

RISK MANAGEMENT
AN IMPERATIVE FOR ALL
FIRESTOP CONTRACTORS INTERNATIONAL ASSOCIATION MEMBERS

After more than a decade of broad availability of comprehensive corporate insurance and declining rates, suddenly ***the party's over!***

There are three ingredients to the pricing equation for insurance claims, portfolio investment returns, and inflation. Fortunately inflation is in check, however, insurance losses are mounting and investment returns are marginal at best. As a result, insurance rates are increasing at a pace not seen since the mid-1980's.

Adding to insurance company woes are the catastrophic losses associated with terrorist acts and the continuing efforts of plaintiff's attorneys to convert capitalism into a litigious nightmare (cases in point *toxic mold, "employment practices liability", construction defects*).

Insurance has always been the #3 expense on FCIA Members P & L. Cost of goods sold, payroll, then insurance. Add together property, liability, auto, workers compensation, retirement plans, and employee group health insurance, and the impact on the corporate bottom line becomes profound.

Business owners show little interest in analyzing insurance expenditures. Insurance policies are complex, written in a *legalese* born out of endless judicial interpretation, and represent the one single expenditure individuals or businesses make they hope is a waste of money. The only way to get ahead of the insurance

companies is to have a warehouse fire, a truck accident, a serious illness, or die prematurely ... some victory!

Fortunately there are steps you can take, now, to reduce exposure to loss, mitigate unavoidable losses, and sensibly finance the balance. Following are some suggestions:

Employee Benefits --

1. If you haven't done this already, begin immediately to create a database that you own that captures, in one file:
 - a) The name, social security number, address, city, state, phone, fax, and e-mail (business location and home) of every current employee as well as retirees and "COBRA eligible" employees.
 - b) Marital and dependent status including the employment and educational (full time student?) status of all insured and uninsured dependents. Include name, date of birth, and marital status of children (e.g., is an 18-year old daughter married?)
 - c) Catalog and retain for at least five years, copies of health insurance master policies and certificates of insurance and summary plan descriptions.
 - d) A list of insured employees (and dependents) together with uninsured employees (and the reasons they are not covered -- i.e., covered by spouse's plan, unwilling to make required insurance premium contribution, etc.).

- e) Aggregate premium and claim loss data for the current and at least the prior three (hopefully five) plan years. If there are multiple plans and/or separate locations, so indicate and, where feasible, maintain separate premium/claim data by plan and location.

Within restraints imposed by state and federal privacy regulations track, by plan year, the cause, total expense and outcomes (e.g., the cancer was successfully treated, the patient died, etc.) of so-called *catastrophic claims* (generally defined as claims that exceed the threshold level of \$5,000 or \$10,000).

- f) Retain copies of Annual Reports prepared by insurance carriers, HMO's, or Third-Party Administrators (TPA's). Be sure to include copies of reports to government agencies such as the Department of Labor. You might ask agents, brokers, administrators, and insurance companies to separately display risk charges, specific and aggregate stop loss charges, claims administration fees (as a percent and dollar amount), and state premium taxes.

Note: The object here is to segregate paid and/or "incurred" claims from the *expense factors* of health care providers and brokers/TPA's.

The initial effort to gather and catalog all of this information will be a huge pain. Insurance companies resist, agents are never thrilled about highlighting what they are paid, and unless this data is easily retrievable such an exercise could prove to be a waste of time and money. However, as with many other aspects of running your business, ***information is power***. Having an up-to-date, well

constructed file puts you in the driver's seat when the time comes to invite competitive quotations for your employee benefit plans.

2. Inquire as to whether or not your state, as well as your health insurance provider, includes a "subrogation provision" whereby illness or injury that is a result of someone else's negligence allows for recovery of medical expenses otherwise charged to your plan. If you are able to subrogate, monitor on an on-going basis the outcomes of subrogation proceedings.
3. Initiate a dialog between management and representatives (a cross section) of your work force regarding life, accident, and disability benefits, the cost to your corporation, the portion of the expense absorbed by the employee(s), and the trend factors impacting the cost of providing benefits.

As suggested previously, "information is power" or at least "empowering". Most people, given the facts of a situation, arrive at reasonable and supportable conclusions. Conversely, people who are uninformed, subject to the so-called "mushroom principle" whereby they perceive that *"they are being kept in the dark and manure is being heaped upon them"* lose trust and arrive at wrong conclusions.

The medical care of a spouse or dependent child is every bit as important (if not more so) to rank-and-file employee as it is to owner/managers. Decisions regarding plan design, eligible providers, deductibles, co-insurance, and the like should be shared decisions or, at the very least, based on well documented and adequately explained factors.

4. It's fair to state that it takes at least 60 to 90 days to pursue health plan alternatives, negotiate benefits and rates, and then transition from one health plan to another. We are talking about 60-90 days from the time you provide complete underwriting information until you receive the final proposal with firm rates.

Is it fair to be placed in a situation where coverage could be canceled or rates increased by more than 10% or 20% on just 30 or sometimes ten days notice? We think not.

Try to negotiate contract provisions or at least have a binding Letter of Understanding that requires agents, brokers, and insurance companies to provide advanced notice (at least 60 days) of any plan modification, termination, or a cost increase in excess of 15%.

5. At some point we will have a Patients Bill of Rights (PBR). Versions of PBR passed both Houses of Congress but were bottled up in conference. When and if a Bill finally passes and is signed by the President, there is little doubt it will increase the liability exposures of every fiduciary and every benefit provider. It seems that plaintiff lawyers are running out of firms to bankrupt over asbestos or toxic mold. As part of their "business development" initiatives, lawyers want the right to sue every corporation and everybody in the channel of health care distribution and delivery. Unless and until the business community raises up enmass in outrage and indignation (why it hasn't happened thus far is beyond me) things will only get worse.

You might as well add privacy violations and "denial of care" to the list of exposures that you must eliminate, mitigate, transfer, or insure.

A first step would be to negotiate bilateral hold harmless or indemnification provisions in contractual agreements with brokers, administrators, and health care providers. Beyond that, prepare to demonstrate regulatory compliance and commitment to loss prevention to underwriters providing “employee benefit liability insurance”.

6. In the months and years ahead, you are going to hear a lot about a concept now generally referred to as “Consumer Driven Health Care”. The concept comes under generic and trade names including Defined Contribution, Destiny Health, Diversity, Lumenos, etc. The common theme running through these emerging plans is that we must begin to educate employees and their families, make them more informed buyers of health care, and increase their motivation by making sure they have some “skin in the game”.

Following are examples of medical expenses and aspects of health care plans now coming under the focus of “consumer-driven” health care initiatives:

- Unnecessary trips to a hospital emergency room and/or doctors office (often a phone conversation with a physician or a nurse can provide professional guidance to a concerned individual or parent).
- Ordering **brand-name** instead of **generic** prescription drugs. A case in point I take Indomethacin for gout. Cost of 100 50 mg capsules \$106.00 brand ... \$31.00 generic. That’s a 300% increase in cost for the brand name.

Basically speaking, if the purchasing decision is beyond your control or beyond your ability to manage/budget, such medical expenses should be

covered by insurance; otherwise, these expenses should be subject to the plan deductible. Consideration should be given to mechanisms allowing employees to pay health insurance premiums and/or uninsured medical expenses with **pre-tax dollars**. This could include Internal Revenue Code Section 125 Plans (Flexible Benefit Plans), Medical Savings Accounts (MSA's), and the like.

Keep in mind that the proverbial "80/20 Rule" applies to employer provided health insurance programs 80% of aggregate claims dollars will be generated by 20% of insured employees and their families. "Defined Contribution" plans and similar initiatives aimed at creating incentives for employees to become informed and prudent purchasers of health care not only make good sense, they help assure that quality health care remains affordable.

Property & Casualty --

1. As in the case of employee benefits, begin to take control of the policy renewal process. Start by categorizing by policy/calendar year copies of all insurance contracts, claim activity (loss runs), and the nature and causative factors associated with any significant claim(s).

Insurance companies, agents, and brokers have a practice of delivering bad news with as little advance notice as is legally allowed. Upon notification of a new restriction in coverage or double-digit rate increase, most firms begin searching for alternatives. To offer its most competitive pricing, every insurer will want detailed information on premiums and claims for at least three and ideally five years. It can take months to assemble an underwriting file, particularly if you have to chase the insurance company to produce loss runs. Get ahead of the game by creating and maintaining in hard copy and/or digital

format complete histories regarding the wording of insurance policies, premiums paid, and losses incurred.

2. Invite insurance representatives to work with designated corporate managers on the development of accident prevention and claims mitigation processes and procedures. A sensible risk management program, documented and deployed can warm the cockles of an underwriter's heart. Avoiding a property loss, vehicle claim, or work-related accident is the best way to control the cost of insurance going forward.
3. Practice "preventative law", invite your legal advisors to review contracts with suppliers and customers alike and incorporate mediation and arbitration provisions as alternative dispute mechanisms. Seek hold harmless indemnification provisions, where practical ask for *broad form vendors endorsements* or better yet ask to be named as an additional insured on a supplier's or customer's policies.
4. Request at least 60 (hopefully 90) days notice of any material change to any existing policy or any rate increase exceeding 10%-15%.
5. Ask your insurance agent or broker for a professional assessment of what you are not insured against. It's far more important to know what you are not covered for. Examples can include Employment Practices Liability (EPL), Environmental Impairment Liability (EIL), Nuclear, mold related claims, and computer crime (i.e., theft of intellectual property, violation of privacy, destruction of data, etc.). With the exception of nuclear, most of these exposures are insurable (at a sometime steep price).

Miscellaneous --

1. Analyze the operation of 401-K plans. Make certain you are in compliance with new IRS and DOL regulations. Interrogate plan administrators and investment advisors regarding total plan charges (e.g., administration fees both employer/employee, insurance company and mutual fund sales loadings and *asset charges*). Often such expenses exceed 2% and sometimes can be as high as 3%, 4%, or more. It doesn't make sense to earn 3% or 4% in a Bond Fund only to spend more than that to administer the plan.
2. With long term disability insurance, employers can provide important protection often for less than one half of one percent of payroll.
3. For non-smokers in excellent health, term life insurance is a phenomenal value. Employees with young families can obtain term life insurance at rates possibly less than accidental death coverage. Many insurance agents avoid talking about term life since they would rather you purchase cash value life insurance with its much higher commissions. Employers can be the source of timely and objective information on low cost insurance of which employees may otherwise never be aware.
4. Finally, take a look at some of the *non-insurance* discount plans offering substantial savings for prescription drug, vision, chiropractic, and other types of health care. Opportunities for savings are everywhere.

Conclusion --

There is little doubt that corporate risk management does not receive the time and attention it deserves. At the same time, you cannot overstate the benefits derived from avoiding uninsured loss or controlling the ever-increasing cost of insurance.

You are encouraged to assemble a risk management team including representatives of insurance companies, your broker, legal counsel, human resource managers, and members of your “safety committee” to take the pulse of your risk exposure and take all reasonable measures to pro-actively *manage risk* and in doing so minimize corporate insurance expense.