

# Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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## Jury award in tobacco case opens door to punitive damages

MIAMI—Five cigarette makers are facing a possible multibillion-dollar punitive damage verdict in the wake of a Florida jury's award of \$12.7 million in compensatory damages in a closely watched tobacco liability class-action suit.

The jury awarded \$2.9 million to one of three plaintiffs who brought the suit and \$4 million to the estate of a second plaintiff who died last year. Jurors also awarded \$5.8 million to a third plaintiff but blocked him from collecting the award, finding that a

*See Updates on next page*

## Top managed care mandates

From a self-reported survey of NAIC jurisdictions

Rank by popularity	Provisions	Total number of states
1	Prohibits gag clauses	48
2	Protects privacy of medical records	47
	Requires plans to disseminate information to consumers	47
3	Establishes internal appeals process	44
4	Establishes rules for coverage determinations	43
5	Prohibits genetic discrimination	42

Source: National Assn. of Insurance Commissioners; March 2, 2000

# U.S. bill takes aim at 'tax havens'

By GAVIN SOUTER

WASHINGTON—A bill introduced in the House of Representatives last week would impose additional taxes on U.S. insurance risks reinsured by affiliated companies located in domiciles that have tax rates of 7% or less.

The bill, H.R. 4192, is the widely expected attempt to close an alleged tax advantage enjoyed by companies located in Bermuda that have substantial operations in the United States, such as ACE Ltd. and XL Capital Ltd.

Sponsored by members of the House Ways and Means Committee—Nancy L. Johnson, R-Conn.,



Richard E. Neal, D-Mass., and Robert Matsui, D-Calif.—the bill is backed by several U.S.-based insurers, including Chubb Corp., the Hartford Financial Services Group Inc., Liberty Mutual Insur-

ance Co. and Kemper Insurance Co.

The legislation would impose extra taxes on insurers and reinsurers that reinsure U.S. business they underwrite with their Bermuda affiliates. The legislators and U.S. insurers charge that, because the reserves on those risks grow tax-free, the Bermuda-owned insurance companies have a 10% cost advantage over their U.S. rivals.

This alleged advantage would be eliminated under the bill by effectively taxing the reserves growing tax-free in Bermuda at the same rate as if they were

*See Loophole on page 25*

# Employers fear dual regulation

## Patient bill may cause chaos

By MEG FLETCHER

WASHINGTON—Employer groups are joining state insurance commissioners in voicing their fears that the dual regulation provisions proposed in the federal compromise "patients' bill of rights" could cause chaos and confusion if adopted nationally.

The specter of congressional conferees adopting a bill that would require employees with health plan questions to seek answers from both federal and state authorities worries those who favor a more-streamlined regulatory structure.

"Dual regulation is a major concern for the Risk & Insurance Management Society," said Daniel Barry, director of government affairs for the New York-based organization.

While a little dual regulation already exists in areas such as mental health benefits parity, current federal proposals could exacerbate the situation by applying a wide variety of mandates to all employer-sponsored health care programs.

Such dual regulation "can only lead to confusion and inconsistency. That is a result that is not in the best interest of RIMS' membership or its employees," according to a RIMS' position paper. That paper primarily dealt with the organization's initial concern that employers providing insurance might be held civilly liable for health care coverage decisions.

"Dual regulation will create enormous friction costs that will hit hardest at the more-complicated, elaborate and choice-oriented health care programs," like those of large employers, said Wayne Salen, director of risk management for New Millennium Care Inc. in East Aurora, N.Y. The company operates long-term care facilities in seven states.

In addition, the Washington-based National Assn. of Manufacturers considers dual regulation one of three key issues it is raising before conferees, along with employer liability and "medical necessity"—whether a covered benefit is medically appropriate for a particular person—said Neil Trautwein, NAM's director of employment and human resources policies.

Those groups plan to continue lobbying congressional conferees who are reconciling provisions of separate patient protection

*See Mandates on page 26*

## Falling out of favor with providers

# Capitation in decline

By MICHAEL PRINCE

The peak may have passed for capitation.

Capitation arrangements, in which health plans pay physicians a fixed amount per patient, have not disappeared, nor does anyone expect them to. Nevertheless, there has been a marked shift among health plans away from using capitation agreements in compensating health care providers.

Despite capitation receiving high marks as a means of keeping health care costs under control, employers and experts do not see the decline of capitation as a factor in rising health care costs of

the past few years. What it will mean for employers in the future, however, remains to be seen.



Colorado is reviewing its capitation system. Page 23

The move away from capitation agreements primarily stems from health care providers seeking changes in how they are paid, observers note.

Many providers "have found they lost a lot of money with capitation, and they don't want to participate anymore," said Stuart Altman, professor of national health policy at Brandeis University in Waltham, Mass.

For several years, health plans have been lowering the capitation rates they pay providers, experts agree. At first, this just squeezed some money from the providers' pockets; recently, however, levels have gotten so low that some

*See Capitation on page 23*

# RIMS slams OSHA plan

## Critics of ergonomics rules decry mandates

By MARK A. HOFMANN

WASHINGTON—Risk managers and insurers are calling for voluntary, rather than mandatory, ergonomics standards as the Occupational Safety and Health Administration continues public hearings on its controversial ergonomics proposal.

Representatives of the Risk & Insurance Management Society Inc. offered their thoughts during a March 31 hearing in Washington, just one day after RIMS' second annual Capitol Hill visits ended (BI, April 3).



RIMS, like other employer groups, has criticized the long-awaited ergonomics proposal as inflexible, overly expensive and lacking the scientific evidence needed to justify the imposition of a sweeping standard.

"We would rather see it be voluntary," Lance J. Ewing, leader of RIMS' external affairs team, told the hearing.

Mr. Ewing noted that RIMS entered into a "partnering" relationship with OSHA in 1998, and, as part of that arrangement, offered to provide OSHA with details of successful ergonomics programs. He said that Assistant Labor Secretary Charles Jeffress, who heads OSHA, did not respond to RIMS' offer.

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**Updates**

**Tobacco jury awards \$12.7 million**

*Continued from previous page*

four-year statute of limitations on his claim had passed, according to press reports.

Florida Circuit Judge Robert Kaye said he would decide later how to handle the \$5.8 million award and did not immediately decide how the awards would be allocated among the defendants, press reports state. The defendants are Philip Morris Inc., R.J. Reynolds Tobacco Co., Brown & Williamson Tobacco Corp., Lorillard Tobacco Co. and Liggett Group Inc.

The plaintiffs in the case, *Engle vs. R.J. Reynolds et al.*, had sought \$13.2 million in compensatory damages for lost wages, medical costs and pain and suffering.

The jury will now consider punitive damages, which could cost the tobacco industry billions of dollars for the illnesses of all of Florida's sick smokers.

William S. Ohlemeyer, vp and associate general counsel for Philip Morris, said the company is considering how to ask an appellate court quickly to review the trial procedure that led to these verdicts.

Philip Morris also attacked the idea of a classwide punitive damage award, pointing to the compensatory award that the jury barred on statute of limitations grounds.

"The mixed verdicts highlight the practical and legal problems of going forward with a lump-sum, classwide punitive damage claim," the company said. "The mixed verdicts are a direct result of an inappropriate trial procedure fashioned by the judge."

Plaintiffs' attorney Stanley Rosenblatt was unavailable for comment. Last July, the Florida jury ruled that the tobacco industry had produced a defective product (*BI*, July 12, 1999).

**Court faults delayed claim notice**

COLUMBUS, Ohio—A policyholder's delay in notifying insurers of environmental claims prejudiced the insurers and permits them to deny the claims, the Ohio Supreme Court ruled on Wednesday.

In 1966, the policyholder, Ormet Primary Aluminum Corp., first learned that water at its site in Hannibal, Ohio, was contaminated by chemicals. After years of testing and negotiations with state and federal environmental officials, the U.S. Environmental Protection Agency in 1986 sent the company a letter stating that it could be held responsible for paying for the site's cleanup. But it was not until 1992 that Ormet notified its insurers—Employers Insurance Co. of Wausau, Globe Indemnity Co., Home Indemnity Co. and underwriters at Lloyd's of London—about the situation and its intent to make claims to cover any cleanup costs, the opinion states.

The insurers balked at the claims, arguing that Ormet violated the policy's provisions requiring it to file claims in a timely manner. Both the trial court and an Ohio appeals court ruled in favor of the insurers and dismissed Ormet's declaratory judgment suit.

On appeal, the state's highest court upheld the rulings of the lower court and stated that the insurers were prejudiced by Ormet's delay. Specifically, the opinion states that more than 10 witnesses have died since the discovery of contamination on the site, other witnesses have diminished memories of key events, and the site itself has changed dramatically from the cleanup.

As a result, the court ruled that "reasonable minds could only conclude that the appellees suffered actual prejudice from the delay," wrote Justice Evelyn Lundberg Stratton for the court's six-member majority. One justice wrote a dissenting opinion.

Justice Lundberg Stratton further wrote that "in addition to opportunities for fraud, options available to the insurance companies rapidly diminish as time passes, leaving them to deal with decisions made by the insured that may not be in either the insured's or the insurer's best interest."

*Ormet Primary Aluminum Corp. vs. Employers Insurance Co. of Wausau et al., Ohio Supreme Court, April 5, 2000, 98-2456.*

**Arizona captive bill vetoed**

PHOENIX—Arizona's hope of becoming a captive domicile has been scuttled, at least for now.

Legislation that would have made the state a domicile had passed through both chambers of the state Legislature, but Gov. Jane Dee Hull vetoed H.B. 2630 on March 31.

Enactment seemed certain, but the Arizona Department of Insurance opposed the measure because legislators declined to provide additional expenditures to create a new division dedicated to regulating captives, said Marc Lapointe, managing director in Phoenix for Aon Insurance Managers (USA) Inc.

Mr. Lapointe helped introduce the legislation. Despite the setback, the drive to create a domicile for captives in Arizona is not dead, he said. Winning approval for appropriations bills is tough during an election year, he said, vowing to try again.

**Terra Nova halts in Bermuda**

HAMILTON, Bermuda—Markel Corp. has stopped writing new business from the Bermuda office of Terra Nova (Bermuda) Holdings Ltd., which Markel bought earlier this year, in an effort to cut costs.

The Bermuda office of Terra Nova wrote comparatively few premiums—\$30 million in 1999—in a domicile with high administrative expenses, said Bill Wedlake, chief financial officer of Terra Nova (UK) Holdings P.L.C. in London, which will soon be renamed Markel International P.L.C.

"It was a marginal operation in a very high-cost place," he said. The property catastrophe and proportional treaty business written in the Bermuda unit that Terra Nova wishes to retain can easily be written through the London-based unit, Mr. Wedlake said.

The 12 employees in the Bermuda office will be laid off, he said. *See Updates on page 26*

**Bornhuetter, asset sale aid Frontier restructure**

By DOUGLAS McLEOD

ROCK HILL, N.Y.—Analysts are taking a wait-and-see approach to restructuring moves through which Frontier Insurance Group Inc. aims to put itself on firmer financial footing.

Frontier last week announced that Ronald L. Bornhuetter, retired chairman of NAC Re Corp., will join Frontier's board. The addition of the widely respected Mr. Bornhuetter follows Frontier's decision to sell its surety operations, which accounted for nearly 20% of 1998 net premiums, and a small medical malpractice unit, Western Indemnity Insurance Co.

Richard Seyffarth, Frontier executive vp, said the company may also sell a small auto insurance unit, Regency Insurance Co. The

scaled-back Frontier operations will then focus on their "historically profitable" specialty program business, Mr. Seyffarth said. He declined to say how much the company expects to raise through the asset sales.

A "significant" share of the proceeds from the sales, though, will be used to pay down Frontier's bank debt, he said. Improving the company's capital base is a major goal of the restructuring. Rising losses cut Frontier's shareholder's equity to \$128.3 million last year, a 67.5% decline from \$394.2 million in 1998, according to unaudited figures prepared using generally accepted accounting principles.

Analysts appear encouraged by the restructuring effort.

The asset sale "will appease all

the parties involved," predicted Michael G. Paisan, a vp with Keefe, Bruyette & Woods Inc. in New York. "I think it will get the rating agencies off their backs for a little while and will get regulators off their backs for a little while."

Mr. Bornhuetter's arrival also lends credibility to the restructuring efforts, he added.

"If there is one thing Frontier needs more than anything else, it's someone who understands reserve analysis," Mr. Paisan said. Now "you've got the guy who wrote the book on reserve analysis."

How Frontier performs in the long run, though, remains to be seen.

After spinning off the surety operations—and with its earlier sale *See Frontier on page 25*

**Insurer tax system set**

**Repeal of Illinois sunset clause likely**

SPRINGFIELD, Ill.—Illinois consumers are expected to benefit from having more insurers writing coverage in the state now that a three-year struggle to develop a workable tax system is almost resolved.

The Illinois Legislature late last month approved a bill—S.B. 1326—that repeals a sunset provision on a successful tax system adopted last year so that the system will remain in effect.

Gov. George Ryan is expected to sign the measure, according to the National Assn. of Independent Insurers in Des Plaines, Ill.

The tax issue surfaced in 1997, when the Illinois Supreme Court ruled unconstitutional Illinois'

system of allowing in-state insurers to avoid paying a premium tax while out-of-state insurers could deduct the amount of income taxes paid from the premium taxes they owed, according to an NAII statement.

A replacement tax structure enacted in 1998 required Illinois officials to assess a higher tax rate against out-of-state insurers doing business in Illinois, in part to keep state revenues constant. That approach, however, caused other states to retaliate by subjecting Illinois-based insurers to higher taxes.

"Legislation enacted last year sought to correct this problem by establishing a modified corporate income tax for out-of-

state companies. These companies would pay an income tax that is the lesser of the Illinois rate or their home state rate, provided that the calculation would not fall below 1.25% of premium volume written in Illinois," according to the NAII analysis.

"Leveling out the tax rate further improves the competitive insurance environment in Illinois, and this means more options for consumers," said Donald Cleasby, assistant general counsel for the NAII. "It also results in Illinois insurers paying fewer tax dollars to other states when doing business out of state."

The measure would go into effect Jan. 1, 2001.

—By Meg Fletcher

**401(k) directory deadline nears**

*Business Insurance* will publish its annual Directory of 401(k) Plan Administrators on May 22.

That issue will include an editorial feature on pensions and retirement plans. The directory is published as an editorial service, and there is no charge to be included.

To be listed, a company must

provide 401(k) plan administration services such as enrollment recordkeeping, daily maintenance of participants' accounts or handling of account activity. Plan administration services must be available on an unbundled basis.

If your company meets these requirements and has not received a questionnaire, please request one

immediately by calling Michel Schwartz at 312-649-5313.

Copies of the questionnaire also may be printed from the directory area of the *Business Insurance* Web site at [www.businessinsurance.com](http://www.businessinsurance.com).

Completed questionnaires must be submitted by the extended deadline of April 21. **BI**

**Inside**

•The Quality Health-Care Coalition Act now before the House of Representatives would stymie competition among physicians, this week's editorial says. **PAGE 8**

•Despite decades of research, even today few doctors practice medicine based on evidence of the best treatment. **PAGE 18**

•The United Kingdom, unlike many other European countries, does not currently exclude the coverage of flooding in its commercial and personal lines policies. But faced with predicted catastrophic flooding along England's southern and eastern coastline, partly due to climate change and rising sea levels, insurers are being forced to review their risk position. **PAGE 19**

•Aviation insurers are calling for rate hikes after being hit in 1999 by a record amount of insured hull losses on Western-built aircraft. **PAGE 19**

•Publisher Kathryn J. McIntyre shares responses from those who have a difference of opinion. **PAGE 25**

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*Business Insurance* (ISSN 0007-6864) Vol. 34, No. 15, is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207. \$4 a copy and \$89 a year in U.S. \$108 in Canada and Mexico (includes GST). All other countries \$209 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Copyright 2000 by Crain Communications Inc.

# Disaster aid plan may move ahead

## FEMA considering making property coverage a requisite for federal assistance

By **RODD ZOLKOS**

WASHINGTON—An initial comment period on a federal proposal to require public entities to purchase property insurance to qualify for federal disaster assistance ends today, and implementation of a new regulation may follow on a fast track.

The Federal Emergency Management Agency published an "Advance Notice of Proposed Rulemaking" in the Federal Register on Feb. 23 and has since been gathering input on the insurance proposal.

FEMA's proposal has sparked concern from some public officials—particularly those in California—that such a regulation could dramatically increase public-entity insurance costs and could cause capacity problems in some insur-

ance markets.

In its notice, though, FEMA explained that it intends any new rule "as a means to achieve a nationally consistent level of responsibility among public and certain private non-profit entities for natural disaster risks."

The notice set out the three options FEMA is considering:

- Making the repair or replacement of public buildings ineligible for federal disaster assistance.
- Maintaining the current eligibility of public buildings for public assistance funding whether they are insured or not.
- Making the repair of public buildings eligible for disaster assistance only if the buildings were insured at the time of the disaster.

"The bottom line is Option 3 is the

one I think they're really thinking about doing," said Daniel J. Pliszka, manager of risk management for the unified government of the city of Charlotte and Mecklenburg County, N.C., and the Charlotte-Mecklenburg Board of Education.

Among other things, FEMA's February notice points out that, by paying for building repair costs whether or not a building had property insurance, the agency currently provides a disincentive for public entities to purchase insurance.

"Many potential public-assistance applicants have told us, in so many words, 'Why carry insurance on our buildings when we know that FEMA will be there to pick up the costs when the disaster hits?'" the agency said in its notice.

See FEMA on page 6



PHOTO: AP/THE CHARLOTTE OBSERVER, LAYNE BAILEY  
Hurricane Floyd wreaked havoc on eastern North Carolina, including this flooded street in Grifton.

## Training facilities prepare for the worst

# Crises call for risk expertise

By **LEE FLETCHER**

Nearly a year after deadly gunfire broke out at a Colorado high school, many law enforcement and military units nationwide are increasing their training, and some observers say risk managers can help strengthen the response to future crises.

A training facility, called R.U. Ready High School, was built last summer in Moyock, N.C., to teach law enforcement and military personnel special tactics for potential school crisis situations like the tragedy at Columbine High School in Littleton, Colo.

While risk managers generally are not included in such law enforcement crisis-response training, their expertise can be helpful, according to observers.

Risk managers are somewhat left out of the loop in crisis response efforts because many crisis situations such as school shootings are a law enforcement issue, said Aden Hogan Jr., town administrator of Parker, Colo. Mr. Hogan was assistant to the city manager of Oklahoma City when the Alfred P. Murrah Federal Building there was bombed in 1995.

"Police departments and sheriff departments all across the country could certainly benefit from including their risk managers in their strategizing and training planning," Mr. Hogan said.

Risk managers can give law enforcement officials a broader perspective about other risks associated with a school incident, according to Mr. Hogan.

"Certainly you're going to have more than just a situation itself to deal with. You're going to have parents, the media, traffic control issues—all those sorts of things that risk managers and emergency managers have been dealing with for decades," Mr. Hogan said.

Preparation and training for special situations are helpful for professionals "in any industry," said Bill Masciangelo, president of Blackwater Training Center, which operates R.U. Ready.

He described the facility as "a two-story, all-steel house with live gunfire shooting inside and the use of explosives for

See Crisis on next page

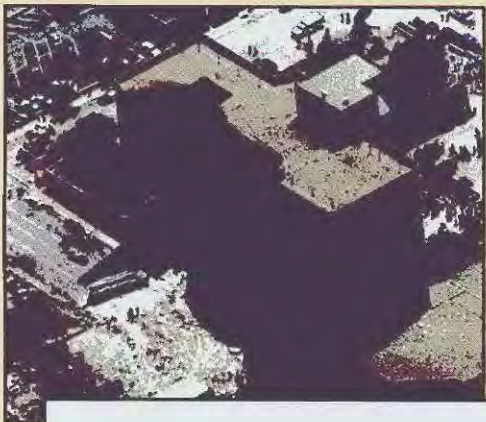


PHOTO: REUTERS



PHOTO: STEVE PETERSON/ZUMA

The bombing of the Alfred P. Murrah Federal Building (top) and the shootings at Columbine High School have been catalysts for crisis-response training.

# NAIC critiques federal proposals

But some financial modernization suggestions draw complaints from the Alliance, NAI

By **MEG FLETCHER**

# NAIC

KANSAS CITY, MO.—Federal regulators should take additional steps to protect consumers' privacy in this era of financial modernization, according to comments filed recently by the National Assn. of Insurance Commissioners.

In critiquing the federal proposals, the NAIC said it agrees with "the bulk" of proposed federal rules, including defining "personally identifiable financial information" that protects consumer health information.

But the NAIC also suggested several pro-consumer changes in similar March

31 letters sent to the six federal agencies involved in implementing the Gramm-Leach-Bliley Act, which breaks down the barriers between banks and insurers (BI, March 27).

Those agencies are the Federal Deposit Insurance Corp., Federal Reserve System, Federal Trade Commission, National Credit Union Administration, Office of the Comptroller of the Currency and the Securities and Exchange Commission.

The NAIC's comments disappointed analysts from at least two insurer trade associations—The Alliance of American Insurers in Downers Grove, Ill., and the National Assn. of Independent Insurers in Des Plaines, Ill.

The analysts said they felt the state insurance regulators had gone too far in encouraging specific consumer protections.

The NAIC urged federal regulators to:

- Eliminate confusion over jurisdictional authority by adding a new section to the federal rules that clearly states "none of the agency's privacy regulations apply to any insurance provider which is functionally regulated by state insurance authorities under Titles III and V" of the act.
- Define "non-public personal information" according to the source of the information, not its content.

See NAIC on next page

# Insurer sued over comments posted on Web

By **JUDY GREENWALD**

BALTIMORE—A financial services company is suing a financial guarantee insurer, the insurer's parent and a former executive over statements posted online that the plaintiff charges led to a decrease in its capitalization.

Baltimore-based Creditrust Corp. filed suit last week in federal district court in Baltimore against Enhance Financial Services, its subsidiary, Asset Guaranty Insurance Co., and former EFS Senior Vp Charles Henneman. The suit contends that Mr. Henneman anonymously posted "maliciously false and disparaging statements" against Creditrust on a Yahoo! message board.

Creditrust is seeking \$130 million in compensatory damages and \$390 million in punitive damages. The company's suit says the false statements made by Mr. Henneman were launched to coincide with

Creditrust's February 1999 registration for a secondary stock offering of 3 million shares. The company completed an offering of 2.4 million shares on March 19, 1999.



According to court papers,

the postings began just six days before Enhance announced a joint venture with Milwaukee-based MGIC Investment Corp., called Sherman Financial Group, that was created to compete with Creditrust, which acquires, manages and collects delinquent consumer receivables.

The 21 Yahoo! postings, which lasted until November 1999, repeatedly criticized Creditrust's accounting practices, financial status and management, among other factors, and were based purportedly on insider knowledge of both the industry and the company itself, according to Creditrust.

Creditrust said Mr. Henneman knew these postings were false because of confidential information that was provided to Asset Guaranty by Creditrust as an Asset Guaranty policyholder. Joseph Rensin, Creditrust chairman and chief executive officer, is a plaintiff in the suit, according to Creditrust.

As a result of the postings, Creditrust charges, the company had to reduce the scope and price of its offering, and its capitalization dropped by more than \$300 million between Feb. 17, 1999—the date of the first posting—and last week. The company has about \$245.6 million in assets. A Creditrust spokesman could not be reached.

An Enhance spokesman said Mr. Henneman was terminated by the company the week before the

See Enhance on page 6

# Crisis

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dynamic entry through the doors."

He said the 24-room building has six stairwells and a catwalk across the ceiling for instructors to watch the trainees as they move through the building.

"Over 300 law enforcement and military personnel have trained at that particular building since it opened last September, and it is leased almost 45 weeks out of the year," Mr. Masciangelo said.

It's evident that many police officers have come to Blackwater on their own to train and are paying their own way, observed Mr. Masciangelo. "They're investing in their future survival on the job. They don't feel that during the course of the year they are prepared for the challenges they are facing today on the streets," he said.

Mr. Masciangelo emphasized that regular-duty patrol officers are often those who have to respond first to an

incident.

They're the ones who aren't being trained through their departments as well as the SWAT teams are trained, he said.

While the R.U. Ready facility training is restricted to law enforcement and military personnel, other training would be valuable to risk management professionals, according to Mr. Masciangelo. "Any professional for any industry should be trained. The more you train, the better you get," he said.

Harold J. Pumford, CEO of the Prague, Okla.-based Assn. of Government Risk Pools, agreed that many public entities could benefit from providing crisis training.

To prevent crises such as school and workplace shootings, for example, Mr. Pumford said specific techniques to identify potential assailants should be developed.

He said that an immediate, clearly structured response—as opposed to waiting until all the forces are marshaled—is particularly important in environments where there are a lot

of individuals such as students or workers.

"I think that, through in-service training required by states or departments, pools will be a major method of delivering (training) because of the extensive number of local governments that they are providing liability coverage for," Mr. Pumford said.

For the past 15 years, risk pools have been the leaders in providing services to help governmental units reduce their exposure and adopt best practices, according to Mr. Pumford.

Stephen A. Finley, director of risk management for the Denver public schools, said that in December 1998, the school district distributed a classroom emergency response guide that covers a variety of situations, including weather-related catastrophes, strangers on campus, and fire and bomb threats. Mr. Finley's district does not include Columbine High School.

"What we want the schools to do is take the overall guidance plan that we've put together and write a site-

specific supplement which will take into account their particular population," such as students or faculty who are disabled, Mr. Finley said.

"Whenever there is an ongoing situation, whether it's a fire, a hostage situation—we're going to take our directions from the local law enforcement," said Mr. Finley.

Local law enforcement is more than likely going to get there as quickly as the risk manager can, he remarked.

The Denver public schools are "spread pretty thin as far as security force goes," Mr. Finley said.

"We're trying to train everybody, but that's an unrealistic goal. We're trying to get to the administrators, the building administrator, the principal and, possibly, in front of teachers," he said.

According to Mr. Finley, there are 125 schools in the Denver public school district, with about 70,000 students.

"Like all school districts, we're riding on the thin edge of resource allocation, and we have no opportu-

nity to get large groups of people together to do this type of training. It's kind of on a school-by-school basis," he noted.

Mr. Hogan said that including risk managers in crisis response can actually take some of the burden off of law enforcement agencies.

A risk manager can shed some light on some peripheral matters, such as security measures within a building, and let law enforcement "focus on managing the event itself," Mr. Hogan said.

At most conferences, when risk managers talk about catastrophe response, the topics are typically related to natural disaster, weather events or massive process failure, according to Mr. Finley.

"Of course, in many respects the responses are very similar. You have to get control of the scene, allocate your resources, marshal your reserves and start to attack the problem. It's just that the tools are different in a tactical scene than they are in a natural disaster scene," Mr. Finley said. **BI**

# NAIC

Continued from previous page

- Define "publicly available information" to mean information that is actually obtained from public sources, not taken from consumers.

- Double the amount of time—to 60 days from 30 days—consumers are given to exercise their right to opt out of having their information shared with non-affiliated third parties.

- Require that opt-out applications sent to consumers should be "easy and cost-free" for those wishing to use them. The NAIC recommended written notices with convenient check-off boxes and pre-addressed, postage-paid return envelopes or allowing the use of standardized electronic for-

malts for e-mail responses.

In addition, the NAIC recommended that federal regulators use practical examples to illustrate and clarify general privacy rules.

"State insurance authorities have an important stake in consumer privacy regulations established by federal agencies, because they will set the standard by which state privacy standards will be compared," according to the letters signed by NAIC President George Nichols III, the Kentucky insurance commissioner, and Vp Kathleen Sebelius, the Kansas insurance commissioner.

But Rey Becker, vp-property/casualty for the Alliance, found several of the NAIC's recommendations "counterproductive."

For example, the NAIC's approach "treats names, addresses

and phone numbers like state secrets, even when readily available in your local phone book," Mr. Becker said.

If federal authorities adopt such an approach, "it will require unnecessary duplication of research to obtain the information," said Robyn Rowen, the NAI's senior counsel in Washington.

The insurer analysts also disagreed with the NAIC's recommendation to double the duration of the opt-out period to 60 days.

In addition, Ms. Rowen said, notification requirements should be more general and flexible.

Both organizations detailed their views in letters sent to some of the federal agencies, the analysts said.

Federal authorities are expected to issue final rules on or before May 12, with the rules going into effect in mid-November. **BI**

## Business Insurance makes staff changes

CHICAGO—*Business Insurance* has made several changes in its Chicago editorial and production staff.

*BI* has promoted an editorial staffer and added two editorial staff members. In addition, the magazine has a new production manager, following Elmer Kerstowske's retirement last month. Mr. Kerstowske had served in production at *BI*'s publisher, Crain Communications Inc., for 30 years.

Matthew T.C. Scroggins has been promoted to copy editor, while Dermot Connolly has joined as a copy editor and Shirley Henry comes to *BI* as editorial assistant. Cheryl Magiera is now production manager.

Mr. Scroggins, 26, previously was assistant copy editor at *Business Insurance*. He joined the magazine in 1997 as assistant directory editor, moving to the copy desk in 1999. Previously, Mr. Scroggins

worked as an assistant in the human resources department of Crain Communications and before that as a part-time researcher for *BI* and sister publication *Advertising Age*.

He graduated summa cum laude from Millikin University in Decatur, Ill., with a bachelor of arts degree in philosophy.

Mr. Scroggins can be reached at 312-649-5483.

As a copy editor, Mr. Connolly, 32, will be responsible for editing news stories and writing headlines. Before joining *BI*, he was a business

editor/reporter for the Southwest News-Herald and Southwest Courier, two weekly community newspapers in Chicago. Prior to that, he was a staff writer for Gannett Suburban Newspapers in New Rochelle, N.Y., and was a Chicago reporter for the Irish Echo Newspaper Corp.

He has a bachelor of arts degree in journalism from Western Illinois University in Macomb.

Mr. Connolly can be reached at 312-649-5440.

Ms. Henry, 23, will assist the editorial staff and directory department as editorial assistant. Before joining *BI*, she was an editorial intern at sister publication *Modern Healthcare*, assisting its directory department with research and production, as well as creating a photo database for the graphics department.

She has a bachelor of arts degree in English writing from the University of Illinois at Chicago.

Ms. Henry can be reached at 312-649-5398.

Ms. Magiera, 29, will have advertising and production responsibilities as production manager. She previously served as production manager at sister publication *Crain's New York Business*. Prior to that, Ms. Magiera was art director/production manager for the Illinois Real Estate Journal.

She has a bachelor of arts degree in advertising from Columbia College in Chicago.

Ms. Magiera can be reached at 312-649-5337.



Mr. Scroggins



Ms. Henry



Mr. Connolly



Ms. Magiera

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# FEMA

Continued from page 3

A related problem, the agency said in the notice, is that FEMA's existing practice prompts some public entities to cut their insurance costs by opting for very high deductibles, knowing that the agency will cover any portion of a loss not covered by insurance.

FEMA stressed that it intends that any new policy "should not require entities to substantially re-order their spending priorities," and that any new policy should not deny assistance to entities that cannot obtain the required insurance.

It also emphasized that the required insurance should be provided by the private sector, rather than through any federally directed program.

In its proposal, FEMA sets out what it would consider adequate insurance limits by category—all-

risk, earthquake, flood and wind—based on either individual building-by-building policies or blanket policies, as well as deductibles eligible for reimbursement.

quired to obtain coverage at least to the level of that cap.

With FEMA's initial comment period on the new regulation ending today, the next step will be publication of a proposed regula-

## 'It's not going to continue to be a situation where public entities just do not get insurance and figure that FEMA is always going to be there,' says Thomas L. Vance.

To ensure that no public entity would face the burden of exorbitant premiums, FEMA has proposed qualifying its minimum coverage level requirements with a rate cap, expressed as a percentage of the building's replacement cost. The proposed cap is 30 cents per \$100 value, with entities re-

tion in the Federal Register, followed by a 90-day comment period on that specific proposal.

Also following the proposed rule's publication, the agency will create a panel of experts that includes insurance company representatives, brokers and public-sector risk managers, said Thomas

L. Vance, risk manager of Anaheim, Calif.

"That is the group that I hope will be able to do a good job of addressing the capacity issue," he said.

Mr. Vance has worked closely with FEMA in developing its proposed regulation, and he said, "It's important to understand that FEMA is trying to write a one-size-fits-all regulation that fits a city in California in an earthquake zone and another city up in North Dakota."

Mr. Vance conceded that the best outcome for municipalities would be for the disaster recovery agency to maintain its existing policy, but he noted, "There's absolutely no question that something's going to change."

"It's not going to continue to be a situation where public entities just do not get insurance and figure that FEMA is always going to be there," Mr. Vance said. "My view all along has been to cut the

best deal possible."

Work must still be done on addressing how the proposal fits into self-insurance arrangements, Mr. Vance said, as well as on "the formula part that deals with waivers from the state insurance department when the entity wants to go to their state insurance commissioner and say the coverage is not readily available at standard prices and terms."

The Anaheim risk manager credited the federal agency for its efforts thus far in developing the new rule.

"This has been a difficult process," he said. "I personally think FEMA's done a good job of soliciting input."

Regarding the regulation's future, Mr. Vance said, "It's my understanding that the director of FEMA, James Lee Witt, is committed to getting this regulation in place while he's in office. So I think they're going to try to fast-track this." **BI**

# Enhance

Continued from page 3

suit was filed but would provide no further details. "We are confident that Enhance Financial and Asset Guaranty will prevail in this litigation and that we have strong defenses" against Creditrust's claims, he said.

The court is likely to consider several factors in evaluating Enhance and Asset Guaranty's potential liability, assuming the charges against Mr. Henneman are correct, said Gretchen Sayers, senior claims counsel for Media/Professional Insurance in Kansas City, Mo. "A key one is if anyone at the company encouraged him to do that, or even knew that he was doing that," remarked Ms. Sayers.

"Another factor a court might consider is, did he post the com-

ments from his office computer, or is it something he did from home on his own time?" she said.

The court is also likely to consider any arrangement he may have had insofar as gaining from the joint venture, said Ms. Sayers. "Did he have a direct interest in profits for that new company, or was he just a salaried employee?" she asked.

In addition, "What, if any, policies did Enhance have as far as employee and even executive use of the Internet" are concerned? If Enhance has a corporate policy on the Internet, "the court would at least look at it to see if there was something there that might guide them," said Ms. Sayers.

Clearly, she added, if Mr. Henneman had been acting on the company's instructions and advice, there is a big chance his employer could be found liable.

"The hard call is if no one knew

anything about it, but for some reason he thought he had the authority and was doing this on the company's behalf."

Joel Smith, an attorney with Century City, Calif.-based Leopold Petrich & Smith, said that "Generally, an employer does not have the responsibility for

what its employee does, unless there's some special doctrine that applies," such as if an employer knows the employee has a propensity to do certain kinds of unlawful acts.

"Certainly if the evidence were to support that the employee engaged in unlawful conduct at the

behest of the employer, that's like Tort Law 101—the employer's responsible," said Mr. Smith.

But he predicted there will be a dispute between Enhance and Mr. Henneman as to what was said and authorized on the matter.

Mr. Henneman could not be reached. **BI**

# OSHA

Continued from page 1

"We're disheartened" with OSHA's lack of response, said Mr. Ewing, who is director-in-charge and loss prevention for GES Exposition Services Inc. in Las Vegas.

Mr. Ewing suggested that the special compensation treatment OSHA's proposal would afford workers suffering from musculoskeletal disorders, or MSDs, would invite fraudulent claims.

Billie Fae Fuschi, a member of the RIMS external affairs team and director-workers compensation for Methodist Healthcare in Memphis, Tenn., also stressed that requiring employers to provide workers who have MSDs with a 100% income replacement—far more than the usual workers comp benefit—would cause problems.

"We fear it will not take long for workers and their attorneys" to realize that having MSD claims could be far more

lucrative than working, Ms. Fuschi told the Washington hearing.

Workers comp was also on the agenda when Wayne McOwen, vp of Wilkes-Barre, Pa.-based Guard Insurance Group, presented comments to

## 'The proposal effectively creates a presumption' that any MSD is caused by workplace conditions, says Wayne McOwen.

the panel on behalf of the Des Plaines, Ill.-based National Assn. of Independent Insurers.

The MSD management provisions conflict with workers comp laws, Mr. McOwen said. He also noted that the proposal "effectively creates a presumption" that any MSD is caused by workplace conditions.

Two other insurer trade groups are scheduled to testify later this month. Keith Lessner,

vp-safety and environmental for the Downers Grove, Ill.-based Alliance of American Insurers—which will offer its testimony at public hearings in Portland, Ore.—said the Alliance believes that encouraging voluntary initiatives, rather than using coercion, is the better way to get employers to implement ergonomics programs.

He added that the ambiguity of the OSHA proposal will make compliance more subjective, which will raise costs.

"The desired activity that OSHA wants will not be achieved by the rulemaking process," he said in an interview last week.

The American Insurance Assn. is scheduled to give its comments at hearings in Chicago. The group is still preparing testimony, but Bruce C. Wood, assistant general counsel for Washington-based AIA, said last month that "every portion of the proposed regulations that would alter state (workers comp) laws and their underlying policies should be deleted in their entirety."

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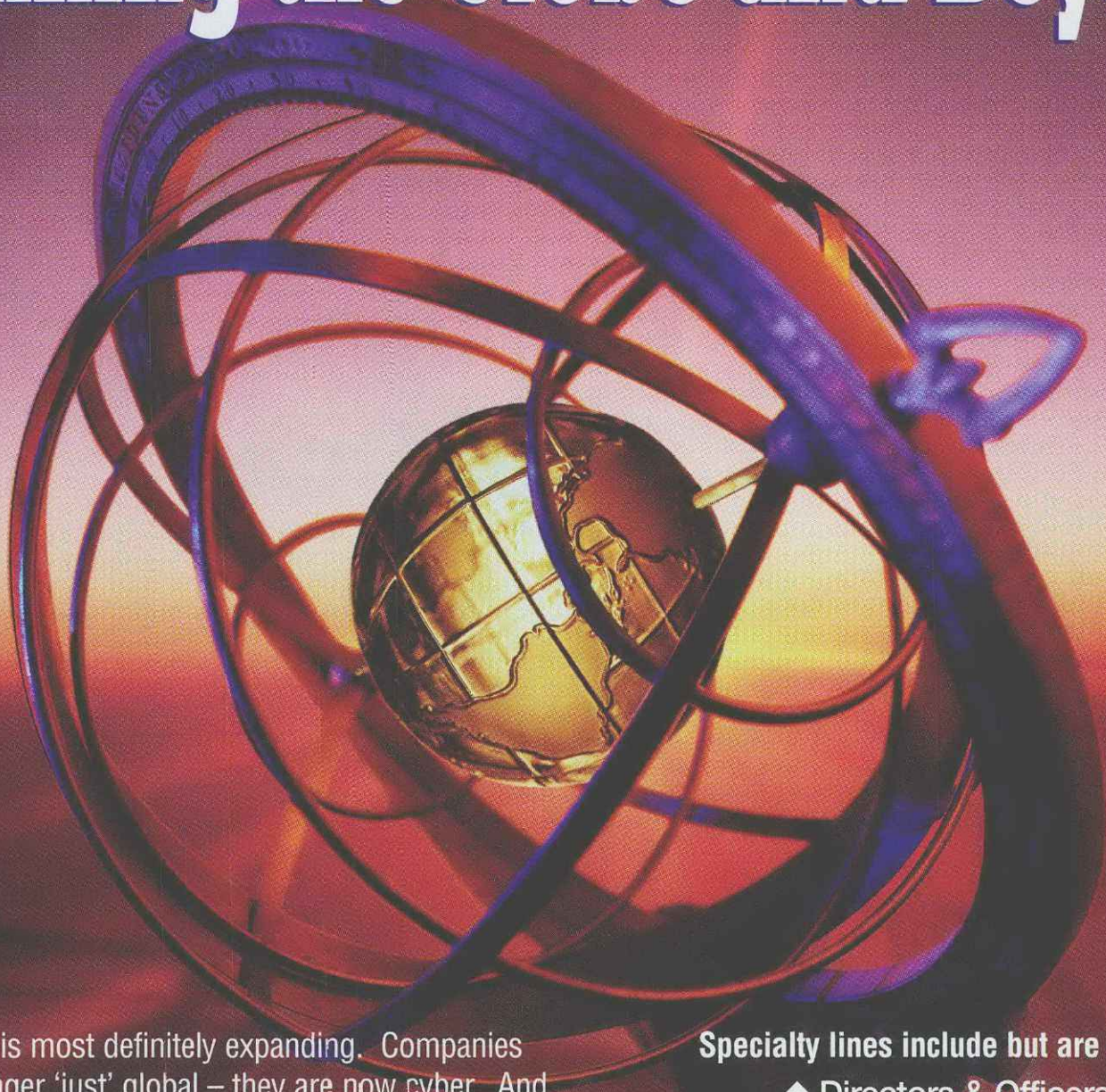
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## Opinions

## Good reasons to reject bill

WHEN EMPLOYERS AND THE JUSTICE Department—which don't often see eye to eye on issues—join state legislators and some health care practitioners in blasting a piece of legislation, odds are their concerns merit a good deal of attention before that measure moves forward and becomes law.

That's exactly the case with the misleadingly named "Quality Health-Care Coalition Act," which won the approval of the House Judiciary Committee late last month. The bill, which would grant independent physicians an exemption from federal antitrust laws to bargain collectively with health plans and insurers, appears more likely to make access to quality health care more difficult.

Ironically, the Judiciary Committee gave its approval to the proposed antitrust exemption for doctors just as a federal judge was preparing to throw the book at Microsoft Corp. for alleged anti-competitive activity and as the public was feeling the pinch of the Organization of Petroleum Exporting Countries' successful efforts to jack up oil prices by keeping production lower than demand.

The Quality Health-Care Coalition Act would permit—in fact, encourage—physicians to engage in anti-competitive activity of their own by forming what would be, in effect, cartels.

That's just what the collective negotiating units would likely turn out to be. Contrary to every antitrust principle, competing physicians would be able to join together and, as a single group, dictate the terms and conditions of their relationship with managed care plans and health insurers. The message would be: "Deal with us or don't deal at all"—essentially a closed shop.

Proponents of the legislation, primarily the American Medical Assn., maintain that physicians need the antitrust exemption to protect the interests of their patients when dealing with managed care plans. In fact, an AMA official issued a prepared statement to the effect that the measure, if enacted, would "put us well on our way to repairing the damage that allows health plans to choose profits over patients."

A cost estimate the Congressional Budget Office issued shortly before the Judiciary Committee voted, however, indicates that the bill's backers weren't entirely unconcerned about their own profits.

The CBO estimated that the measure's full impact wouldn't be felt for five years. After the five years, however, the bill would increase private health insurance costs by 2.6% over what they would other-



wise have been, according to the CBO. The report noted that not all independent physicians would join the coalitions but estimated that those who did would enjoy an average 15% increase in fees.

It's hard to see how a double-digit increase in some doctors' fees and a jump in the cost of private health insurance—to say nothing of the increased costs to publicly funded health care programs—will translate into better quality. It's much easier to see how it could translate into decreased access for some individuals.

After all, health care costs are already on the upswing after years of being held in check by managed care. Anything that serves to accelerate and enlarge those cost increases is going to lead some employers, particularly the smaller ones, to reconsider the economic wisdom of providing group health coverage to their employees. When people lose their private coverage, the public ends up paying.

Any legislation that would reduce competition in any field of endeavor deserves extra scrutiny. Given the special-interest fingerprints all over the mislabeled "Quality Health-Care Coalition Act," the House Judiciary Committee clearly didn't provide that needed oversight before voting on this legislation.

Now it's up to the full House—and if those members should fail in their duty, the Senate—to subject this piece of legislation to the closer examination it demands and consign it to the legislative defeat it so roundly deserves.

## RIMS makes its voice heard

FOR THE SECOND YEAR IN A ROW, risk managers have made their voices heard on Capitol Hill.

This year, though, the Risk & Insurance Management Society Inc.'s federal legislative initiative did not end with visits to congressional offices during the annual "RIMS on the Hill" meeting.

As we report in this issue, only a day after the meeting ended, representatives of RIMS also were on hand to present the society's concerns over the Occupational Safety and Health Administration's controversial ergonomics proposal during a public hearing in Washington.

Both events demonstrate that RIMS intends to be an increasingly active participant in, rather than an observer of, the national political scene.

As representatives of a professional discipline, risk

managers have a different perspective to offer lawmakers and regulators from that of representatives of a single industry.

And by carefully targeting their lobbying efforts on a small number of issues of broad concern to RIMS members—as participants did in both this year's and last year's Washington gatherings—risk managers can be increasingly effective advocates on the Hill.

"RIMS on the Hill" is on its way to becoming a tradition. The event provides risk managers a welcome opportunity to make their voices heard where it counts.

By continuing and building on this tradition, RIMS will help increase the chances that its members' words will carry even more weight on Capitol Hill in the future.

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Business Insurance is published by Crain Communications Inc.

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Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Fax 312-280-3174, Email: biweb@crain.com, Offices: 711 Third Ave., New York, N.Y. 10017-5806, Fax 212-210-0704, CRAIN.COM NYK; 473 Fairfield Ave., Gretna, LA 70056, Fax 504-364-1337; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202-638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 323-655-8157; 967 Bermuda Court, Sunnyvale, Calif. 94086-6750, Fax 408-774-1155; New Garden House, 78 Hatton Garden, London EC1N 8LD England, Fax 207-457-1440; 8157 N. Torrey Way, Tucson, Ariz. 85743, Fax 520-579-3476; 777 E. Speer Blvd., Denver, Colo. 80203-4214; Fax 303-733-2244. \$4 a copy and \$89 a year in U.S. \$108 in Canada and Mexico (includes GST). All other countries \$209 a year (includes expedited air delivery). DON MIERENDORF, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 888-446-1422 or 313-446-0450, Fax 313-446-6777. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: JOSEPH P. HANLEY, Crain News Service, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-254-0890. For reprints or reprint permission contact: KAREN BROWN TUCKER, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, 312-649-5319, Fax 312-280-3174.



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# System eases benefit, payroll administration

RESTON, Va.—Best Software Inc. recently released CustomHRMS, a human resources/payroll solution that gives employees access to their HR information via the Internet and their own personal computers, without using in-house information technology resources.

CustomHRMS is the initial service in Best Software's planned suite of hosted HR applications. It upgrades the client/server technology of its award-winning Best! Imperative HRMS. Whereas the Best! Imperative application is installed on the employer's premises, CustomHRMS is accessible via the World Wide Web

## Products & Services

through an agreement with Qwest Communications, a business-to-business Internet service provider. Rather than purchasing and installing a physical product, employers simply pay a monthly service fee so that employees and HR/payroll departments can access the company's intranet HR system from the worksite, from their homes or from any other remote location.

CustomHRMS offers a reduced up-front investment and a pre-

dictable per employee per month pricing structure, making it more affordable than traditional client/server-based applications, according to a company press release. It includes a self-service application that extends the reach and value of an employer's HR and payroll departments. For example, an employee who experiences a life-event change, such as marriage or the birth of a child—can access his or her password-protected account online and update the record automatically.

Through an exclusive partnership, The Tribus Cos., a full-service insurance broker and consulting firm, is using CustomHRMS for its employer clients on an outsourced, hosted basis. The product will be available for general use in May 2000 through hosting agreements with application service providers.

Best Software's nationwide professional team will install and tailor CustomHRMS to client specifications, such as integration with the current payroll system, and will manage ongoing network maintenance.

For information, contact Bob Rabinowitz, Best Software product manager, at 703-709-5200, ext. 3290; by e-mail to [vacustserv@bestsoftware.com](mailto:vacustserv@bestsoftware.com); or visit [www.bestsoftware.com](http://www.bestsoftware.com).

### Real-time claims data

CHICAGO—RSKCo, a division of CNA Risk Management, has implemented an Internet-based risk management information system that gives risk managers real-time access to claims information.

RSKCo's Clearview Information Services are Windows-based tools designed to meet the needs of individual companies and risk managers. The Internet connection speeds the process of gathering and analyzing data to perform outcomes studies and reduce loss costs.

Advantages of the Internet-based Clearview system include:

- Real-time access to adjuster notes and payment information, including the options to look at data chronologically, by topic or by key words.
- The ability of clients to run standard reports or design custom reporting functions to look at claims in a variety of ways, such as by the type of workers compensation injury, the bodily location of the injury or the litigation status of a claim.
- Weekly updating of information

for analytical reporting.

- Comprehensive and ongoing training and support, including the option of having an information services representative go online with clients to assist them in learning the system and in troubleshooting.

- Easy logon to a highly secure, password- and firewall-protected Web site through a reliable network connection.

With more than 600 Clearview users, RSKCo has one of the largest installed risk management databases in the country.

Prices for the Clearview system are on a sliding scale, starting at \$12,000 per user.

For information, contact Nancy Gicewicz, information services assistant vp for RSKCo, at 312-822-6442.

### Site for small buyers

TORRANCE, Calif.—ePolicy.com has launched a service to allow small businesses and professionals to retrieve information on commercial insurance, get quotes, apply for coverage and purchase it—all online.

The "power of the pen" that the insurers give ePolicy eliminates the need to pass policies back and forth between broker and insurer.

One of the first full-service online insurance providers developed for small businesses and professionals, ePolicy's products are supplied by top-tier insurers and are typically less expensive than identical policies purchased through traditional channels. With ePolicy, the entire process of buying coverage takes only five to 15 minutes, compared with the days or weeks offline purchases require, according to a company press release.

ePolicy has secured underwriting agreements with Fireman's Fund Insurance Co., Kemper Casualty Co., TIG Specialty Insurance Solutions and Interstate Insurance Group. Based in Torrance, Calif., ePolicy was co-founded in June 1999 by insurance industry veteran Donald E. Martin, founder and former president of The Cal-Surance Cos. Inc., and Louis A. Kwiker, former president of Bristol Farms, Wherehouse Entertainment and Handleman Co.

Currently, ePolicy is rolling out professional liability insurance nationwide for more than 300 types of small businesses and professionals. It will soon introduce business owner's policies and workers compensation insurance nationwide.

The commercial insurance provider has 40 employees.

For information, contact Tracy Bechtold, public relations manager at ePolicy, 310-819-3239.

### Online marketplace

WRENTHAM, Mass.—StarNex Inc., a developer of software and Web-based products and services, has received venture capital financing to provide a single, business-to-business, e-commerce marketplace for the insurance industry.

The initial \$11 million in venture capital financing is provided by Firemark Investments of Morristown, N.J., and IVANS Inc. of Greenwich, Conn. The funding will let StarNex pursue its mission of bringing insurance providers, brokers and third-party vendors into the same information-sharing marketplace.

StarNex intends to dedicate its resources to three main areas:

- Expanding its distribution network by opening sales and support offices throughout the United States
- Creating a fully integrated marketing communications program
- Hiring technical talent to enhance and expand StarNex offerings

The StarNex environment is designed to eliminate the redundant paper processing that occurs in the quoting and distribution of insurance products. Brokers and insurance providers will have the opportunity to increase revenues, expand distribution, reduce costs and improve customer service in most segments of the insurance industry.

The company will concentrate initial sales and marketing efforts on the 175,000 U.S. benefits brokers.

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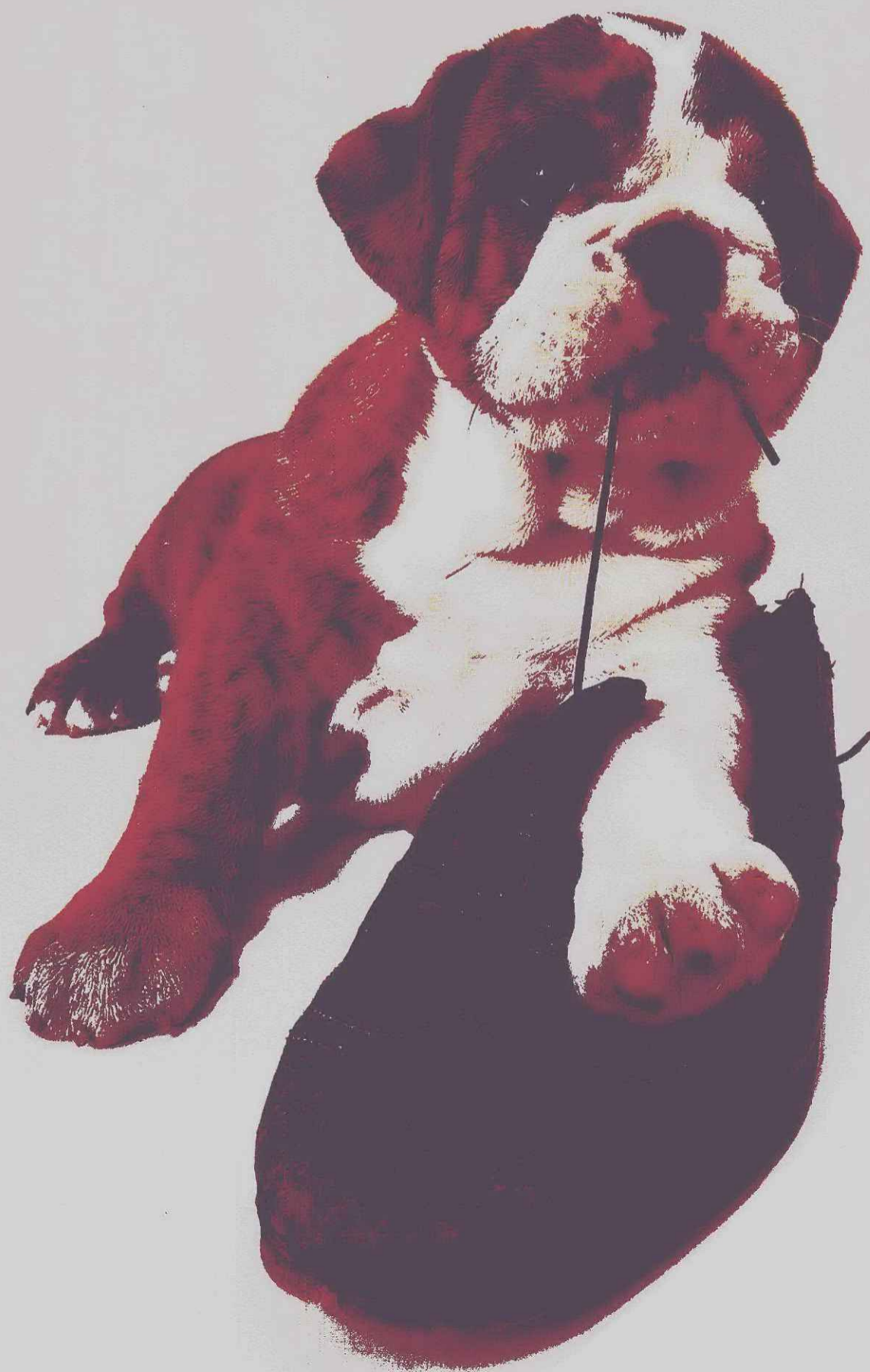
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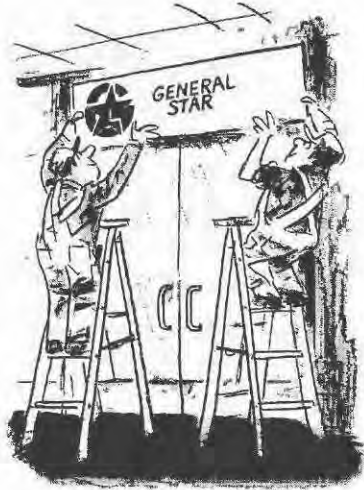
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# ASK A BENEFIT ACTUARY

**Q**

**Are we getting value from our 401(k) plan?**

**A**

This question comes from the chief financial officer of a Fortune 1000 company. The CFO knows what her company spends on matching contributions to the 401(k) plan, as well as the costs of the recordkeeping and other administrative fees, and she is

questioning whether her company is getting a benefit from the plan that justifies these expenditures.

In order to help answer this and similar questions from plan sponsors, we can turn to available research that helps plan sponsors analyze the value of 401(k) plans across four components:

- **Relative contributions:** How much of the total of plan contributions is borne by employees themselves?
- **Participation:** How high is the level of participation, given the demographics of the employees eligible for the plan?
- **Investment efficiency:** How do employees' investment patterns compare to an optimal asset allocation based on the demographics of the participant population?
- **Benefit adequacy:** Does the plan generate adequate retirement income for participants?

Plans are measured in each component against a database of similar plans. Because plan sponsors' objectives differ across each of these components, each component is weighted according to where an individual plan sponsor ranks it in importance (e.g., a sponsor may consider benefit adequacy a more important goal than lower relative contributions).

Available research focuses on the underlying goals that motivate the sponsorship of a retirement plan, assessing how well a plan is meeting those goals. It also quantifies the value of a 401(k) plan to its sponsor and provides a way to benchmark the plan's effectiveness. Using such research, a plan sponsor can more easily identify misalignment between the plan and its goals and can diagnose where the plan is falling short. Plan sponsors can then focus their resources in the most cost-efficient manner to improve the value delivered.

The category of relative contributions looks at the share of total plan contributions made by workers themselves. In most plans, participants provide 70% to 79% of total contributions (see Figure 1). This is simply a reflection of the fact that most plans provide a 50% match and that employees often make non-matching contributions. Plans in which participants contribute

Most employers' goal is to maximize participation among those eligible for the plan. At a basic level, the participation rate might simply be measured as the ratio of participants in the plan relative to the total number of eligible employees. But participation in 401(k) plans is sensitive to the salary levels and ages of employees, with older and highly paid workers participating more frequently.

balances, the typical retirement age under the plan, projected rates of return on retirement savings, the presence and generosity of a defined benefit plan, and the presence of retiree health benefits.

The results from the four components—relative contributions, participation, investment efficiency and benefit adequacy—are then weighted based on the plan sponsor's weightings to determine its overall results. All

four components of the value equation are not necessarily equal, however. Here's how the database of plan sponsors rates each component by average weighting:

- **Relative contributions:** 14.7%.
- **Participation:** 30.8%.
- **Investment efficiency:** 20.3%.
- **Benefit adequacy:** 34.2%.

Applying these weightings to each plan's component scores provides its overall score. The results are shown



Figure 2

The available research can provide a measure of the ratio of the actual participation rate in a 401(k) plan to the expected participation rate, based on a general population of such plans. This ratio is the participation index. It takes into account the plan's match rate, the average age and wage of eligible workers, the existence of a defined benefit plan in the company, and whether some of the eligible workers are covered by a union agreement. (Figure 2) shows how plans are performing relative to one another. (Again, a score of 100 represents the "ideal" plan.)

Maximizing the return on investment is a critical success factor for 401(k) plans. With traditional defined-benefit pensions, an employer's institutional investing ability helps determine the long-term value of the plan. With 401(k) plans, the investment elections of employees themselves drive value.

This third research component is based on the expected rates of return on the assets currently in the plan, as allocated by the participants relative to an "optimal" portfolio. The underlying assumption at work here is that individual investors tend to invest their own retirement assets somewhat more conservatively than do plan sponsors, especially those investors using professional advisers to make

investment decisions. The baseline optimal portfolio is constructed by estimating the desired equity holdings in the plan based on the ages of a worker participating in the plan.

The last part of the research examines the extent to which a company's 401(k) plan, taken together with other government- and employer-sponsored plans, meets the income needs of retiring workers. Here, the research measures whether the savings rates of plans are sufficient to accumulate the assets needed to maintain

pre-retirement standards of living upon retirement. This model takes into account participant account

below:

The percentile distribution shown in Figure 3 is skewed to the right, indicating that many plan sponsors are largely successful in realizing the principal goals of their plans. The relatively low scores by a significant number of plans, however, suggest that many plan

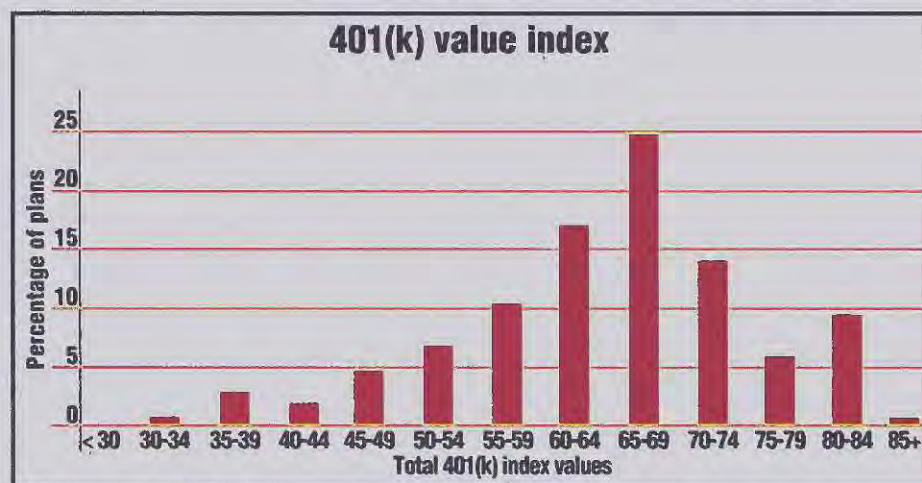


Figure 3

sponsors are not meeting their specified goals.

The question regarding the value delivered to an organization by its 401(k) plan need not be elusive. A plan sponsor can understand the degree to which its plan is aligned with its objectives. **BI**

*Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.*

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*This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago. Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field. Christopher E. Mandel, senior director of risk management at Tricon Global Restaurants Inc. in Louisville, Ky., answers questions on risk management.*



Mr. Miner

*Dennis J. Nirtaut, managing director of compensation and benefits for Arthur Andersen L.L.P. in Chicago, answers questions on employee benefit plans.*

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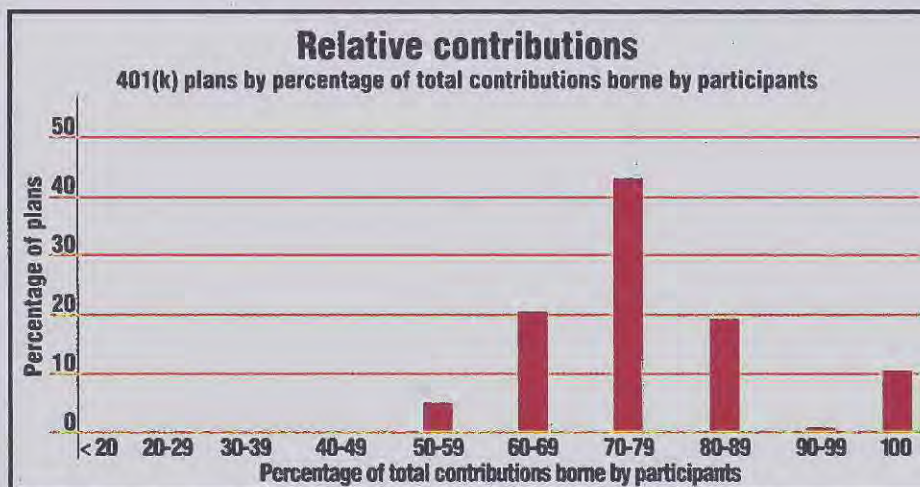


Figure 1

50% to 59% of the total contributions have 100% employer match rates.

# Best outcomes sorely needed in medicine

**"Demanding Medical Excellence: Doctors and Accountability in the Information Age"**

By Michael L. Millenson  
University of Chicago Press  
451 pages  
800-621-2736  
\$16

By Michael Prince

**W**hat's one of the leading causes of death and injury in the United States? Doctors. And what's being done about it? Not enough.

This, in a nutshell, summarizes a newly issued paperback edition of "Demanding Medical Excellence: Doctors and Accountability in the Information Age." Its author, Michael Millenson, a veteran health care journalist turned consultant, plunges headlong into the complex problem of delivering high-quality medical care in this thoroughly researched and highly readable book.

The book opens with a dramatic example of doctors debating the best treatment for a man suffering from heart disease. Rather than arriving at a decision through persuasion or pulling rank, the doctors use computer models to determine the patient's best chances for long-term survival. Sounds common. But, as Mr. Millenson demonstrates, it's not.

"Although genetic engineering, organ transplants and hormones that promise everlasting youth make front-page news, in an overwhelming number of cases, the average doctor treating everyday ills simply does not know what works best," Mr. Millenson writes.

This sweeping, candid and often compelling book lays bare the fallacy that medicine is science. He calls medical mistakes the nation's leading cause of preventable death, noting that such mistakes annually kill four times as many people as do traffic accidents. In addition, medical errors injure 1.3 million people each year, he states.

From post-World War I England, to Vermont in the 1960s, to Eisenhower-era Utah, Millenson lays out the work of his story's heroes—researchers who painstakingly established that doctors typically choose courses of treatment with little understanding of the best outcome. Despite decades of research, even today few doctors practice medicine based on evidence of the best treatment.

"Whether the setting is a small town, a suburb or the heart of a big-city medical center, study after study shows that few physicians systematically apply to everyday treatment the scientific evidence about what works best," Mr. Millenson writes.

For example, Mr. Millenson tells the story of a hospital outside Pittsburgh that experienced high death rates among pneumonia patients. A close examination revealed that a higher-than-expected death rate was seen among patients that usually survive pneumonia—those who are young and otherwise healthy. When the hospital delved into these patients' records, it discovered that these patients did not receive the recommended care, such as an antibiotic treatment beginning within four hours of admission. In response, the hospital changed the treatment for these patients, and the death rate plunged.

While the book describes numerous similar stories of hospitals that changed treatment and improved care, Mr. Millenson stresses that such developments are few and far between. Instead, care remains spotty. Mr. Millenson cites a study that showed just one in five heart attack patients received a beta-blocker drug, a proven means of increasing patients' chance of survival. What's lacking, he writes, is not the knowledge about how to improve care, but rather the desire to implement this knowledge.

Perhaps even more distressing, Mr. Millenson notes, is that changes don't occur even when it has been shown that a procedure lacks scientific support.

In one example, Mr. Millenson looks at tonsillectomies. During the 1950s, he notes, children of insured workers had a 50% chance of having their tonsils removed. "Yet an exhaustive review of the medical literature up to that time found no evidence that a tonsillectomy accomplished its purposes," he writes.

Although later studies disputed the wisdom of the procedure, it wasn't until the 1970s that the rates of tonsillectomies declined. This is but a sampling of the picture he paints of a medical profession that conducts itself unburdened by the standards of science and quality control that other fields adopted long ago.

But, Mr. Millenson writes, not every hospital operates this way. For example, an entire section of the book is devoted to Salt Lake City's LDS Hospital. There, starting in the early 1950s, a small group of doctors and engineers pioneered a computer system that analyzed patient care. Through the years, the system grew and added more features; today, it is used throughout the hospital to monitor adverse drug interactions, help diagnose patients and prevent infections from surgery.

The results have been startling. The hospital's rates of adverse drug reactions and surgical infections are significantly lower than the national norm, sometimes even lower than hospitals' acceptable levels.

Still, not every story of improved quality is positive. The book takes us to Northfield, Minn., a small town where a four-doctor group in the early 1990s devoted itself to high-

quality care. The clinic rigorously implemented practice guidelines and developed its own methods of caring for patients in the most cost-efficient way.

But something unexpected occurred. "The better the clinic got at practicing cost-efficient medicine, the emptier its waiting room became," the book states. For instance, patients with simple illnesses were effectively treated over the phone, eliminating office visits and tests. Because treatment and tests declined, the clinic's revenues dropped. By 1995, the clinic, facing financial ruin, was forced to sell to a larger health plan.

Another study Mr. Millenson cites shows that, on average, an adverse drug reaction increases the cost of a hospital stay by \$2,300. And this doesn't include the cost of lost productivity resulting from the worker's absence.

When the book first appeared in 1997, the topic of quality medical care was not in the headlines. But this newly issued paperback edition, which contains an updated afterword, notes that, in the past few years, the problem of poor medical quality has come into the public eye.

During that period, new research into the quality of medical care has been conducted. In particular, a study was published late last year by the Washington-based Institute of Medicine, a private non-profit institute that is part of the National Academy of Sciences. The study concluded that between 44,000 and 98,000 hospital patients die each year because of medical errors, prompting President Clinton in February to announce steps the federal government will take to improve patient safety.

Despite the heightened publicity, it's not clear that the medical community has been moved to act. Ultimately, doctors will not change without pressure from those who pay the bills—the employers.

"For many hospitals and doctors, the financial incentives simply do not yet justify aggressive efforts to reduce clinical 'waste,'" the book starkly states.

But, with any luck, this dynamic and compelling book may spur at least some employers to act. **BI**



Michael Prince is an associate editor of Business Insurance in New York.

## Direct contravention of order nullifies workers comp

An injury that occurred while an employee was attempting to work in direct contravention of his employer's order not to report to work, due to his physical condition, was not compensable under state workers compensation law, according to the Supreme Court of Kentucky.

Donald Ray Phillips was employed as a laborer for Jenmar Inc. from 1990 until Aug. 18, 1995, the date of his injury. It was undisputed that he suffered from alcoholism. Records revealed that, before Aug. 18, Mr. Phillips had decided to quit drinking and that he began to suffer symptoms associated with delirium tremens.

According to court papers, the owner of the company directed Mr. Phillips to take a specific day off because of his physical condition. Nevertheless, Mr. Phillips showed up for work on that day and was found gripping the production rack and trembling. His grip failed and he fell backward, striking his head on the concrete floor.

Mr. Phillips sustained a severe head injury as well as an injury to his right arm, and he filed for workers compensation. His claim was denied.

The appellate court said that the safety rules generally pertain to the manner in which work is to be performed; here, however, Mr. Phillips' injury did not result from failure to obey an order concerning workplace safety. "He was injured," the court said, "because he disobeyed an

### Legal Briefs

order not to work due to his physical condition."

Because Mr. Phillips was on the employer's premises the day of his injury in direct contravention of the employer's order, the court found that he was not present as an employee and that the injury did not occur in the course and scope of his employment. The court affirmed the denial of workers comp benefits.

*Phillips vs. Jenmar Inc.*, Supreme Court of Kentucky, Aug. 26, 1999, (BI/01/A.- \$10)

### ERISA plan-change disclosure

An employer has an affirmative duty to disclose information about proposed changes to an Employee Retirement Income Security Act-covered plan to participants and beneficiaries, the 9th U.S. Circuit Court of Appeals ruled.

Ernest Bins worked for Exxon Co. USA for 15 years. In the months before he retired, Mr. Bins unsuccessfully attempted to confirm rumors that the employer was considering offering eligible employees a lump-sum retirement incentive under an existing benefit plan covered by ERISA.

Two weeks after Mr. Bins retired, the employer announced precisely the sort of retirement incentive about which Mr. Bins had inquired. He sued, alleging the employer had violated its fiduciary duty by failing to inform him prior to his retirement that it was considering the benefit change. The trial court ruled against Mr. Bins.

The appellate court said information about a potential change in benefits is material to plan participants and beneficiaries when the employer begins serious consideration of such a change. Furthermore, the court said that once an employer-fiduciary seriously considers a proposal to offer changed benefits under an existing ERISA plan, the employer-fiduciary has an affirmative duty to disclose information about the proposed changes to plan participants and beneficiaries whom it knows or should know are considering retirement and to whom the information would be useful. The trial court decision was reversed.

*Bins vs. Exxon Co. U.S.A.*, 9th U.S. Circuit Court of Appeals, Aug. 30, 1999, (BI/02/A.- \$10) **BI**

*These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

## INTERNATIONAL

## Global Briefs

**Copenhagen Reinsurance Group** plans to launch a new syndicate at Lloyd's of London in October. The new syndicate, managed by PXRE Managing Agency Ltd., will write Copenhagen Re's marine and financial institutions business, as well as the facultative portfolio, for the company's U.K. branch. Copenhagen Re expects the syndicate to generate annual premiums in excess of £40 million (\$63.7 million), representing 20% of the reinsurer's worldwide premium volume. . . . Talks in Beijing between China and the European Union over a financial services accord broke down late last month. The two sides had hoped to agree on a trade deal that would aid **China's accession to the World Trade Organization**, but negotiators failed to reach an agreement over certain crucial issues, including majority foreign ownership in Chinese financial services firms. . . . Fusion, the e-commerce subsidiary of Lloyd's managing agency **SVB Syndicates Ltd.**, plans to sell directors and officers liability coverage online. Starting in November, a broker using the system will be able to obtain quotes online and then negotiate by telephone with an underwriter who has the authority to agree to terms. Brokers will receive policy wordings online within seconds of an agreement being reached, SVB said. . . . Rating agency Standard & Poor's Ltd. has warned that the earnings of **South Korean insurers** will remain under pressure in 2000. S&P said that, despite signs of an economic recovery in the country, insurance premium volume continued to decline in 1999. . . . French credit insurer **Euler S.A.** has opened an office in Sao Paulo, Brazil, to give Euler companies access to improved information on business risks in South America. . . . **Zurich Financial Services Group Inc.** posted record net income in 1999 of \$3.26 billion, up 15.9% over the previous year. Zurich, Switzerland-based ZFS plans to spend \$1 billion on a new Internet strategy in a bid to triple its customer base to 100 million over the next three years, the company said. Meanwhile, ZFS unveiled a new business unit that will offer holistic risk management solutions, including integrated risk financing, for global companies. The new unit, Zurich Corporate Solutions, will target FTSE and Fortune 500 companies. . . . The proposed merger between German banking giants Deutsche Bank and Dresdner Bank has fallen through. Insurer **Allianz A.G.**, which has a stake in each, had been set to acquire a 49% share in Deutsche's retail bank, Deutsche Bank 24, its asset management arm, and its life insurer, Deutsche Herold Leben. Allianz' shares fell 14% upon news that the bank deal had collapsed. . . . Meanwhile, Allianz has set up a Romanian subsidiary. **Allianz Romania S.A.**, based in Bucharest, will initially sell property/casualty insurance products. . . . U.K. insurance group **Amlin P.L.C.** has merged two of its Lloyd's of London managing agencies, Amlin Underwriting Ltd. and Angerstein Underwriting Ltd. The combined entity, which retains the Amlin Underwriting name, manages £538 million (\$852 million) of capacity. . . . **CEFOR**, the Norwegian Central Union of Marine Underwriters, has warned that global marine insurers are facing losses of \$3 billion for the 1999 underwriting year. Cefor predicts a loss ratio of 170% for 1998 and 200% for 1999. . . . The U.K. **National Health Service** is facing a massive bill for negligence claims. The national Audit Office estimates that potential liabilities stand at £2.4 billion (\$3.87 billion) as of March 1999.

## '99 aircraft hull losses soar

AIOA calls for increased rates

By SARAH VEYSEY

LONDON—Aviation insurers are calling for rate hikes after being hit in 1999 by a record amount of insured hull losses on Western-built aircraft.

Insured hull losses totaled \$985 million last year, according to the Aviation Insurers Offices' Assn.

Although 1999 was a relatively safe year in terms of passenger fatalities—with only 512 deaths recorded on commercial flights—the rising value and complexity of aircraft made 1999 a very costly one for aviation hull insurers, said Keith Selby, the outgoing chairman of the London-based AIOA at its annual committee meeting in

London.

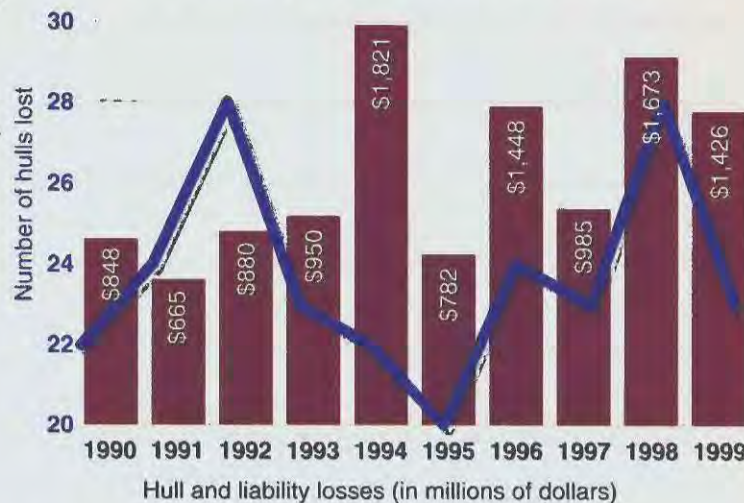
"Whilst the number of fatalities from (commercial airline) flights was mercifully low in 1999, an extremely high level of hull losses can be attributed to an increased complexity of aircraft design and consequent increase in airline value," said Graham Nichols, chief executive/underwriter at Westminster Aviation Insurance Group and the new chairman of the AIOA.

In 1999, 58 Western-built jets and turboprops were total losses, while 75 Eastern-built jets and turboprops were total losses. There were 76 major partial losses to Western-built jets and turboprops, and two major partial

See Aviation on next page

## A decade of aviation losses

Hull and liability losses for Western-built aircraft



Source: Aviation Insurers Offices' Assn./Airclaims Ltd.

GRAPHIC BY ADAM DOI

## Huge flood risk predicted for English coasts

By CAROLYN ALDRED

CHICHESTER, West Sussex—Faced with a possible catastrophic loss scenario along England's southern and eastern coastline, the Assn. of British Insurers is urging local authorities and government departments to look closely at existing flood defenses and future building on flood plains.



If insurers in the United Kingdom are to continue offering flood insurance as part of standard commercial and personal policies, local authorities must wake up to the effects of climate change and the increased risks of flooding, Chris Mounsey, ABI's manager of property and household insurance, warned at a conference late last month on climate change.

The United Kingdom, unlike many other European countries, does not currently exclude the coverage of flooding in its commercial and personal lines policies. But growing development on flood plains and the increased like-

See Climate on next page

## Aussie tobacco class suit denied

By PAULA WESTON

SYDNEY, Australia—The Federal Court of Australia will not permit six plaintiffs to file a class-action lawsuit against three tobacco companies.

The federal court in Sydney ruled recently that the suit against Melbourne-based Philip Morris (Aust.) Ltd., Sydney-based Rothmans of Pall Mall (Aust.) Ltd. and Sydney-based WD & HO Wills (Aust.) Ltd. was "fundamentally flawed," making class-action status inappropriate.

Lawyers for the plaintiffs say that the decision could jeopardize other class actions and that they may appeal.

The claimants have until today to apply for leave to appeal the decision to the High Court of Australia.

A Philip Morris spokeswoman said the federal court had agreed with the tobacco companies' contention that the case

See Tobacco on page 22



PHOTO: NEWSMAKERS

Pete Goss, skipper of the Team Philips catamaran, inspects his damaged hull in St Mary's Bay, Isles of Scilly.

## Team Philips yacht is insured for loss

ISLES OF SCILLY, England—Team Philips, the huge carbon fiber catamaran that snapped in two during its first sea trial, is insured for £2.6 million (\$4.2 million) by the London-based yacht insurance agency Sextant International Ltd.

Team Philips, which had been built to break the Jules Verne record—71 days—for sailing around the world, is a revolutionary design and is one of the largest carbon-fiber constructions ever built. It was named by Queen Elizabeth II in London on March 14 in a blaze of publicity.

The yacht was also expected to compete in an upcoming event called The Race, the first ever non-stop, no rules, round-the-world yacht race that is scheduled to start from Barcelona, Spain, on Dec. 31, 2000.

The designers of Team Philips predicted that it would be able to circle the globe in 65 days, shaving six days off the current record.

The yacht is skippered by Pete Goss, who risked his life and sacrificed victory in the 1996-97

Vendee Globe race when he turned back to rescue a fellow competitor whose boat had overturned 1,000 miles off the coast of Australia.

The Team Philips mishap occurred March 29, when a 45-foot section of one of its 120-foot twin bows snapped off during the catamaran's first trip to sea off the Isles of Scilly, near the southwest coast of England. The vessel and its crew were towed back to Dartmouth, Devon.

The yacht will be taken back to the site of its construction in Totnes, Devon, where the damage will be assessed, said a spokeswoman for Sextant, one of the yacht's sponsors.

Sextant was formed in September 1999 to provide worldwide yacht coverage under policies written in English, French, Italian and German. One of Sextant's insurers is Brockbank Underwriting Ltd., a Lloyd's of London underwriting agency whose syndicate number 861 underwrote Team Philips' insurance coverage, said the spokeswoman. Brockbank is part of XL Capital Ltd.

—By Carolyn Aldred

## Aviation

Continued from previous page  
losses to Eastern-built jets and turboprops. The vast majority of insured active aircraft are Western-built hulls.

One of the most expensive losses in 1999 was a Korean Airlines accident on April 15, when an MD-11 aircraft crashed shortly after taking off from Shanghai, China. The hull of the aircraft was insured for \$80 million. In addition, a China Airlines MD-11 that flipped over after landing in a severe rainstorm in Hong Kong on Aug. 22 also cost hull insurers \$80 million.

Mr. Nichols said the loss of a Qantas Boeing 747-400 that overshot the runway after landing at Bangkok in a heavy rainstorm on Sept. 23 illustrated the increased cost of aircraft. Although the Qantas plane was declared only a partial loss, the damage to the plane totaled \$74 million.

In fourth-quarter 1999, two major losses hit the aviation insurance industry. On Oct. 17, a Federal Express Corp. MD-11 aircraft overshot a runway in the Philippines and ended up in Subic Bay, costing hull insurers slightly more than \$90 million.

The worst accident in that period, in terms of passenger fatalities, occurred Oct. 21, when an EgyptAir Boeing 747 en route to Cairo plunged into the Atlantic Ocean 30 minutes after takeoff from New York's John F. Kennedy airport. All 202 passengers and 15 crew members perished.

In addition to losses to aircraft while in operation, hull insurance losses were also hit by damage done to several aircraft at Sydney Kingsford Smith Airport when a freak hailstorm struck Sydney, Australia, on April 14. Related repair costs are estimated at \$80 million.

Hull losses for the first quarter of 2000 have been estimated at \$220 million, according to Dave Matcham,

secretary to the AIOA. He said the association estimated that, in addition to this figure, there would be about \$50 million in attritional hull losses—significant partial losses—some of which have not yet been declared. The AIOA bases its estimates for attritional hull losses on previous statistics, said Mr. Matcham.

Of 20 estimated total or partial losses for the year to date, 11 were Western-built jets, he noted.

"This is probably one of the least-encouraging first quarters we have ever had," said Mr. Nichols.

At its annual meeting in London, the AIOA committee said that the aviation market remained soft, despite consolidation among insurers, such as ACE Ltd.'s \$3.5 billion acquisition of CIGNA Corp.'s property/casualty operations in 1999.

"In spite of the widely perceived serious inadequacy of premium income from airline insurance, the market was unable to achieve the necessary corrective action during the fourth-quarter renewal season," Mr. Selby said.

"In reality, the market remained overcapacitated and severely depressed throughout the year," he said. "The longer the corrective action is delayed, of course, the greater the need for it becomes, as the aggregation of exposure to underwriters marches ever onward."

Mr. Selby said he hoped that rates would increase by year end, after underwriters feel the effects of a withdrawal of retrocessional capacity and the increased cost of catastrophe reinsurance.

"In the meantime, though, it is to be hoped that the hull loss experience in 1999, coupled with the airline loss experience in the first quarter of 2000 to date, will serve to strengthen underwriters' resolve to set out on the long path to recovery before being forced to do so by the exigencies of constructing a realistic business plan for 2001," he said.

"There is a lot of effort being put in in London to get back to a realistic level of premium," Mr. Nichols said. "It is an area of great concern, and we continue to have robust discussions

**'There is a lot of effort being put in in London to get back to a realistic level of premium,' says Graham Nichols.**

with our clients."

He stressed, however, that time was of the essence.

"Clients will require higher limits and broader coverage for the new generation of aircraft in the future, and we must meet their needs from a healthy market position. I believe that 2000 will be a make-or-break

## Climate

Continued from previous page  
likelihood of claims from flooding, partly due to climate change and rising sea levels, is forcing insurers to review their risk position.

Research on coastal flooding conducted by the ABI identified several high-risk areas about which the ABI is in discussion with the Environment Agency, the government agency responsible for flood relief. The ABI wants the Environment Agency to improve sea defenses in those areas identified by the ABI as high risk, said Mr. Mounsey.

Meanwhile, the ABI has just commissioned consultants to look at the risk of loss due to river flooding in the United Kingdom, said Mr. Mounsey.

The ABI now is trying to alert local authorities to the increasing dangers of flooding.

It is also important to make the public and businesses aware of the dangers, said Mr. Mounsey.

"The insurance industry can continue to offer a wide availability of cover for flood, windstorm and subsidence risk if all the stakeholders work together," said Mr. Mounsey, adding that future insurance availability depends on "cooperation and coordination."

"Weather and climate change continues to pose a real threat to the insurance industry. In particular, coastal flooding presents a catastrophe risk which could cause billions and billions of losses. Drier summers and wetter winters, rising sea levels and more-extreme weather events will cause greater losses from flood, windstorm and subsidence," Mr. Mounsey told approximately 50 attendees at the conference on climate change, held at West Sussex County Council hall in Chichester, England.

The conference, which was attended by employees and elected officials of local authorities, environmental groups and community representatives, was convened to discuss the findings of a recent report on the impact of climate change on southeast England in the 21st century.

The report, "Rising to the Challenge," was prepared by Epsom-based engineering consultant W.S. Atkins Consultants Ltd. The report was sponsored by the county councils of West Sussex, Surrey, Hampshire and Kent; several government agencies, including the Meteorological Office and the Environment Agency; Thames Water Utilities Ltd.; the Agricultural Development Advisory Service; the U.K. Climate Impacts Programme and several environmental groups.

According to the report, by the

year for the structure of the market. The time has arrived for change," Mr. Nichols said.

Meanwhile, there has been a withdrawal of capacity in the space insurance market, according to Janet Sadler, who is senior vp of Chubb Corp. unit Federal Insurance Co., and an AIOA committee member.

"The space market is also a market that is overcapacitated, but because it is more casualty-based than liability-based, there has been a withdrawal of capacity," she said. "The trend for the first quarter of 2000 is that there seems to be more discipline, and bad risks are becoming harder for brokers to place."

Ms. Sadler said that the space market is concerned about the level of losses.

"We had an awful lot of losses last year, probably about \$750 million. In 1998 and 1999 combined, space losses totaled about \$2.25 billion," she said. "From an insurance perspec-

tive, there is a great deal more discrimination now. But it is, and always will be, a very high-risk industry."

Ms. Sadler said that the only space loss so far this year was the ICO Global Communications satellite, which was destroyed when being launched on March 12. The satellite was insured for \$225 million.

"Those people involved in the Sea Launch project were devastated," she said. "It is now believed to have been caused by a software error."

The AIOA was formed in 1948 to represent the interests of aviation insurers in the London market. The association, which has 14 members, recently created a membership category for former members who have put their aviation book into runoff. In 1999, the AIOA became an affiliate member of the London-based International Underwriting Association and functions as an IUA technical committee. **BI**

Mr. Mounsey stressed that the ABI is not opposed to all development on flood plains, because there is so little land available. But, he said, there are ways of dealing with such development that should be adopted. Examples Mr. Mounsey cited included altering building construction to cope with the risk of flooding and introducing flood contingency plans.

Similarly, risk management techniques can be adopted to reduce the risk of windstorm and subsidence damage, including using different building techniques; increasing building maintenance; making people more aware of the risk and consequences of windstorm and subsidence; and monitoring the risk of damage from downed trees and limbs, said Mr. Mounsey.

For many industries in the area, including farming and tourism, adaptation to the changes will be the key to survival, the report notes.

For example, increasing temperatures will have a profound effect on farming techniques and the crops that can be grown, said Jo Hossell, Wolverhampton, Midlands-based senior research scientist for the Agricultural Development Advisory Service.

The water industry also must be particularly alert to the changing rainfall patterns and the increasing demand for water, noted conference attendee Derek Giles, water resources technical manager of Southern Water P.L.C. in Worthing.

A survey of companies located in the southeast showed a wide range of awareness of the likely impact of climate change on their businesses, Colin Fenn, a director of WS Atkins Water division, told the conference.

Heavy users of water, such as paper manufacturers, were among the most aware, he noted, although the consequences of climate change will have an impact on all sorts of businesses, he said.

"A rise in sea level is probably our greatest future threat from an operational viewpoint," said Robert Mackenzie, a hydrographic technician with the Dover Harbour Board, in the report. "An increasing incidence of storm-surge tides during the period August to April, especially if accompanied by strong winds and wave activity, also pose serious problems, with disruptions of ferry services to the Continent and quayside flooding."

Business, manufacturing and service industries all are affected by severe weather events, such as floods, windstorms, hot dry spells, frost and severe cold spells, according to the report. In addition, a rise in sea level is a concern to economic activity based on the coast, the report said. **BI**

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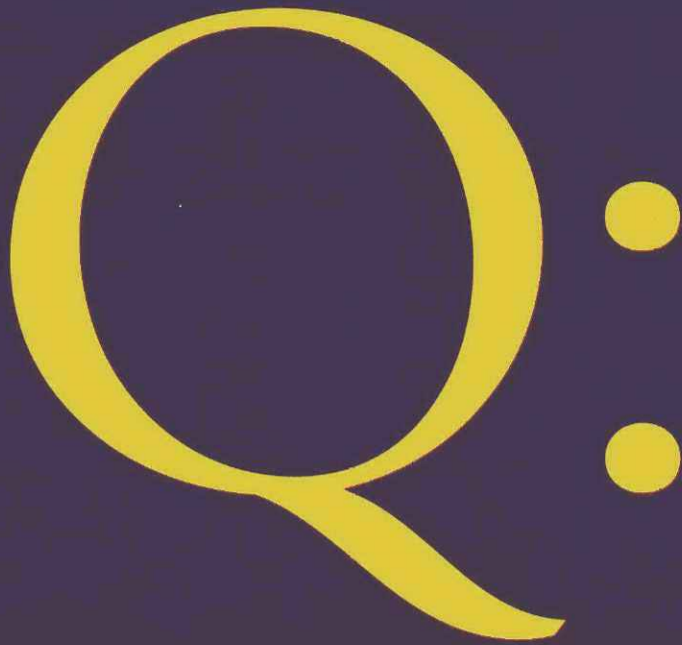
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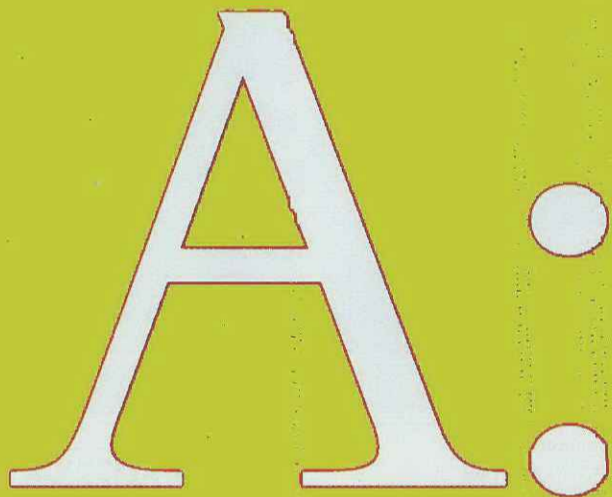
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## INTERNATIONAL

## Tobacco

Continued from page 19  
should not be heard as a class action.

"The court confirmed what Philip Morris has been saying all along—that class actions are not appropriate where claims give rise to numerous issues that must be determined on an individual-by-individual basis," Ms. White said.

"Every smoker is unique, having smoked different products, at different times, in different quantities and for different lengths of time. Different smokers also have different lifestyles," she said.

The claimants' attorney, Andrew Brech of the Sydney-based plaintiff law firm Slater & Gordon, criticized the ruling.

Mr. Brech said that, although class actions are relatively new in Australia and there is not a large body of case law, clear principles nevertheless exist.

He said the judges' opinion that every class member is different could be applied to every potential circum-

stance for a class action.

"We believe an application for leave to appeal has reasonable prospects to succeed, as does the action itself," Mr. Brech said, adding that the claimants have not yet decided whether to appeal or pursue some other approach.

The tobacco action initially was filed by Slater & Gordon in the federal court on April 16, 1999. The plaintiffs claim that they contracted a variety of illnesses—cancer of the lung, larynx, pharynx, tongue or esophagus, and/or emphysema, chronic bronchitis, airflow obstruction, peripheral vascular disease and coronary disease—between April 16, 1996, and April 16, 1999. The injuries, claimants charge, were a consequence of smoking, over a 40-year period, cigarettes manufactured by the companies named in the suit.

The claimants say they did not stop smoking because manufacturers advertised, marketed and promoted cigarettes as "enhancing life" and made public statements denying or casting doubt on evidence linking smoking to health risks. In addition,

they claim that manufacturers lobbied governments to minimize health warnings and restrictions on advertising, that the companies were silent on health risks of which they were aware, and that they implemented strategies to induce smoking.

The tobacco companies challenged the claimants' right to proceed on the basis that the claims were not similar enough to be grouped together.

Last August, Federal Court Justice Murray Wilcox ruled that litigation could proceed. The tobacco companies appealed that decision to the full court of the federal court in Sydney, comprising Justices Jeff Spender, Donald Hill and Ronald Sackville.

The judges issued an interim order suspending the action. On March 13, they upheld the appeal, setting aside Justice Wilcox's decision and ordering the claimants to pay the tobacco companies' legal costs.

The Philip Morris spokeswoman said the tobacco companies' appeal was not meant to "deny a person his or her day in court."

"It was to ensure that the mechanism for the resolution of individual

claims is the most efficient, effective and appropriate in the circumstances," she said. "While there are many strong opinions concerning tobacco, we believe the community is better served by resolving our differences through constructive dialogue, consultation and cooperation, rather than confrontation and time-consuming, costly litigation."

Mr. Brech said the claimants could now "apply for special leave to appeal to the High Court, abandon the process as a class action and continue to run the claims as individual actions, or abandon the action altogether."

Still another option is for the plaintiffs to file the claim in the Supreme Court of the state of Victoria.

However, Slater & Gordon is involved in another class-action suit that is testing whether that court has jurisdiction to hear such actions. Melbourne-based Exxon-Mobil Australia Pty. Ltd. has challenged a class action seeking compensation for contaminated aviation fuel (BI, Feb. 21).

Mr. Brech said the Exxon-Mobil challenge was heard in Victoria's court of appeal in February, and the parties are awaiting a decision. The Exxon-Mobil action has been suspended, pending the decision.

Class actions were introduced into Australia's Federal Court Act (Part IVA) in 1991, following a Law Reform Commission inquiry and report.

Last month, state and federal government attorneys general met to discuss filing a lawsuit against tobacco companies. While the federal government opted out of litigation, state and territory attorneys general agreed to establish a working party to consider possible joint actions to seek reimbursement of government expenditures for smoking-related diseases.

According to Queensland Attorney General Matt Foley, if the attorneys general decide to pursue litigation, their lawsuit could be based on the U.S. action that led to a \$206 billion settlement between tobacco companies and 46 attorneys general (BI, Nov. 23, 1998). **BI**

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## LEGAL NOTICES

## LEGAL NOTICES

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IN THE MATTER OF THE LIQUIDATION )  
OF ALLIANCE GENERAL INSURANCE COMPANY ) 00 CH 00293

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**PLEASE TAKE NOTICE**, that on January 7, 2000, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against Alliance General Insurance Company ("Alliance"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Alliance ("Liquidator").

**TAKE FURTHER NOTICE**, that on March 1, 2000, the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of Alliance and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of January 7, 2000, unless otherwise provided in prior or subsequent orders of the Court.

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# Capitation

Continued from page 1

providers have gone bankrupt, critics of the arrangement contend. This has served as a warning to other providers that the system needs to be changed.

"If your capitation levels are set below your costs, you can't stay in business," said Dr. David Friend, managing director at Watson Wyatt Worldwide in Boston. In certain areas, such as the West Coast and the Northeast, capitation rates are generally lower than those in the rest of the country, and this disparity has spurred providers in those areas to confront HMOs over the capitation system.

Because of this growing resistance by providers, some HMOs have decided that the negative response to capitation outweighs its benefits in controlling costs. Some are raising their capitation rates, while others are abandoning the approach altogether.

When capitation first took hold in the early 1990s, providers welcomed it as a way of regaining control of their practices from utilization review and stopping health plans from scrutinizing every treatment decision. Doctors thought that "if they took the middleman out, they could do it better and cheaper," said Gary Hagen, president and chief executive officer of San Francisco-based Western Health Guaranty Fund, a financial guarantee insurer for health care providers.

In addition, health care policy experts touted capitation as the antidote to a fee-for-service model that caused high utilization of services, leading to rising premiums. At the outset, "everyone thought it was going to hold doctors and hospitals accountable for their services," said Don Gasparro, president of Apex Management Group, a consulting firm in Princeton,

N.J.

But "the vision has not been realized," said Laurel Pickering, executive director of the New York Business Group on Health.

In particular, capitation has fallen short of its goal because it overestimated the business acumen of doctors, said Jonathan Dopkeen, a consultant with The Segal Co. in Chicago.

Because capitation arrangements pay the providers a fixed, per-patient rate, the burden of health care cost increases falls largely on the providers. This benefited HMOs, which had willingly transferred such risk. But the burden landed on doctors not always equipped to accurately calculate the amount of financial risk they were assuming, experts said, noting that when the HMOs lowered the capitation rates, the risk became even greater.

"They're set up to be doctors and not risk bearers, not insurers," Mr. Dopkeen said.

Compounding this situation is the fact that the many providers lacked the capital to withstand successive bad years, Mr. Hagen said.

Another factor was that HMOs made access to doctors easier by charging low copayments. This increased utilization beyond what doctors had expected, said Michael Lichman, senior vp with Willis Lichman, senior vp with Willis Lichman America Inc. in New York.

Perhaps the best illustration of this is the situation in California.

The rates paid to providers in California have dropped continually in recent years, said Steven Thompson, vp for government relations for the California Medical Assn. in Sacramento. Low rates have caused 133 medical groups to declare bankruptcy from 1997 through 1999 and have pushed many others to the brink of insolvency, he said. Health care "is in serious

crisis in California," he said.

A study showed that capitation rates in California are 23% below the national average, he said. The state's health care market is dominated by a handful of HMOs that control virtually all the patients, giving them the clout to push down the capitation rates paid to providers, he explained.

Mr. Dopkeen of Segal said that "to some extent, the drive for market share led doctors to accept capitation rates they couldn't live with."

To counter what they see as an uneven bargaining position, the California Medical Assn. is lobbying the state Legislature to pass legislation that would exempt doctor groups from antitrust laws. Similar legislation passed in Texas in 1999, and another comparable measure is pending at the federal level. The California measure would permit doctor groups to band together and bargain as a unit, gaining more leverage to negotiate higher capitation rates (BI, March 13).

The need for an antitrust exemption and the notion that capitation rates are too low are disputed by the California Assn. of Health Plans, the trade group for the state's HMOs. The group asserts that the study cited by the CMA showing below-average capitation rates is flawed and that rates are actually much higher.

Provider groups in California lost money because they took on prescription drug risks, whose costs have skyrocketed, asserted Sally Pinkham, vp of network operations for CIGNA HealthCare of California in Glendale. She acknowledged that capitation rates declined for a period in the 1990s, but said they have increased in recent years. She also noted that low reimbursement rates from the state and federal governments have cut into the providers' revenues.

Colorado providers have also expe-

rienced problems with capitation.

In the past two years, the state's two largest independent practice association networks have failed, leaving unpaid doctor bills to be assumed by the health plans. IPAs are provider groups that negotiate on behalf of providers and sign agreements with HMOs and health insurers. The IPAs receive funds from the plans, usually on a capitated basis, and then pay the providers in the group. Both networks failed to take in enough money from health plans to cover rising costs, leading to their demise, explained a spokeswoman for the Colorado Division of Insurance in Denver.

These failures have prompted the Colorado insurance commissioner to establish a task force, scheduled to begin meeting in June, to look at the use of capitation arrangements (see related story).

CIGNA HealthCare of Colorado announced that it will end all capitation agreements with physicians in the state, instead switching to a fee-for-service arrangement.

CIGNA's decision also reflects a larger concern of HMOs. Colorado law, like that of many other states, requires HMOs to assume the unpaid debts when IPAs become insolvent. If capitation agreements are too low and bankrupt the IPAs, the health plans could be looking at double payments—first paying an IPA under the agreement, and then paying the IPA's unpaid bills if it goes under.

Also of concern to HMOs is a wave of class-action suits targeting the plans' business practices. Many of the suits allege that the HMOs put profits ahead of care, and capitation could be one of the practices targeted in that charge.

As a result, capitation is "becoming not very attractive to (HMOs) as well," said Mark Abernathy, director at

Navigant Consulting Inc. in Tampa, Fla.

Opinions vary on whether capitation can be considered a success.

Willis' Mr. Lichman said that, in response to shrinking capitation rates, doctors have been forced to spend less time with each patient. While this helped reduce unnecessary treatment, it also limited the doctor's personal involvement in the patients' lives.

"The unintended consequences of capitation is the way doctors can maximize profits is to not see you or limit the time spent with you," he said. This has hurt patients' perception of the quality of the care, he said.

"Marcus Welby doesn't exist any more," he added. "He can't exist. He wouldn't be able to stay in business."

In addition, doctors have generally not thrived under the system, observers note. Capitation "wasn't the boon a lot of providers thought it was going to be," noted Mr. Abernathy.

On the positive side, more doctors have become aware of how their treatment decisions affect the bottom line, Mr. Gasparro said.

Mr. Lichman said that capitation's attempt to control costs was still better than not trying at all.

Not everyone even agrees that capitation is in decline. Segal's Mr. Dopkeen said that, in areas where the capitation rate is high, such as the Midwest, there isn't the resistance by providers seen in California or the Northeast. And CIGNA's Ms. Pinkham said the HMO has not reduced its number of capitation agreements, except in rural areas.

No clear alternative yet emerged to replace capitation as a payment system. Shaping the alternatives is employers' increasing wish to improve plan quality while keeping costs under control. In addition, employee complaints about managed care in general have forced many employers to take a second look at its practices, Ms. Pickering said.

Employers want an alternative from managed care plans "that still holds (plans) accountable but doesn't have the incentive to skimp on care that some think capitation has done," said Sally Coberly, director of public policy for the Washington Business Group on Health.

Although employers generally leave the payment methods up to the health plans, "it doesn't help the employer to have angry doctors treating their employees," Ms. Pickering said.

But with capitation declining or rates rising, these higher medical costs fall on HMOs more than in the past. And with no place left to turn, the health plans might look to make up the difference by charging higher premiums, Dr. Friend warned. **BI**

## Colorado to study capitation practices

By SALLY ROBERTS

DENVER—The Colorado Division of Insurance is forming a task force to explore a variety of issues surrounding health care capitation arrangements, possibly including whether self-insured employers can use capitated contracts.

Currently, health care providers or provider networks such as independent practice associations are prohibited from entering into capitated contracts with health plans, including self-insured health plans, unless a licensed insurer is ultimately responsible for the risk.

In a January 1999 bulletin issued by former Colorado Insurance Commissioner Jack Ehnes, the division said that, when an IPA or other unlicensed provider directly accepts risk for health care services from another unlicensed entity on a capitated basis, it is engaging in the business of insurance without an insurance license and is, therefore, in violation of state insurance laws.

Last month, current Commissioner William J. Kirven III issued a declaratory order in response to a petition filed by Connecticut General Life Insurance Co., a unit of CIGNA Health Care of Colorado. In its petition, CGLIC had disagreed with the division's application of the law, as stated in the 1999 bulletin.

CGLIC had entered into administrative-service-only agreements with certain self-funded employers, providing them with access to provider networks through CIGNA. CGLIC, among other things, argued that provider networks providing limited health care services on a prepaid, capitated basis through ASO agreements are not engaged in the business of insurance.

But in the declaratory order, Mr. Kirven disagreed with CGLIC. He ruled that, within CGLIC's arrangement, self-funded plans are pooling risks and then transferring them to the provider network, arranged through CGLIC and CIGNA, in exchange for capitation payments.

That arrangement, he said, "possess the hallmarks of a classic insurance arrangement."

In February, CIGNA HealthCare of Colorado abandoned capitation and began paying primary care physicians on a fee-for-service basis.

Capitation—specifically, the shifting of risk from insurers to physician groups—is of increasing concern to the Colorado insurance department.

Within the past two years, 13 IPAs have folded in Denver, according to Denver-based Healthcare Computer Corp. of America, which publishes the Colorado Managed Care Newsletter.

Three of those IPAs, representing 865 physicians, were part of the Paramount Physician Network, which folded in 1998. Three other IPAs, representing 755 physicians, were part of Millennial: Colorado's Physician Alliance, which dissolved last year. In most cases, Paramount and Millennial included, the IPAs failed due to issues involving capitation, according to HCCA.

"The health care delivery system in Colorado, especially the relationship between carriers and IPAs, is in a serious state of disarray," Mr. Kirven said. "I'm going to try to form a task force that will bring together representatives from carriers and physician groups, with the goal to have them agree on a fair way to set physician compensation."

Letters seeking participation in the group will be mailed within the

next two weeks, Mr. Kirven said.

"Generally, I'd like to work out the problems ourselves," he said. "I would like to see some decent contracting standards... and more cooperation between parties." If that doesn't work, "we'll try the regulatory process," Mr. Kirven said.

He said that although the original intention of the task force was to look at the relationship between insurers and IPAs, he also will "probably" include discussion of self-funded plans and how they can participate in capitation arrangements.

Prior to the 1999 bulletin, large Colorado employers most commonly bought self-funded products through HMOs and paid physician groups that subcontracted with HMOs on a capitated basis. Those self-funded plans now contract on a fee-for-service basis.

"Those employers who believe in capitation as a reasonable reimbursement methodology and are large enough would prefer to self-fund," said Chris Watts, a principal in the Denver office of William M. Mercer Inc. "Since this bulletin has come out, (HMOs) have had to undo their capitation arrangements for self-insured plans and go back to fee for service. In most cases, that is a more-expensive arrangement for employers to offer employees."

Mr. Watts, noted, however, that most Colorado employers are not affected by the insurance law.

Consultants say that PacificCare of Colorado has most of the state's self-funded contracts. A spokeswoman for the HMO said that it has converted all of its self-funded capitated products to fee for service.

Tom Boldt, Western region group and health care practice leader for Watson Wyatt Worldwide in Den-

ver, said that it is "too bad" that self-insured Colorado employers no longer can use capitation.

"Capitation is the right way to pay providers," he said. Fee-for-service arrangements, he said, come with the notion of "the more I do, the more I make."

Mr. Kirven agrees that capitation, if properly managed, "is a good thing." The commissioner's concern, however, is employers and health plans that shift all of their health care risks to physician groups, which, he said, are not equipped to manage utilization or bear the risk.

Under Colorado's "double-pay statute," HMOs and other health plans are liable to pay physicians whose contracting organization has gone bankrupt, even though the plans have already paid their IPAs in advance for services.

On the other hand, if a self-insured plan were to contract with an IPA, whether directly or through an administrative contract, and if that IPA were to go bankrupt, the self-insured employer would not be liable to pay the providers or any outstanding claims, because it is not subject to the state double-pay law, Mr. Kirven explained.

"I'd like to see self-insureds participate in some way in capitation, but they need to remain on the hook," he said. Although self-funded plans are subject to federal and not state law, they still "cannot act in any way that violates state insurance laws," Mr. Kirven said.

Whether Mr. Kirven can enforce something of that nature and not be pre-empted by ERISA remains to be seen. Pre-emption under the Employee Retirement Income Securities Act does not apply to state insurance laws.

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# STRIKE IT RICH

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## Readers speak out on Bermuda, ads

As much as I would like to ignore the e-mails I just received taking issue with two of my recent commentaries, I can't. My conscience requires me to share the viewpoints of readers who disagree with me as well as those who concur.

The commentaries at issue are my criticism of the efforts of some U.S. insurance companies to impose a new U.S. tax on Bermuda-based companies that reinsure the business of their U.S. subsidiaries and my expression of distaste for "cheesy lawyer ads."

One reader wrote, "I missed the original commentary but read the March 27 column on the Bermuda tax issue. I would like to comment. While cycles of the insurance industry seem to be bent on creating new competition, why should the new competition be tax-protected? The companies that went offshore went more for the lack of regulation than for the tax advantage. In my opinion, if the offshore havens cannot survive without tax protection, they shouldn't survive."

I would strongly argue that the Bermuda-based companies went offshore more to establish themselves quickly and to offer new products under manageable regulation than for the lack of regulation.

And I don't think for a moment that their tax advantage in Bermuda guarantees survival. Many a Bermuda-based company has proven, unfortunately, that it is just as easy to go broke from bad underwriting in Bermuda as it is anywhere else in the world.

And rather than advocating tax protection for the "new competition," in my March 13 column I was expressing skepticism that it really amounts to as much as some allege.

The reader also said that my point "seems to be that, since this competition was created by the foolishness of the (U.S.) insurance industry, they should continue to suffer unequal competition without complaint."

But that was not my point at all. I was just commenting on the irony of it all.

Another reader wrote: "In fairness to the U.S. insurers, you might have pointed out that the long memories of the U.S. managers weren't long enough to recall the soft market prior, when the same risk managers marketed their glorious accounts to every Tom, Dick & Harry insurance broker and company they could find in order to save a few cents on their renewal premium. This made them look good to their managers and earned them salary bonuses. As usual with *Business Insurance* and its columnists, the truth lies elsewhere than as presented in this publication."

To the extent that risk managers chose price over service and financial security, I can say with a fair degree of confidence that those risk managers whose insurers did not pay claims lost their jobs. To the extent that risk managers did business with well-capitalized insurers that were willing to give away their surplus, I guess it's seller beware.

As for reporting the truth, we do our best in our news reports. And in my commentaries and in the columns of others that we publish, we are simply presenting honest statements of our opinions. Being mere mortals, we may hold our opinions strongly, but I doubt that any of us would ever contend that our opinions are "the truth."

Regarding my earlier commentary on cheesy lawyer ads, an attorney who also is an intermediary wrote: "Put simply, your commentary was unbalanced and inflammatory. Although I readily acknowledge that you are indeed correct in a number of your observations regarding inappropriate lawyer advertising, the fact remains that there are American Bar Assn. guidelines addressing this concern. Furthermore, many jurisdictions have adopted these guidelines (in toto or otherwise modified) as binding rules, in an attempt to assist both advertising lawyers and the public.

"Your empirical conclusion that all lawyer ads 'are unprofessional and demean the judicial system' is rather shallow. As with many ads in the insurance profession, there are many high-quality, educational ads produced by and on behalf of legal professionals."

I believe that is true in print journalism, but I've yet to see an ad promoting a lawyer or law firm on television or hear one on the radio that fits this description. I was writing about electronic media advertising.

This attorney also challenges insurance professionals to stack up their pro bono work against that of lawyers. Now that's an interesting challenge.

*Publisher and Editorial Director Kathryn J. McIntyre's commentary appears fortnightly. She can be reached at kmcintyre@crain.com.*

## Loophole

Continued from page 1  
located in the United States.

Specifically, "the investment income of the domestic person shall be increased each year by an amount equal to the product of (i) the average of the applicable federal mid-term rates... and (ii) the sum of the reserves and/or liabilities related to the United States risks ceded to the foreign reinsurer," the bill says.

The extra tax would not be imposed on companies that elect to pay U.S. taxes or on companies that cede risks to affiliates in countries that impose a tax of more than 20% of the maximum U.S. corporate tax rate of 35%.

By including that provision, the legislation effectively is restricted to tax havens. Thus, it is unlikely to affect U.S. tax treaties with countries such as Switzerland or Germany, where other substantial insurance and reinsurance companies with U.S. operations are located, according to the insurers that lobbied for the bill.

The bill would eliminate an existing 1% excise tax on premiums ceded to foreign affiliates in tax havens.

Supporters of the measure urged Congress to move quickly to close the alleged loophole.

"We must act in a swift, bipartisan manner to shut down this blatant abuse of the tax code," said Rep. Johnson in a statement to the House. "If not," she added, "the result will be a significant erosion of the U.S. tax base, a continued unfair competitive advantage for foreign reinsurers over U.S. insurers in our own market, and a policy that encourages U.S. insurers to move offshore."

ACE immediately blasted the proposed legislation.

"The Johnson/Neal legislation is pork barrel politics at its worst," an ACE statement said. "It would favor a few Northeastern U.S. insurance companies but jeopardize the ability of the industry to meet the capacity needs of the domestic market, particularly with respect to coverage for hurricanes, floods and other natural disasters."

The U.S. insurers that lobbied for the legislation, however, present a starkly different viewpoint.

They say action is needed to counter a movement that became apparent last year, when ACE and XL bought substantial U.S. operations.

Before then, the Bermuda-based insurers covered U.S. risks but were restricted by U.S. law from marketing their programs directly in the United States. Also, when the Bermuda insurance companies were established in the mid-1980s, they primarily offered high-layer casualty coverage for risks that U.S. insurers shunned, so they were not seen as a competitive threat.

Now that ACE and XL are competing directly with insurers in the U.S. market, without marketing restrictions, the U.S. insurers say, the Bermuda-based insurers have an unfair advantage due to the tax-free

accumulation of loss reserves, which amounts to about a 10% pricing advantage (BI, March 13).

The situation has been exacerbated by the redomestication or planned redomestication to Bermuda by several U.S.-based insurers and reinsurers to, among other things, take advantage of the tax situation. Those companies are Everest Reinsurance Holdings Inc., PXRE Corp., White Mountains Insurance Group and Trenwick Group Inc.

Their companies operating in the United States reinsure, or will likely reinsure, much of their risks to their Bermuda affiliates, the bill's supporters contend.

An XL spokesman said the insurer is reviewing the bill and "will respond in due course."

### Bermuda-based ACE Ltd. blasted the measure, calling it 'pork barrel politics at its worst.'

Officials at PXRE would not comment on the bill. Officials at Everest and Trenwick could not be reached last week.

Other Bermuda companies counter that any intercompany reinsurance they do conduct is, by law, conducted at market rates and that the ceding commissions paid to the U.S. affiliates are taxed in the United States. And the current 1% excise tax may seem small, but it is imposed on all the premiums ceded, not just profits, they note.

Rep. Neal, in his statement to the House, said the intercompany reinsurance is just a tax dodge. "In these cases, reinsurance is written between related parties—a U.S. subsidiary cedes U.S. business to its foreign-based parent—simply to obtain a tax benefit. No risk has been spread in this transaction; the company is simply moving money from one pocket to another pocket within the same corporate entity. The primary purpose is to escape U.S. income tax," he said.

In a joint letter to other representatives, Reps. Johnson and Neal quote news reports saying that if all property and casualty insurers in the United States move offshore, the Treasury could lose \$7 billion a year.

The bill's detractors, however, say that it would hinder companies with affiliates offshore from legitimately reinsuring business to those affiliates.

The proposal ignores existing tax legislation that governs intercompany reinsurance by imposing additional taxes on U.S. companies carrying out legitimate transactions, said Raymond Barrette, president of White Mountains Insurance Group in Hanover, N.H.

"This would be an additional tax because, if I want to reinsure with ACE in Bermuda, that would be fine, but if I want to reinsure under exactly the same terms with White

Mountains in Bermuda, I'd have to pay an additional tax. That's silly," he said.

ACE labeled the legislation "protectionist."

"At a time when the United States is rightly trying to open the insurance markets of China and Japan for U.S. insurers, the Johnson/Neal bill can only be seen as a protectionist measure and a contradictory message to allies and competitors abroad," the ACE statement said.

Also, it is unrealistic of the bill's supporters to suggest that the entire U.S. insurance industry could move offshore, because Bermuda does not have the space or the infrastructure to support it, an ACE spokeswoman added.

Efforts to target tax havens aside, the bill would violate existing tax treaties the United States has with other countries, said Francis Bouchard, vp and director of federal affairs at Zurich Financial Services in Washington.

Swiss companies with U.S. operations that reinsure to an affiliate in Bermuda would be affected by the tax increase, and that would be a violation of the U.S.-Swiss tax treaty, he said.

"While we are still analyzing the proposal, it is safe to say that the bill violates not only the U.S.-Swiss tax treaty but the very fundamentals of international tax law," Mr. Bouchard said.

Zurich will urge members of Congress to reject the bill, he said.

The bill also would set a dangerous precedent that may lead to increased taxes on U.S. companies with international operations, said Todd Malan, executive director of the Organization for International Investment, a Washington-based body that represents the U.S. subsidiaries of foreign-based companies.

The United States has a lower tax rate than some other countries, and those countries may use the bill as an excuse to raise taxes on U.S. companies overseas, he said. "It is very dangerous to use the tax code to address competitive issues," Mr. Malan said.

The bill is a protectionist move that could ultimately disadvantage U.S. companies, he said.

But supporters argue that the legislation is not protectionist because it doesn't exclude or prevent foreign business on U.S. soil.

The bill is intended to put Bermuda-owned companies on the same competitive level as U.S. rivals and is not protectionist, said Daniel Conway, senior vp-external affairs at Chubb Corp. in Washington. "All we are seeking is to have people treated equally, and that is the linchpin of international trade agreements," he said.

The bill would not limit the amount of reinsurance capacity available to U.S. insurers as ACE asserts, said William Malchodi, senior vp and director of taxes at The Hartford. "That objection doesn't address the proposal at all, because the bill is only addressing related-party reinsurance," he said. **BI**

## Frontier

Continued from page 2  
of Lyndon Insurance Group Inc.—Frontier will emerge as a much smaller company.

"It will take a while for them to build up the franchise," Mr. Paisan observed. "Do I think they will go out of business? No. Do I think they're in dire straits? Yes.

"They do have a solid franchise in specialty program business," he added. "It will be a much smaller franchise, but it will be a fran-

chise."

One of the expenses Frontier now faces as a result of its financial difficulties is the cost of using fronting insurers—including Clarendon National Insurance Co.—for policyholders who require coverage from A-rated companies, analysts note. A.M. Best Co. last month downgraded Frontier to B from B++, and Standard & Poor's Corp. withdrew its BB+ rating of Frontier's insurance units.

Mr. Seyffarth acknowledged the additional cost, but he said the majority of Frontier's core busi-

ness does not require A-rated paper.

Meanwhile, analysts and investors are awaiting Frontier's 1999 10-K filing with the Securities and Exchange Commission. Frontier notified the SEC that the filing would be delayed while the company decides whether it needs additional or modified disclosures "as a result of the potential effects of recent downgrades by certain rating agencies."

Frontier's stock fell below \$1 per share on Friday, far below the 52-week high of \$17.25 per share reached in May 1999. **BI**

# Mandates

Continued from page 1

bills that earlier passed the Senate (S. 1344) and the House (H.R. 2990).

These opponents of dual regulation face a tight timetable, because both Senate and House Republican leaders have announced they would like to have the reconciliation completed by April 23, according to Kathleen Sebelius, vp of the National Assn. of Insurance Commissioners in Kansas City, Mo., and chair of its Health Insurance and Managed Care Committee.

The NAIC is seeking the support of other state officials to lobby the conferees, because "there are several aspects of the patient protection bills that, if not corrected, will have serious ramifications for enforcement of state consumer-protection provisions," said Ms. Sebelius, who is also the Kansas insurance commissioner.

"States have focused on consumer protection and access to health insurance for well over a decade, and the legislation that is pending before Congress threatens to undermine and undo access to affordable health insurance as well as to pre-empt the effective and user-friendly consumer complaint and appeals networks in place around the country," according to a statement by the NAIC.

The degree of state involvement in mandating consumer protections for managed care programs was demonstrated in a recent NAIC survey of leading mandates (see chart, page 12). For example, 48 jurisdictions reported that their laws have at least a partial prohibition on gag clauses for health care providers.

Meanwhile, a 1999 survey by the Blue Cross & Blue Shield Assn. found that at least seven states had more than 40 mandated health benefit laws (BI, Feb. 21).

Under the current regulatory system for health plans, large employers often can legally skirt such mandates by forming self-funded group health plans, which are federally regulated. Self-funded group health plans assume the financial risk associated with health insurance by paying employees' medical bills so they can be regulated solely under the Employee Retirement Income Security Act. Employees enrolled in such plans typically call the U.S. Department of Labor for resolution of their questions.

Smaller employers and individual consumers that typically purchase health insurance directly from insurers are subject to states' requirements and are regulated by state agencies, usually the state's insurance department.

However, the House version of the patients' bill of rights "would dramatically complicate this environment because of 'dual regulation.' Consumers who want a straight answer to a question about their health plan coverage will have to wade through a regulatory quagmire of state and federal agencies," according to a BC/BS analysis.

Specifically, consumers might have to call their state department of insurance or the Health Care Financing Administration or both, according to the analysis. That is because the House bill "depends on the regulatory structure created by the 'Health Insurance Portability and Accountability Act of 1996 (HIPAA),' a law with extremely complicated rules governing the interaction of state and federal statutes," according to the Blues.

As with HIPAA, H.R. 2990's hundreds of provisions form "a federal policy floor," and states are encour-

aged to amend all of their insurance laws and regulations to incorporate the law's requirements, said the analysis. If any state fails to come into compliance or subsequently fails to enforce the law, then HIPAA requires the federal government to enforce the law directly, primarily through HCFA.

Although states may bring some of their laws into compliance, it is "extremely unlikely" they will conform all laws and regulations to the new federal base, which will result in dual regulation, stated the Blues analysis. In addition, there likely will be lengthy discussions about interpretations of regulations.

The Blues cite a provision regarding emergency care as an example of the problems dual regulation can cause: H.R. 2990 would require health plans to cover emergency care provided by non-network providers under a "prudent layperson" standard; more than 40 states have a similar standard. The House bill, however, also would require coverage for maintenance and post-stabilization care rendered at the non-participating institution. Virtually no states have such a requirement.

"So many emergency room patients will be treated in hospitals where the state enforces the prudent layperson standard but the federal government (HCFA) enforces the maintenance/post-stabilization standard," the Blues analysis stated. Patients with questions about an overlapping stay may have to call both state and federal regulators.

In the eyes of NAM's Mr. Trautwein, "I think the worst possible outcome for us would be a system in which there would be a federal floor and in which states would be able to enact mandates that go beyond that."

The NAIC, however, emphasizes other concerns.

It wants to reinforce state authority to regulate insured health plans, clarify how state laws will be compared for compliance with new federal standards

and allow more than 30 states to continue to provide external grievance processes. The Senate bill clearly would preempt all state external grievance processes, while the House bill would allow states' existing consumer protections to continue, according to the NAIC.

In addition, state regulators are urging Congress to provide resources and enforcement authority so that the Department of Labor can respond to consumers' complaints. The state regulators also want conferees to delete "access" provisions that would pre-empt states' efforts to aid small group purchasers, such as programs that provide cost-effective coverage for small risks.

The problems of dual regulation surfaced relatively recently, said Alissa Fox, executive director of legislative policy in Washington for the Blue Cross & Blue Shield Assn.

"We were all so focused on the big issues like liability, external review and all the details that we forgot to step back and really think through how is this going to work,

who's going to do what, who's going to be in charge, who's going to regulate and what would be the roles and responsibilities," she said.

"Embarrassingly, we didn't really start thinking about it until a few months ago, and, once we did, we uncovered this nightmare," Ms. Fox said. A workable regulatory scheme "is the most important protection for everybody—employers and consumers," she said.

"This is the classic articulation of the old saying that the devil is in the details," said Bill Pierce, the Blues' director of public affairs. "Once you moved beyond the big picture and started to look down deep, the devil appeared in the details, and that is what we have got." **BI**

## Top managed care mandates

From a self-reported survey of NAIC jurisdictions

Rank by popularity	Provision	Total number of states
1	Prohibits gag clauses	48
2	Protects privacy of medical records	47
	Requires plans to disseminate information to consumers	47
3	Establishes internal appeals process	44
4	Establishes rules for coverage determinations	43
5	Prohibits genetic discrimination	42
6	Requires access to emergency care	41
7	Requires quality improvement	39
8	Requires access to OB/GYN care	36
9	Prohibits discrimination against providers	32
10	Requires continuity of care	29
11	Establishes external appeals processes	28
12	Requires access to specialists	27
13	Requires point of service option	23
14	Requires access to non-formulary drugs	21
15	Mandates length of hospital stay for breast cancer care	19
16	Requires access to clinical trials	9
17	Grants individuals the right to sue their HMOs	8
	Requires access to pediatric care	8

Source: National Assn. of Insurance Commissioners; March 2, 2000

## Updates

### NAIC seeks chartering comments

KANSAS CITY, Mo.—State insurance commissioners are asking interested parties to comment by April 21 about how they should develop a national system for chartering insurers.

Specifically, the National Assn. of Insurance Commissioners' national treatment working group is seeking suggestions about the concept and several matters related to its implementation, including the legal structures needed to achieve national treatment for insurer licensing, regulation by extraterritorial jurisdictions, company eligibility and benefits to consumers. The working group prefers that interested parties file e-mail comments to Jeff Johnston at [jjohnsto@naic.org](mailto:jjohnsto@naic.org). Mr. Johnston can also be reached at 816-842-3600.

### Australia insurance reforms

SYDNEY, Australia—The Australian government is preparing insurance regulatory reforms that could toughen minimum capital requirements, linking them to the risks assumed by property/casualty insurers.

As part of a proposed overhaul of the nation's financial regulatory regime, the Australian Prudential Regulatory Authority last week released a policy information paper outlining the aims of the reform effort.

One aim is to "make regulation as risk-responsive as possible," the APRA paper says. The authority is analyzing insurer comments on a discussion paper circulated last September outlining the reform agenda; it is also preparing a new discussion paper for release mid-year that will set out "new standards on liability valuation and solvency," the authority said.

APRA expects to finish analytical work on proposed reforms by the end of this year.

The insurance regulatory overhaul, the first since Australia adopted its insurance act in 1973, has been under way for several months. It comes, however, as several Australian insurers have been hurt by heavy catastrophe losses, including GIO Australia Holdings Ltd. and Reinsurance Australia Corp. Ltd., which halted underwriting earlier this year.

APRA reforms affecting property/casualty insurers are part of a larger regulatory overhaul covering banks and other financial services companies and life insurers.

### Associations discuss cooperation

ALEXANDRIA, Va.—Leaders from the American Assn. of Managing General Agents, the National Assn. of Professional Surplus Lines Offices and the Independent Insurance Agents of America Inc. recently met in Alexandria, Va., to discuss opportunities for cooperation among the three organizations.

Among the topics discussed was the IIAA's soon-to-be launched "Big I Markets," a program that gives member agents access to specialty and niche insurance coverages for their clients via the Internet. IIAA expressed a strong desire to AAMGA and NAPSLO to have wholesale agents and brokers participate in the interactive Internet program.

Other matters discussed included legislative and regulatory developments, marketplace concerns, technology's impact on insurance delivery, and education.

"If we, as an industry, are going to succeed in the integrated financial services marketplace that will be prevalent in the not-too-distant future, we must work together," said Timothy Pedersen, NAPSLO's president, in a statement.

"It's imperative that we keep each other informed and work together, not against each other, so that we ultimately get insurance coverages and products to the consumer market in the most-effective manner possible," Mr. Pedersen said.

### Briefly noted

**MetLife Inc.**, the holding company for New York-based Metropolitan Life Insurance Co., raised \$4.43 billion in its initial public offering, which closed on Friday. The shares were priced at \$14.25 when they were issued on Wednesday and closed at \$15.31 on Friday. . . . **Susan M. Donatelli**, risk manager for the town of West Hartford, Conn., has been awarded the 2000 Matthew Lenz Jr. Award for Risk Management Achievement by the New York chapter of the CPCU Society. She will be presented with the award at a luncheon in New York on Tuesday. . . . California Insurance Commissioner Chuck Quackenbush announced Friday that a "cut through" agreement has been reached for Kemper Insurance Cos. to provide reinsurance for new and renewal policies written by **Superior National Insurance Cos.**, which is in conservation. Kemper reinsurance will cover any policies issued on or after April 5. The agreement with Kemper replaces a prior agreement reached with Centre Insurance Co. immediately after the March 6 conservation of Superior National. . . . Citigroup said it is increasing the purchase price being offered in its cash tender offer for all of **Travelers Property Casualty's publicly held shares** to \$41.95 from \$41.50 a share in cash. Citigroup announced last month that it intended to make a cash tender offer for the 15% of Travelers Property Casualty stock it does not already own. The company said also that it and Travelers Property Casualty Corp. have reached a preliminary settlement of the purported stockholder class actions opposing Citigroup's cash tender offer, which are now pending before Delaware Chancery Court. A spokeswoman could not be reached for comment as to the preliminary settlement's details.

# FTR FOR THE RECORD

Excerpts from BI's Daily Online Updates, April 5-April 7, 2000

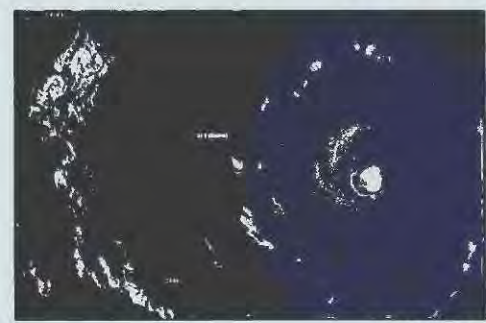


PHOTO: NOAA

**Hurricane forecast** Colorado State University's hurricane forecast team is sticking to its original 2000 prediction, which calls for a "moderate" Atlantic hurricane season. William Gray, a nationally recognized hurricane expert, and his colleagues are predicting 11 named storms, seven hurricanes and three intense hurricanes during the 2000 hurricane season, which lasts from June 1 through Nov. 30. Although the number of storms forecast is higher than average, it calls for fewer storms than have occurred in four of the past five years. The U.S. Atlantic Coast, including peninsular Florida, has the greatest chance—39%—of one or more major storms making landfall this year, according to Mr. Gray's research team. The Gulf Coast faces a 34% probability of one or more major hurricanes coming ashore. Mr. Gray predicts that, compared with the 1998 and 1999 seasons, the 2000 season will see hurricane formation earlier in the season.

**CIGNA sued** Three retired FBI agents are seeking class-action status for a lawsuit alleging that CIGNA Corp. failed to keep a promise that retired agents would continue to pay the same rate as active agents for group life insurance. The lawsuit was filed April 5, in U.S. District Court in Tampa, Fla. The retirees also allege that changes CIGNA made to their group life policy significantly reduced their benefits, despite assurances by the insurer that the changes would enhance them. CIGNA is looking into the suit's allegations, but would not comment on pending litigation, a spokesman said.

**UFG suit settled** NEW YORK—The Securities and Exchange Commission has settled

a civil lawsuit against two jailed former executives of bankrupt broker Underwriters Financial Group Inc. Under the settlement, Donald Ferrarini and Bruno Rumignani are barred from serving as officers or directors of a public company and are enjoined from violating securities laws. Mr. Ferrarini was chief executive officer and Mr. Rumignani was executive vp of New York-based UFG, which collapsed in 1995. They were convicted last year on separate criminal charges of using embezzled client premiums and fraudulently obtained premium finance loans to inflate UFG's income. Mr. Ferrarini is serving a 12 year prison sentence; Mr. Rumignani, a 10 year term. The SEC's action also named Nanette Miller, an accountant with Chadbourne & Miller, a Washington-based firm that audited UFG's financial statements. Ms. Miller agreed to an order finding that she engaged in improper professional conduct in the UFG audits and barring her from auditing publicly traded companies.

**Online facultative cover** SCOR U.S. and General Re Corp. have developed separate Internet-based systems for handling facultative



reinsurance business. Under SCOR's i-fac system, brokers and cedants can submit risks via a Web site, www.scor.com/i-fac. An underwriter reviews the risk and then, using the system, requests any needed information and offers a quote. General Re's system, FacWorld, accepts online facultative reinsurance submissions at www.facworld.com. The rest of the underwriting process takes place through traditional channels, though SCOR plans to expand the system to allow the entire underwriting process to be conducted online.

**Munich Re results** Citing a spate of natural catastrophes, Munich Re reported a 1999 profit of 1.1 billion euros (\$1.05 billion) earlier this month, down from 1.2 billion euros (\$1.15 billion) in 1998. In its provisional earnings report, Munich Re said that last year was its worst ever in terms of claims costs. Among other provisional results, the reinsurer said its gross premium income rose 7.5%, to 27.4 billion euros (\$26.20 billion). Munich Re said it had to deal with an exceptional accumulation of small and medium-size losses from natural catastrophes in 1999. Munich Re said it expects results to be "considerably better" this year.

**Security survey** According to a survey on security issues conducted by security and investigation service company Pinkerton, workplace violence ranks as the No. 1 security problem among Fortune 1000 companies. The survey by Encino, Calif.-based Pinkerton reported that, although workplace violence also ranked No. 1 in 1999, respondents indicated that violence is of even greater concern this year. Additionally, about one-third of the survey's respondents said they had observed an increase in the number of violent incidents at their companies. Survey respondents represent approximately 28% of all Fortune 1000 companies, according to Pinkerton. Ranking second in the Pinkerton study of security issues is concern over Internet and network security, which rose from seventh place last year.

**CitiStreet born** Two huge financial services organizations—Boston-based State Street Corp. and New York-based Citigroup—are forming a joint venture, known as CitiStreet, to provide employee benefit plan administrative and outsourcing services. Both companies currently have units that provide a wide range of employee benefit administrative services. The two organizations estimate that CitiStreet will administer plans with about \$200 billion in assets. CitiStreet will be based in Quincy, Mass.

**Zurich Corporate Solutions**—Zurich Corporate Solutions is expanding its operations beyond the United States, launching a global business unit with regional centers in New York, London and Zurich, Switzerland. The

Zurich Financial Services Group unit provides integrated risk financing to large global companies. Since 1997, ZCS' U.S. operation has handled more than 40 transactions. With the expansion, the global business unit will be based in Zurich. Randall Clouser is president of ZCS Americas, Australia and Japan; Terje Lovik is president of ZCS Europe and Asia; and Tim Atkin is president of ZCS London. Thomas Kaiser is chief executive officer of Zurich Corporate Solutions.



## ZURICH

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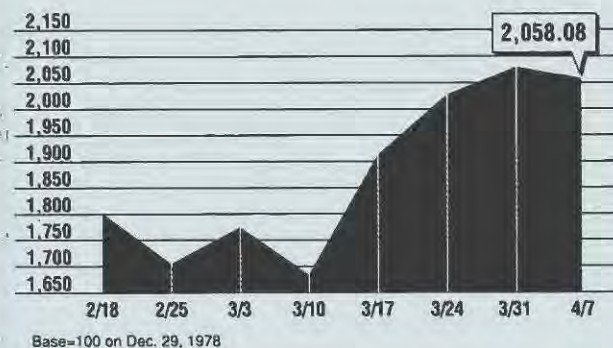
**Briefly noted** Commercial Risk Partners Ltd., the Bermuda-based alternative risk transfer unit of SCOR S.A., increased its profits 12% to \$29 million in 1999. Gross premiums increased by 37% to \$438.9 million. . . . GE Financial Assurance has bought the group life and health operations of Phoenix Home Life Mutual Insurance Co. for an undisclosed sum. The purchase will triple GE Financial Assurance's existing premiums, a spokeswoman said. . . . Teresa L. Pahl has been named Insurance Woman of the Year by the Assn. of Professional Insurance Women. Ms. Pahl is an executive vp of Aon Corp. . . . Superior National Insurance Group Inc. has voluntarily withdrawn its stock from listing on the NASDAQ National Stock Market. California regulators seized the company's insurance units last month, charging they are severely underreserved and insolvent. . . . Between Feb. 25 and March 31, the Business Insurance Index, an index of industry stocks, shot up 22% to 2,079. This advance was more than double the 10.7% rise of the Dow Jones Industrials for the same period. Gains were fueled in part by improved results for some companies, said Ronald W. Frank, managing director of Salomon Smith Barney in New York. . . . The Risk & Insurance Management Society Inc. is partnering with the University of Georgia to develop a standard data delivery format for exchanging workers compensation and auto liability loss data between risk managers and insurance providers. . . . ING Reinsurance International, the international arm of ING Reinsurance in Denver, has opened a life reinsurance office in Dublin, Ireland, to expand its business in Europe. **BI**

Find daily coverage on Corporate Risk, Employee Benefit and Managed Health Care News at [www.businessinsurance.com](http://www.businessinsurance.com)

## BI Industry Stock Report APRIL 3, 2000, THROUGH APRIL 7, 2000

BROKERS						INSURERS/REINSURERS						HEALTH MAINTENANCE ORGANIZATIONS																			
Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)														
Aon Corp.	NYS	29.25	-9.30	-25.88	46.66	20.69	3839	Harleysville Group	NDO	15.88	9.48	11.40	20.88	11.63	167	UNUM Corp.	NYS	16.63	-1.85	-48.15	56.88	11.94	9137								
Clark Bards Holdings	NDO	14.00	-1.75	-2.61	21.00	11.63	57	HSB Group Inc.	NYS	26.88	-7.13	-20.52	42.25	21.50	411	Vesta Insurance Co.	NYS	5.05	-3.00	56.45	7.88	3.44	248								
E.W. Blanch Holdings Inc.	NYS	19.44	-2.81	-68.27	71.75	18.31	778	HCC Insurance Holdings	NYS	13.44	1.42	1.90	25.13	8.00	608	XL Capital Ltd.	NYS	54.25	-2.03	4.58	67.19	39.00	2000								
Gallagher Arthur J. & Co.	NYS	32.94	1.35	1.74	33.13	23.00	741	ING Groep N.V.	NYS	56.31	2.39	-7.68	63.94	46.81	731	Zenith National Ins.	NYS	24.25	9.30	17.58	26.69	18.75	223								
Hibb, Rogal & Hamilton	NYS	28.38	3.89	0.44	29.13	17.00	185	IPC Holdings Ltd.	NDO	12.75	6.25	-14.29	22.50	9.75	748	INSURERS/REINSURERS AVERAGE			-1.14	-3.95											
Kaye Group Inc.	NDO	7.25	10.48	-13.43	11.88	5.00	14	Hartford Financial Services	NYS	46.56	-11.73	-1.72	66.44	29.38	7136	<b>HEALTH MAINTENANCE ORGANIZATIONS</b>															
Marsh & McLennan	NYS	100.31	-9.07	4.83	110.69	61.75	8425	LaSalle Re Holdings Ltd.	NYS	13.00	-6.31	-21.21	18.63	10.88	89	Foundation Health Systems Inc.	NYS	8.25	3.13	-16.98	20.06	6.25	3050								
Brown & Brown	NYS	39.56	2.26	3.26	40.63	30.38	32	Lincoln National	NYS	30.81	-8.02	-22.97	57.50	22.63	4362	Humana Inc.	NYS	8.19	11.97	0.00	17.31	5.88	2589								
BROKERS AVERAGE						1.02	-11.90	Market Corp.	NYS	154.25	6.01	-0.48	193.00	111.50	100	Oxford Health Plans	NDO	14.56	-4.51	14.78	24.25	9.75	6743								
<b>INSURERS/REINSURERS</b>						ACE Ltd.	NYS	21.25	-7.10	27.34	35.25	14.06	7095	Mutual Risk Mgmt. Ltd.	NYS	18.88	-5.63	12.27	40.81	9.81	1237	Pacificare Health Sys.	NDO	52.19	4.64	-1.53	98.13	31.13	1547		
Accel International Corp.	NDO	0.72	-17.94	-28.20	2.75	0.50	12	Mbl Cos. Inc.	NYS	9.88	0.00	14.49	17.44	3.31	495	Sierra Health Services	NYS	4.25	-13.92	-36.45	16.25	4.25	553	United HealthGroup	NYS	61.75	3.56	16.24	70.00	39.36	3936
Acceptance Insurance Cos.	NYS	5.06	-6.90	-11.96	15.94	2.75	206	MBA Insurance Group	NYS	51.19	-1.68	-3.08	71.88	36.31	1280	Wellpoint Health Networks	NYS	73.31	4.92	11.18	97.00	48.25	1502	HMOs AVERAGE			1.40	-1.82			
AEGON N.V.	NYS	80.44	-0.08	-15.77	98.25	63.00	658	Meadowbrook Insur. Group	NYS	5.84	16.25	-11.43	15.31	4.75	61	ALL COMPANIES AVERAGE			0.42	-5.89											
Aetna Life & Casualty	NYS	56.75	1.91	1.68	99.98	38.50	5928	MIMI Cos. Inc.	NYS	9.88	0.00	14.49	17.44	3.31	495																
AFLAC Inc.	NYS	45.50	-0.14	-3.58	56.75	33.56	3435	Mutual Risk Mgmt. Ltd.	NDO	10.25	0.61	5.13	16.00	8.75	1																
Allmerica Financial Corp.	NYS	49.75	-2.45	-10.56	64.81	35.06	790	NYMag Inc.	NYS	13.13	-4.11	-0.47	19.50	12.00	40																
Allstate Corp.	NYS	22.63	-4.99	-5.97	40.75	17.19	15852	Ohio Casualty Corp.	NDO	16.38	-8.39	1.95	20.25	10.75	2255																
Ambac Financial Group	NYS	51.00	1.24	-2.28	83.00	38.88	1759	Old Republic Int'l	NYS	13.19	-4.09	-3.21	20.69	10.63	1020																
American Financial Group	NYS	26.94	-5.90	2.13	37.38	18.38	392	Partner Re Ltd.	NYS	38.13	3.57	17.53	41.69	28.38	725																
American General	NYS	54.38	-3.12	-28.34	82.19	45.63	3409	Penn-America Group Inc.	NYS	7.38	-3.51	-4.84	11.06	6.63	33																
American Intl Group	NYS	108.75	-0.68	0.58	118.89	78.56	19716	PMA Capital Corporation	NDO	17.75	1.43	-10.69	21.13	15.50	95																
American Safety Insurance	NYS	5.69	-1.09	-12.50	10.00	5.50	50	Philadelph Cons. Holding	NDO	16.31	10.59	12.50	25.50	10.81	146																
Argonaut Group	NDO	19.50	-2.80	-1.89	27.94	16.88	156	PXRE Corp.	NYS	15.50	-8.82	19.23	21.25	9.94	119																
AXA-UAP Group	NYS	71.94	0.35	1.32	78.44	53.75	488	Reliance Group Holdings	NYS	3.06	-12.50	-53.77	10.89	2.81	1522																
Baldwin & Lyons Inc.	NDO	19.03	-1.77	-13.98	24.05	16.25	19	ReliaStar Financial Corp.	NYS	29.81	-11.99	-23.92	49.81	23.75	2213																
Berkley W.R. Corp.	NDO	22.28	-3.39	6.74	29.13	14.00	775	RenaissanceRe Holdings Ltd.	NYS	39.05	-4.43	-4.43	43.19	30.00	197																
Berkshire Hathaway Inc.	NYS	56800.00	-0.70	1.25	78600.00	40800.00	4	Risk Capital Holdings	NDO	16.50	0.76	30.69	17.38	11.00	372																
Capitol Transamerica Corp.	NAS	11.38	-6.19	13.04	15.38	9.38	102	RLI Corp.	NYS	33.75	0.75	-0.74	38.81	26.25	39																
Chubb Corp.	NYS	64.06	-5.18	13.76	78.38	43.25	5920	St. Paul Cos.	NYS	31.88	-6.59	-5.38	37.06	21.31	5535																
CIGNA Corp.	NYS	77.19	1.90	-4.19	98.63	80.75	3598	SCOR	NYS	45.75	-3.17	3.39	56.75	40.00	13																
Cincinnati Financial Corp.	NYS	40.00	-6.31	25.49	42.50	26.19	3631	SAFECO Corp.	NDO	25.06	-5.65	0.75	46.75	18.00	4126																
Citigroup	NYS	59.00	-0.53	5.95	63.19	40.13	52494	SCPIE Holdings Inc.	NYS	30.75	0.41	-4.28	36.94	23.69	NA																
CNA Financial Corp.	NYS	31.13	-3.68	-20.06	45.31	24.56	313	Seibels Bruce Group	NDO	1.63	4.00	-7.14	6.25	1.47	103																
CNA Surety	NYS	14.44	3.59	11.06	15.56	9.75	246	Selective Ins. Group	NDO	16.88	-1.10	-1.82	22.50	14.63	219																
EMC Insurance Group Inc.	NDO	7.06	-8.87	-22.60	13.38	7.06	88	Terra Nova Ins Co. Ltd.	NYS	22.75	0.00	####	32.63	20.31	0																
ESG Re Limited	NDO	4.44	10.94	-36.04	20.06	3.19	778	Tokio Marine & Fire	NDO	52.63	0.36	-10.99	67.00	45.00	97																
Enhance Financial Services	NYS	11.44	-19.03	-29.62	22.88	10.75	1409	Torchmark Corp.	NYS	23.56	1.89	-18.92	38.00	18.75	2376																
Everest Reinsurance	NYS	30.13	-7.86	35.01	35.69	20.50	1128	Transatlantic Holdings	NYS	84.25	-1.46	7.93	87.00	58.75	80																
Fremont General Corp.	NYS	6.25	-1.96	-15.25	21.75	4.69	984	Travelers Property Casualty	NYS	41.75	1.21	21.90	42.00	27.69	8062																
Frontier Insurance Group	NYS	1.00	0.00	-70.91	17.25	0.88	2150	Trenwick Group Inc.	NYS	14.00	-0.88	-17.34	32.00	12.00	158																
Gainco Inc.	NYS	5.75	-3.16	6.98	6.94	3.94	189	Unico American Corp.	NDO	5.25	10.53	-25.00	10.75	4.50	26																
								United Fire & Casualty	NDO	19.13	-0.65	-15.47	27.25	17.38	31																
								Unitrin	NDO	37.03	-6.84	-1.58	42.38	30.50	746																

## BI Insurance Index



Top advancing issues: Meadowbrook Insurance Group, Humana Inc., ESG Re Ltd. Leading decliners: Enhance Financial Services, Accel International Corp., Sierra Health Services. Most active issue: Citigroup. The BI Index fell 1.0%; the Dow Jones 30 Industrials increased 1.7%; the S&P 500 went up 1.2%, and the NYSE Composite gained 1.8%. Average P/E: Brokers, 18.6; Insurers/reinsurers, 18.9; HMOs, 11.1. Source: CNET Investor (investor.cnet.com) Boulder, Colo.

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