exceed $1,000 and the maximum out-of-pocket expense per individual could not be more than $1,500. The pools would have to offer a ceiling for lifetime benefits of no less than $500,000.

Pre-existing conditions would have to be covered within six months after an individual joined the pool.

But the way the legislation is drafted, there is no way that the pools could be self-supporting, experts say.

For example, coverage for preexisting conditions such as cancer could mean tens of thousands of dollars in medical bills for just one policyholder.

When a state pool runs out of money, employers with more than 20 employees that do business in that state would be hit with special assessments to pay for the losses.

Employers that refuse to pay the assessments would be liable for a special excise tax equal to 5% of the gross wages it pays.

No one knows how many of the nation's 35 million uninsured individuals would purchase coverage through the state pools.

But the number could be significant if states decide to subsidize the premium. That could happen, experts say, because states may find it much cheaper to pay all or part of a premium than to cover the uninsured in their own public health care programs.

It is possible, for example, that states could dump into the pools catastrophic Medicaid cases or even inmates of public institutions.

As a result, a cost once picked up by society in general will be passed onto employers.

Benefit lobbyists, while sympathetic to the problems faced by the uninsured, are asking why employers, especially those that provide group health care coverage for their own employees, should subsidize the costs of medical coverage for the uninsured.

"Many of the (uninsured) beneficiaries have no connection with employers; their coverage could more appropriately be provided with a broader base, including existing public programs," said ERIC's Mr. Ugoretz.

The proposal fails to provide even minimal fiscal restraints on the pools, Mr. Ugoretz also notes. "It shifts the burden for program cost overruns solely onto employers without the benefit of cost-containment provisions of employer plans or government insurance programs," he said.

Aside from imposing potentially massive costs onto employers, benefit lobbyists are criticizing the pool proposal, which never has been subject to extensive congressional hearings, for sloppy draftsmanship.

They note, for example, that the provision never defines how states should assess employers if the pools fail to collect enough premiums to cover costs.

As a result, multistate employers could face the complicated administrative task of complying with different state assessment formulas.

In addition, the legislation provides that a pool can charge a pool participant a premium equal to 150% of average premium rates for individual standard risks in the state for comparable coverage—but never defines an individual standard risk.

Employer groups, like ERIC, also question whether Congress has the authority to require states to establish the pools. ■

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Non-discrimination

Continued from page 1

compensated employees or if highly compensated employees' benefits are excessive compared with benefits received by lower-paid workers.

But, employers will have to weed through a number of tests, all complicated, to see if their welfare programs are non-discriminatory. Those tests include eligibility tests—which, in turn, have a number of subtests—and a benefits test.

For instance, the benefits test reads: "A plan does not satisfy the benefits test unless the average employer-provided benefit received by non-highly compensated employees under all plans of the employer of the same type is at least 75% of the average employer-provided benefit received by highly compensated employees under all plans of the employer of the same type."

There also is a special alternative test to the eligibility and benefits tests; a test for spouses and dependents; a special dependent care assistance test; and a special rule covering part-time employees.

"These tests are an absolute nightmare to go through," said Edward J. Davey, vp with Johnson & Higgins in New York.

Consultants suggest that some employers may find it cheaper to run the risk of operating a discriminatory plan than setting up the administrative machinery needed to see if their plans pass the various non-discrimination tests.

If a welfare plan were found discriminatory by the government, the only penalty would be that highly compensated employees would be taxed on the cost of the portion of a provided benefit that is found to be excessive.

In that case, an employer might simply "gross up" a highly compensated employee's pay to make up for the extra taxes they would pay, said Gerald Uslander, a principal in the Louisville, Ky., office of benefit consultant William M. Mercer-Meidinger Inc.

Consultants suggest that some employers may find it cheaper to run the risk of operating a discriminatory welfare plan than setting up the administrative machinery needed to see if their plans pass the various non-discrimination tests created by the tax legislation.

But employers may never end up in the position of having to comply with the non-discrimination rules, which will not go into effect until at least Jan. 1, 1988.

Some observers believe that there will be so much employer outrage over the rules that congressional staffers will be forced to revise them in a technical corrections bill next year.

"I wouldn't be surprised if an aroused employer community lobbies to get these rules overturned," predicts J&H's Mr. Davey. "There will be an uproar."

Benefit lobbyists note the irony in the rules: While tax reform was initially promoted as tax simplification, the non-discrimination rules for welfare plans have ended up incredibly complex.

But there is some good news in the final version of the tax bill.

For example, employees who participate in savings programs, like 401(k) salary reduction plans, that allow both pretax and aftertax contributions, still will be allowed to withdraw their aftertax contributions before they have to withdraw their pretax deferrals.

An earlier congressional summary of the legislation had suggested that withdrawals would have to be pro-rated between aftertax and pretax contributions.

"This is quite a pleasant surprise," said James Brickman, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

Currently, an employee can first withdraw aftertax contributions from a 401(k) plan. Since these are aftertax dollars, the employee is not taxed on the the funds that are removed.

But under the summary of the bill prepared by the Joint Committee on Taxation, withdrawals would have been divided for tax purposes between those aftertax contributions and pretax and employer matching contributions, which are taxable.

That change would have taken away an incentive for employees to make aftertax contributions to a plan since the employees always would have been immediately taxed on a withdrawal—assuming there were employer matching contributions or if the employee had made pretax contributions to the plan.

The tax bill, contrary to that summary, makes clear that employees still can withdraw aftertax dollars from a plan without having been considered to also have withdrawn taxable contributions.

However, in a slight change from current law, the bill says when an employee withdraws aftertax contributions, he or she also will have been considered to have withdrawn the taxable interest earnings generated by the aftertax contributions.

As a result, the amount withdrawn, for tax purposes, will be taxed on according to the ratio of earnings on aftertax contributions to the actual amount of the aftertax contributions.

Meanwhile, the final version of the tax bill contains the other benefit and risk management provisions that have been reported earlier.

The bill would:

- Limit maximum annual 401(k) salary deferrals to $7,000.
- Bar pretax contributions to Individual Retirement Accounts by middle- and upper-income participants in employer-sponsored pension plans.
- Give employers a choice of two minimum vesting schedules for their defined benefit and defined contribution plans. One schedule would require participants to be fully vested after five years, while the alternative schedule would require 20% vesting after three years and 20% annually for the next four years.
- Continue the tax-free status of educational assistance and group legal benefits through 1987.
- Impose a 10% excise tax on most pension plan reversions, retroactive to to Dec. 31, 1985.
- Impose current tax on income to shareholders of offshore captives with 25% or more U.S. ownership.
- Tax a portion of property/casualty insurers' tax-exempt and unearned premium income and require discounting of reserves for tax purposes. ■

Epton elected Illinois exchange chairman

CHICAGO—Bernard E. Epton, the former Illinois state representative who first introduced enabling legislation for the Illinois Insurance Exchange, is the new chairman of the IIE board of trustees.

Mr. Epton, only the second person to hold the IIE's chairmanship during the exchange's five-year existence, is among several new and returning IIE officials and board members.

Mr. Epton is a current board member and an attorney with the Chicago firm of Epton, Mullin & Druth.

He succeeds Louis W. Biegler, who did not seek re-election. Mr. Biegler had held the chairmanship since the IIE was formed in 1981.

Mr. Biegler, president of Corporate Advisors Inc. of Northbrook, Ill., remains on the 13-member IIE board, with one year remaining in his three-year board term.

Richard E. Foss, president of Chicago-based IIE syndicate LUI Syndicate Inc. and LUI Management Inc., is the new vice chairman of the board.

Mr. Foss, in his second year on the board, succeeds Donald L. Cole, president of Hartford, Conn.-based Constitution State Management Co. and Travelers Illinois Syndicate Inc. Mr. Cole, whose board term expired this year, did not seek re-election.

J. Howard Payne, senior vp of Chicago-based broker Rollins Burdick Hunter Co. and a current board member, is the IIE's new secretary.

And, Jerome M. Shaw, president of IIE syndicates First Mercury Syndicate Inc. and Second Mercury Syndicate Inc. as well as Mercury Management Inc., is the exchange's new treasurer. Mr. Shaw also is a new IIE board member.

IIE officers are elected to one-year terms.

In addition to Mr. Shaw, new IIE board members are:

- Wolfgang Daniel, president of Los Angeles-based Talon Re Inc., which manages IIE syndicate Resure Syndicate Inc.
- Phillip O'Connor, chairman and president of Chicago-based Palmer Bellevue Corp., an asset management firm for regulated industries. Mr. O'Connor is a former director of the Illinois Department of Insurance and a former chairman of the Illinois Commerce Commission.
- Gordon L. Teach, vice chairman and chief executive officer of The Illinois Co. Inc. of Chicago, an investment banking firm. Mr. Teach is filling the remaining year of Peter Van Cleave's unexpired term. Mr. Van Cleave, of Peter Van Cleave & Associates of Chicago, had resigned.

The IIE board members who were re-elected are:

- Steven Weicholz, president of IIE syndicate Britamco Underwriters Inc. and Weicholz Management Corp. of Coral Springs, Fla.
- Jeremiah Marsh, chairman of the Chicago law firm of Hopkins & Sutter.

Members of the IIE's board of trustees are elected to three-year terms.

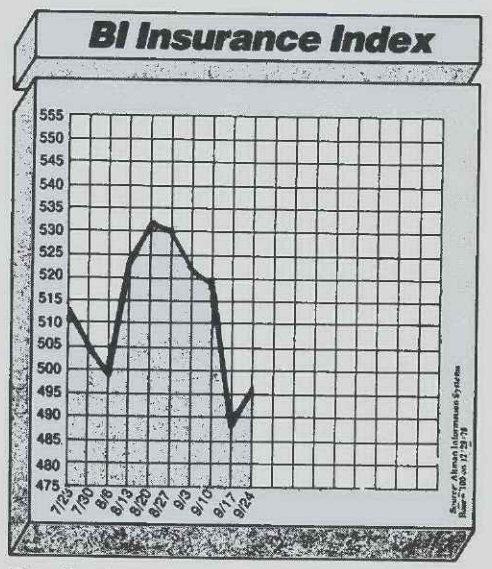
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Baldwin & Lyons Inc	OTC	24.00	0.0	30.8	0.16	0.7	24.00	24.00	0.0
Corroon & Black Corp	NYSE	36.00	9.1	18.1	0.65	1.8	36.00	32.00	334.8
Crump E H Cos Inc	OTC	32.50	0.8	31.3	0.25	0.8	32.63*	32.25	346.5
Gallagher Arthur J & Co	OTC	31.00	8.8	25.0	0.20	0.6	31.00	29.00	173.9
Hall Frank B & Co Inc	NYSE	20.00	0.6	0.0	0.00	0.0	20.13	19.63	141.0
Marsh & Mclennan Cos Inc	NYSE	66.63	4.1	23.5	1.90	2.9	68.13	64.50	1,048.1
Poe & Assoc Inc	OTC	14.00	-1.8	0.0	0.32	2.3	14.25	14.00	3.8
AGENTS/BROKERS	AVERAGE			-62.7		1.7			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	57.88	0.0	11.0	1.36	2.3	58.50	57.38	2,881.4
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	0.0	31.9	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	6.88	0.0	0.0	0.00	0.0	7.13	6.88	846.7
Berkley W R Corp	OTC	30.75	5.1	23.3	0.24	0.8	30.75	29.50	441.9
Berkshire Hathaway Inc Del	OTC	2660.00	-0.6	647.2	0.00	0.0	2675.00	2625.00	0.9
CIGNA Corp	NYSE	55.38	1.1	0.0	2.60	4.7	55.75	54.88	1,399.2
CNA Finl Corp (CNA)	NYSE	54.50	2.8	15.1	0.00	0.0	54.88	52.63*	279.0
General Re Corp	NYSE	58.88	1.3	25.6	0.88	1.5	58.88	57.75	549.1
ITT (Hartford Group)	NYSE	49.38	0.8	23.4	1.00	2.0	49.50	49.00	2,091.3
Sears Roebuck & Co. (Allstate)	NYSE	41.13	1.5	11.8	1.76	4.3	41.75	40.00	3,607.8
Teledyne Inc (Argonaut)	NYSE	318.88	1.0	11.7	0.00	0.0	321.50	317.00	101.7
Transamerica Corp (Occidental)	NYSE	34.00	0.4	14.9	1.76	5.2	34.50	33.50	782.5
CONGLOMERATES/HOLDING COS.	AVERAGE			91.8		0.3			
Insurers									
Aetna Life & Cas Co	NYSE	59.50	4.2	11.9	2.64	4.4	59.50	56.63	2,396.2
American General Corp	NYSE	39.63	0.3	11.8	1.12	2.8	39.63	39.00	1,192.4
Amern Heritage Life Invt Co	NYSE	39.63	0.3	14.3	1.32	3.3	39.75	39.50	0.3
American Indty Finl Corp	OTC	17.00	3.0	0.0	1.12	6.6	17.00	16.50	44.0
American Intl Group Inc	NYSE	124.38	0.1	20.3	0.50	0.4	125.25	123.50	688.7
Aneco Reins Ltd	OTC	2.25	0.0	0.0	0.00	0.0	2.25	2.25	7.3
Avemco Corp	NYSE	26.88	-2.3	14.1	0.50	1.9	27.25	26.88	8.2
Business Mens Assurn Co Amer	OTC	26.88	-2.3	22.0	1.10	4.1	27.25	26.75	92.0
Chubb Corp	NYSE	66.63	4.9	49.7	1.56	2.3	66.63	62.88	426.6
Combined Intl Corp	NYSE	55.63	3.2	10.8	2.24	4.0	55.63	54.00	121.6
Continental Corp	NYSE	44.38	3.2	0.0	2.60	5.9	44.38	43.13	532.0
Crown Life Ins Co	OTC	350.00	0.0	0.0	6.40	1.8	350.00	350.00	1.5
Durham Corp	OTC	42.50	0.0	11.9	1.36	3.2	43.00	42.50	3.3
Farmers Group Inc	OTC	44.00	4.8	15.3	1.00	2.3	44.00	42.50	586.2
Fairmont Finl Inc	AMEX	16.88	-2.9	17.4	0.00	0.0	17.50	16.88	176.5
Fireman Fd Corp	NYSE	35.88	5.1	0.0	0.30	0.8	35.88	33.38	557.3
Fremont Gen Corp	OTC	19.00	-8.4	0.0	0.48	2.5	19.50	18.88*	196.2
Great West Life Assurn Co	OTC	825.00	4.4	0.0	18.00	2.2	825.00	790.00	0.6
Home Group Inc	AMEX	19.38	3.3	92.3	0.00	0.0	19.38	18.75	549.9
Hanover Ins Co	OTC	62.50	2.5	18.0	0.56	0.9	63.25	62.25	46.2
Hartford Steam Boiler Inspctn	OTC	40.25	-0.6	11.3	1.20	3.0	41.00	39.50	57.9
Kans City Life Ins	OTC	28.25	-1.7	11.1	0.87	3.1	28.75	28.25	12.4
Kemper Corp	OTC	27.00	-3.6	12.3	0.60	2.2	28.00	27.00	646.2
Liberty Corp S C	NYSE	38.00	0.0	14.0	0.72	1.9	38.50	37.88	47.1
Lincoln Natl Corp Ind	NYSE	50.00	0.8	10.8	2.00	4.0	50.25	50.00	342.8
Mission Ins Group Inc	PAC	3.38	0.0	0.0	0.00	0.0	4.38	2.88	5.6
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	31.00	0.0	0.0	0.00	0.0	32.00	31.00	52.0
Nobel Ins Ltd	OTC	14.00	0.9	0.0	0.37	2.6	14.25	14.00	79.1
Northwestern Natl Life Ins	OTC	29.25	3.5	10.8	0.86	2.9	29.25	28.38	243.8
Ohio Cas Corp	OTC	77.75	4.0	16.6	3.00	3.9	79.00	76.00	248.9
Old Rep Intl Corp	OTC	34.50	0.4	11.5	0.78	2.3	34.63	34.00	165.5
Orion Cap Corp	NYSE	31.00	5.1	0.0	0.76	2.5	31.00	30.50	124.2
Protective Corp	OTC	22.75	3.4	12.2	0.70	3.1	23.00	22.25	182.8
Provident Life & Acc Ins Co	OTC	24.63	3.7	9.1	0.84	3.4	24.63	23.00*	428.3
St Paul Cos Inc	OTC	39.00	3.3	23.2	1.50	3.8	39.50	38.25	1,157.1
SAFECO Corp	OTC	57.75	0.9	13.7	1.68	2.9	57.75	56.50	323.8
Seibels Bruce Group Inc	OTC	14.75	-3.3	0.0	0.80	5.4	15.50	14.75	76.0
Selective Ins Group Inc	OTC	23.00	10.8	0.0	0.92	4.0	23.25	21.50	271.0
Statesman Group Inc	OTC	5.13	-4.7	56.9	0.05	1.0	5.25	5.13	53.3
Tokio Marine & Fire Ins Co	OTC	536.25	2.0	101.0	1.66	0.3	536.25	515.50	6.7
Torchmark Corp	NYSE	28.50	4.6	11.5	0.60	2.1	28.50	25.88	652.1
Travelers Corp	NYSE	45.00	2.3	11.2	2.16	4.8	45.00	43.25*	1,069.8
Trenwick Group Inc	OTC	16.00	-13.5	0.0	0.00	0.0	19.00	16.00*	571.8
United Fire & Cas Co	OTC	32.00	9.4	16.8	0.80	2.5	32.00	29.25	9.8
United States Fid & Gty Co	NYSE	38.75	-0.3	0.0	2.32	6.0	39.13	38.75	5,321.4
Uslife Corp	NYSE	45.75	4.9	12.0	1.12	2.4	45.88	44.00	129.8
Washington Natl Corp	NYSE	32.13	1.2	14.5	1.08	3.4	32.25	31.50	49.0
Zenith Natl Ins Corp	OTC	24.00	0.0	41.4	0.80	3.3	24.38	23.50	138.2
INSURANCE COMPANIES	AVERAGE			47.5		2.1			

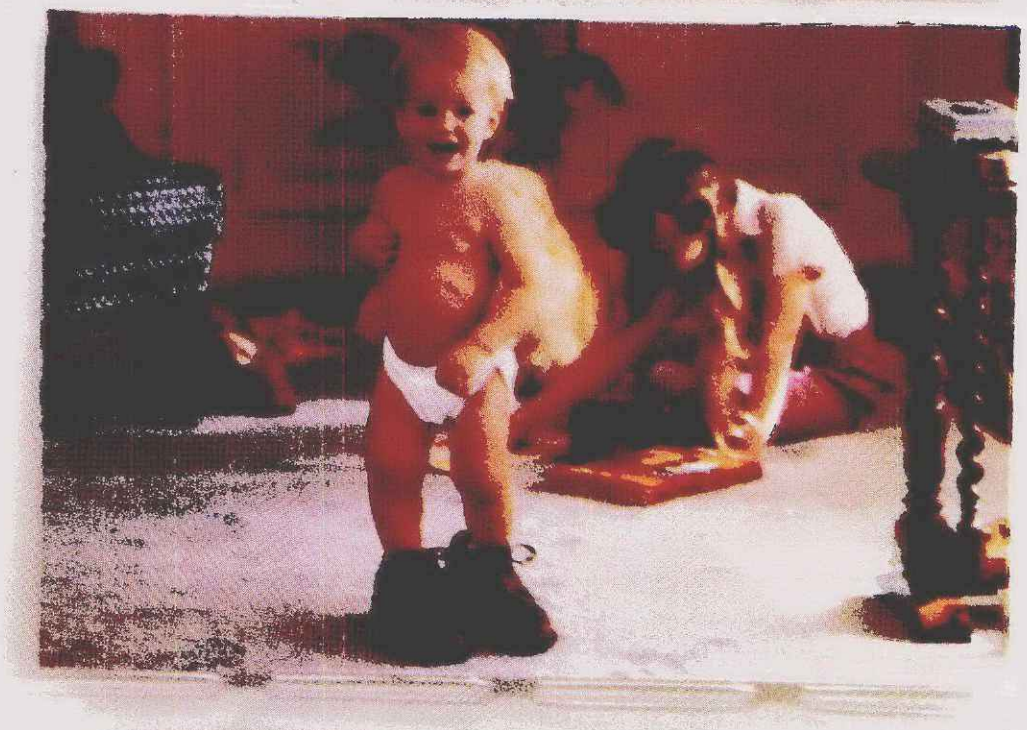
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BI Insurance Index



The *Business Insurance* index of insurance industry stocks closed up 7.5 points at 495.8 points on Sept. 24, rebounding from the previous week's 30.5-point tumble to 488.3 points. A total of 40 stocks advanced, 11 posted losses and nine remained unchanged. The leading gainers were: Selective Insurance Group Inc., up 10.8%; United Fire & Casualty Co., up 9.4%; Corroon & Black Corp., up 9.1%; Arthur J. Gallagher & Co., up 8.8%; and Berkley W.R. Corp., up 5.1%. Stocks that posted the largest losses were: Trenwick Group Inc., down 13.5%; Fremont General Corp., down 8.4%; Statesman Group Inc., down 4.7%; Kemper Corp., down 3.6%; and Fairmont Financial Inc., down 2.9%. The major stock market indicators outpaced the *BI* index's 1.5% average climb.





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