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UPDATES

Many lost-time injuries blamed on MSDs: Report

WASHINGTON—Musculoskeletal disorders—or MSDs—accounted for 34.2% of injuries or illnesses that required off-the-job recuperation in 1999, according to a report released by the Bureau of Labor Statistics last week.

The BLS reported that U.S. workers suffered about 582,300 MSDs in 1999, with a median stay away from work of seven days. But the incidence of injury and the length of recuperation time varied

See **Updates** *on next page*

Acordia, Heath form global broker network

By RODD ZOLKOS

CHICAGO—Acordia Inc. and Heath Lambert Group have entered a joint venture to form a worldwide retail insurance brokerage and risk management services network.

The arrangement essentially involves adding Acordia to London-based Heath Lambert's existing international insurance brokerage network, the Lambert Network. The resulting entity will be named HLA Global, and initially will link partner companies in 55 countries.

The immediate addition of Acordia to its network, announced last week, provides Heath Lambert Group companies a vehicle for meeting retail clients' U.S. needs, while the arrangement helps Acordia meet the increasingly international needs of its clients in the United States.

"From my perspective, within the Heath Lambert Group we've been working on developing a network for years, and the key concept of that was finding local partners, local expertise," said David Margrett, chief executive of HLF Insurance Holdings Ltd. in London.

"That's basically the thought behind the network," added Frank C. Witthun, president and chief executive officer of Chicago-based Acordia. "We're both very locally focused brokers in terms of our clients, and we thought it would bring an awful lot to our clients to have that local network on the ground and have it focused."

See **Network** *on page 20*

PHOTO COURTESY OF ACORDIA

Acordia CEO Frank Witthun, left, and David Margrett, CEO of HLF Insurance Holdings Ltd., announced the formation of their joint venture, HLA Global, last week.

PwC considers its options for Unifi Network

By JERRY GEISEL

NEW YORK—PricewaterhouseCoopers L.L.P. is evaluating whether its large and rapidly growing benefit consulting unit, Unifi Network, will remain a part of the accounting firm.

PwC has retained investment banker Morgan Stanley to review a wide range of possible transactions, including the sale of Unifi.

"There are many options that are being evaluated. The only thing that has been ruled out is the status quo," said Reed Keller, global business leader of the Unifi Network in Atlanta.

While no decisions have yet been made, the end result, Mr. Keller said, must meet several objectives, including retaining Unifi's position as a market leader for its clients and generating a good economic result for its own employees.

"We want the very best outcome for all the people and partners of PwC, one that would generate the very best value for themselves and their sons and daughters," he said.

The rapidly changing role of benefit consultants—driven by client demand—is a key factor behind what could be a separation, in whole or in part, of Unifi from PwC.

For decades, benefit consultants earned most of their revenues from providing advice, such as evaluating the design of benefit plans, or from performing certain administrative services, such as pension valuations. Today, though, customers often demand that consultants take over and run their benefits and other human resource-related programs.

"It is becoming more and more difficult to simply advise

See **Unifi** *on page 29*

Back to drawing board

Ergonomics bill seen as an improvement

By MARK A. HOFMANN

WASHINGTON—Risk managers and insurers are finding some things to like about a Senate bill that would direct the Department of Labor to redevelop an ergonomics standard.

They see the general thrust of the bill as a definite improvement over the ill-fated federal ergonomics standard formally revoked by the stroke of President Bush's pen last month. Nevertheless, they still have serious questions about the legislation, including whether it is needed at all.

The previous standard, issued by the Occupational Safety and Health Administration in November, was rescinded last month, after Congress, for the first time, exercised its authority under the 1996 Congressional Review Act to "disapprove" federal regulations under certain circumstances (*BI*, March 12). By using the law to rescind the rule, Congress barred OSHA from promulgating any substantially similar regulation in the future.

Congress' action generally won plaudits from the risk management community, insurers and employers, all of which viewed the OSHA regulation as overreaching, scientifically unjustified and overly costly. A provision that would have created a special, more generous set of benefits outside of existing state workers compensation systems drew particular fire from risk managers and insurers. They viewed the creation of such benefits as an illegal federal encroachment into state

See **Standard** *on page 30*

Increases were too little, too late for 2000

Higher rate hikes ahead

By JUDY GREENWALD

REINSURER Results

U.S. reinsurers, emerging from a difficult year in 2000, are expected to report better results this year, but the improvement will not be dramatic.

Because most U.S. business renews in January and significant rate hikes did not take effect until midyear, reinsurers still felt the impact of the soft market in their 2000 results.

In fact, reinsurers' results worsened between 1999 and 2000. The 31 U.S. reinsurers that report to the Reinsurance Assn. of America posted a 114.2% combined ratio for 2000, compared with the 113.8% ratio reported by a comparable group in the previous year.

Results are expected to improve this year, as more rate increases begin to take hold, but it will likely take more than one year of healthy hikes for the industry to fully recover from the soft market, observers say.

The top 20 reinsurers, based on premiums written, reported a 111.2% combined ratio vs. a

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SPOTLIGHT ON:
MANAGED CARE TRENDS & ISSUES
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UPDATES

Data released on MSDs

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broadly.

For example, service workers—who suffered the highest number of musculoskeletal disorders—accounted for 152,800 of the injuries, requiring a median five-day absence from work. While workers in the mining industry accounted for only 3,300 of the MSDs, their median recuperation period required 32 days off the job.

The 1999 data reflected a continuing decline in the number of MSDs reported since the BLS began collecting detailed information on the nature of injuries in 1992. In 1992, U.S. workers suffered 784,100 MSDs that required time off, but the number has dropped steadily since then.

MSDs as a percentage of all injuries requiring time off the job for recovery have remained remarkably stable, though, fluctuating between 33.6% and 34.4% throughout the period.

High court to hear bias case

WASHINGTON—The Supreme Court agreed last week to decide what remedies the Equal Employment Opportunity Commission can pursue on behalf of workers who allege that their employers violated federal anti-discrimination laws when the workers' job applications included agreements to submit employment disputes to arbitration.

The case, *Equal Employment Opportunity Commission vs. Waffle House Inc.*, involves allegations that the manager of a Waffle House restaurant in West Columbia, S.C., violated the Americans with Disabilities Act by firing Eric Scott Baker, a worker who suffered from a seizure disorder. Mr. Baker did not seek arbitration but did file a complaint with the EEOC, which sued Waffle House on Mr. Baker's behalf.

A U.S. district court held that Mr. Baker did not have to take his complaint through arbitration, but the 4th U.S. Circuit Court of Appeals overruled the lower court in 1999.

It held that, while the EEOC could sue Waffle House, the arbitration agreement barred the commission from seeking certain damages—including back pay—on Mr. Baker's behalf. The EEOC appealed, and the Supreme Court agreed early last week to hear the case.

Late last month, the high court upheld the right of employers, under most circumstances, to force workers to arbitrate rather than litigate job-related disputes.

Interest in plan model studied

While most California employers are not ready to switch to so-called "defined contribution" health plans, the state's employers are more receptive to the idea than are those in other parts of the country, according to a new survey from the Kaiser Family Foundation.

The study, which compared responses from 857 employee benefit managers at private companies with employees in California against an earlier nationwide survey, reveals that 63% of California companies are unlikely or very unlikely to switch to a defined contribution approach, compared with 78% nationwide.

Thirty-three percent of the California companies report, though, that they are very or somewhat likely to make the switch, compared with 20% nationwide.

The survey defines "defined contribution" health plans as those in which an employer gives its employees funds with which to purchase health insurance directly, rather than arranging for group coverage.

The survey also found that monthly premiums in California remained lower in 2000 than in other states overall. The premium for employer-provided coverage in California was, on average, $192 per month per person for single coverage, compared with $202 nationwide. Total family coverage premiums averaged $492 per month per family, compared with $529 nationwide.

The Menlo Park, Calif.-based Kaiser Family Foundation, an organization that provides analysis of health issues, is not associated with the health maintenance organization Kaiser Permanente. The employer survey was conducted in conjunction with the Health Research & Educational Trust, a private nonprofit organization.

Bermuda life reinsurer forms

HAMILTON, Bermuda—Hampton Re Holdings Ltd., a newly formed Bermuda life reinsurer, has raised $150 million in a private placement.

The company will focus on blocks of in-force life business, mainly as a retrocessionaire of other life reinsurers.

Its management includes Chairman Kaj Ahlmann, a former vice chairman of E.W. Blanch Holdings Inc. and former top officer at Employers Reinsurance Corp.; William W. Walker, president and chief executive officer, who is a former president and CEO of Hannover Life Reassurance Co. of America; and Hank Sulikowski, chief operating officer and a former executive of Scottish Annuity & Life Holdings Ltd.

Mr. Sulikowski declined to identify the investors who contributed Hampton Re's initial capital. The reinsurer may seek additional equity capital at a later date, he said.

Mr. Ahlmann, who resigned his position at reinsurance broker E.W. Blanch Holdings earlier this year, is separately pursuing plans to capitalize another reinsurer, dubbed "Markitas," to cover runoff property/casualty business.

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Regulators seek to ease commercial lines rules

By MEG FLETCHER

NASHVILLE, Tenn.—A National Assn. of Insurance Commissioners' subgroup is planning to encourage commercial lines deregulation in about 15 jurisdictions this year, as a way to demonstrate the NAIC's commitment to modernizing insurance regulation.

The new project, which the NAIC's State-Based Systems Working Group recently began developing with help from several insurance trade organizations, is part of the NAIC's effort to adopt "regulatory framework efficiencies." The project seeks to reduce unnecessary oversight for sophisticated buyers of most commercial lines of insurance and speed up the process by which new products reach the marketplace.

NAIC

"It is time to move forward where opportunities exist," said Lee Covington, the Ohio insurance director who co-chairs the so-called IS3 working group. It was established as an independent working group earlier this year.

The new project will encourage deregulation of some property/casualty commercial lines coverages in: Alabama, Alaska, Connecticut, Delaware, District of Columbia, Iowa, Louisiana, Massachusetts, Missouri, New Mexico, New York, Ohio, Oklahoma, Oregon and South Carolina.

Insurer trade associations helped target those states as having a climate favorable to deregulating commercial lines, said Donald S. Cleasby, assistant general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill. For example, a state's insurance commissioner may have broad authority to implement

See **NAIC** *on page 29*

Texas, Ga. docs join HMO lawsuit

Providers allege RICO violations

SACRAMENTO, Calif.—The Texas Medical Assn. and the Medical Assn. of Georgia have joined a lawsuit originally filed by the California Medical Assn., alleging that managed care companies defraud doctors in violation of the federal Racketeer Influenced and Corrupt Organizations Act.

The Sacramento-based CMA filed its lawsuit last year in the U.S. District Court in Miami against Blue Cross of California, WellPoint Health Networks, PacifiCare Health Systems Inc. and Health Net Inc. Last week, the Texas Medical Assn. joined the lawsuit and named CIGNA Corp. and Humana Inc. as defendants. The Medical Assn. of Georgia named Aetna Inc., United HealthCare, Coventry Health Care and CIGNA as defendants.

The doctors seek both monetary and injunctive relief. They claim the health plans deny and delay payment on legitimate claims, force doctors into contracts that do not cover patient care costs, use financial criteria to deny patient care and provide incentives to claims reviewers who meet denial quotas.

In a statement, Aetna said the lawsuit is without merit and Aetna will aggressively defend itself and expects to prevail.

According to Hartford, Conn.-based Aetna, the suit does not advance the improvement of the nation's health care system.

The lawsuit, and others like it, "inappropriately attempt to usurp control over this country's health policy from legislators and regulators."

—By Roberto Ceniceros

Fire probe faults refiner

Federal agency says Tosco lacked safety procedures

MARTINEZ, Calif.—Better attention to safety practices by management could have prevented a 1999 petroleum fire that killed four workers at a refinery operated by Tosco Corp., the Chemical Safety and Hazard Investigation Board announced last week.

Tosco, which is based in Old Greenwich, Conn., sold the Avon refinery, located near Martinez, Calif., last year.

The CSB announcement follows a two-year investigation. The board found that management at the refinery lacked effective procedures to investigate dangerous maintenance operations and implement necessary safeguards. Neither the parent company, Tosco, nor management at the facility investigated or corrected a "pattern of serious unsafe practices," investigators found.

Worker error was not a root cause of the accident, investigators determined. Effective job planning, hazard review and management oversight could have prevented the tragedy.

The incident occurred Feb. 23, 1999, when workers attempted to remove a leaky petroleum pipe. Corroded and leaking valves hampered their effort to completely drain a highly flammable petroleum mixture from the pipe. When the mixture burst into flames, workers were positioned nearby on scaffolding 100 feet off the ground. They had limited means of escape, the CSB found.

That tragedy came just two years after an explosion at the refinery killed one and injured 46 others, according to the CSB. The CSB recommended that Tosco improve its safety auditing procedures and ensure that its other refineries do not have similar safety deficiencies.

The CSB is a federal agency and a scientific investigation organization. It is not an enforcement or regulatory body.

Tosco will review the CSB's findings, a company spokesman said. The spokesman said, though, that Tosco has spent the past two years making safety improvements that likely have addressed the CSB's concerns.

—By Roberto Ceniceros

INSIDE

- The Portman-Cardin bill now before Congress should be passed on its own, not attached to any other piece of legislation, this week's editorial says. **PAGE 8**
- The rate of mergers and acquisitions in the property/casualty insurance industry is significantly slower than it was two or three years ago. **PAGE 20**
- Lloyd's of London posted a loss of $1.58 billion for the 1998 year of account, noting that things are likely to get worse before they get better. **PAGE 23**
- The insured loss from the recent sinking of a Brazilian offshore oil rig could reach $700 million and may force up offshore energy rates. **PAGE 23**

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SPOTLIGHT REPORT

Benefits: MANAGED CARE TRENDS & ISSUES

Despite price hikes, managed care can still corral costs

By JOANNE WOJCIK

With premiums for health maintenance organizations climbing faster than those for preferred provider organizations, employers are beginning to wonder what happened to the "management" in managed care.

While HMOs may still be less expensive than PPOs or indemnity plans, if they are doing their job in managing costs, why are their prices going up so much?

Industry observers blame three developments.

First, consumer backlash has forced plans to eliminate gatekeepers and specialist referrals and open drug formularies to include more choices—all once thought to be vital to controlling utilization and therefore costs.

Second, many plans are now for-profit entities that must respond to shareholder demands, which also is contributing to cost pressures.

And last but certainly not least, providers are becoming more aggressive in their negotiations with plans, scoffing at capitation and

risk-sharing, and demanding more money and autonomy (see story, page 10).

Despite these setbacks, benefit consultants and employers believe managed care is still the best way to rein in health care costs. It'll just have to do so a little bit differently in the future, they say.

"There is less management" in managed care as a result of "rebellion from both providers and employees," observed Rich Ostuw, global health care practice director at Watson Wyatt Worldwide in Stamford, Conn.

"But, in many situations, even though the rate of increase in managed care is higher, nobody would say we want to go back to an indemnity system," he said.

"What managed care has done best is in the areas of preventive care and reducing the cost and risk of unnecessary surgical procedures," Mr. Ostuw pointed out.

"In many locations, and for many populations, there still is an important place for managed care plans," he insisted. "We shouldn't abandon it in the areas where it's working."

HMOs, once thought to be the

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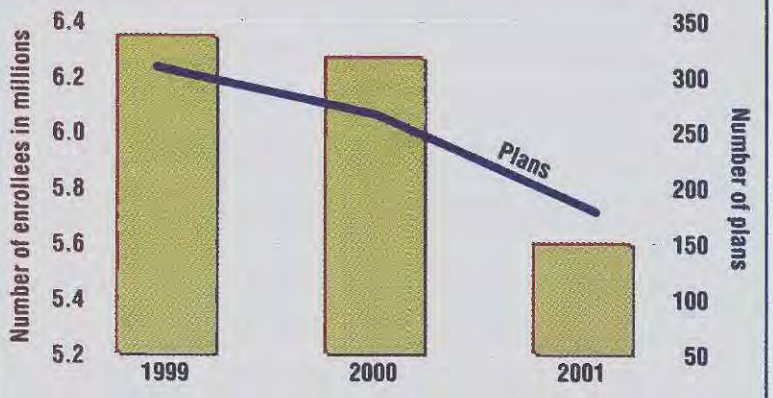
Payment increase may renew Medicare HMO market

Medicare HMOs' decline

Enrollment in Medicare HMOs is slipping as the health plans have exited markets



Source: Health Care Financing Administration

GRAPHIC BY ADAM DOI

By JERRY GEISEL

The ability of Medicare HMOs to deliver rich benefits to retirees and cut costs for employers may be returning after years of being sapped by parsimonious lawmakers.

Only a few years ago, Medicare health maintenance organizations were viewed as a rare win-win-win proposition for the government, retirees and, in many cases, employers.

The mechanics of the arrangement were simple. An HMO, in exchange for a fixed payment from the federal government, would provide at least the level of benefits offered by the traditional, fee-for-service Medicare program. These payments would be slightly less than what the federal government estimated it would cost Medicare to provide the coverage, resulting in cost savings for Medicare.

Because the payments were based on Medicare's costs, the managed care plans often could provide retirees with a much richer benefit package than Medicare offered and still earn a profit.

For employers, Medicare HMOs offered a golden opportunity to reduce retiree health care costs.

Many employers found that the cost of offering a Medicare HMO, even after paying any premiums for additional benefits such as unlimited prescription drug coverage, was considerably less—in some cases up to $1,000 per retiree less—than what they were spending for their indemnity plans that supplemented Medicare.

Given the chance to receive a much richer benefit package at little or no cost, it isn't surprising that retirees in droves moved out of the traditional Medicare program and into Medicare HMOs. Enrollment in Medicare HMOs hit more than 6.3 million in 1999—the high mark of enrollment—up from about 4.3 million in 1996.

But over the last two years, that rosy picture of Medicare HMOs darkened as the impact of a 1997 federal budget law began to be felt. That law, among other things, essentially capped at 2% the annual increases in the federal payments to HMOs. That curb on payment increases came as HMOs' costs—particularly for prescription drugs—began to soar.

"Government reimbursement didn't support HMOs' ability to provide the benefits they had been offering," said Sue Helke, a consultant in the Cleveland office of Watson Wyatt Worldwide.

See **Medicare** *on page 11*

Double-digit growth giving dental PPOs reason to smile

By LEE FLETCHER

While dental indemnity plans still account more than 40% of all dental care coverage in the United States, dental preferred provider plans are growing in popularity by offering cost savings and flexibility.

Evelyn F. Ireland, the executive director at the National Assn. of Dental Plans in Dallas, said that the recent trend has been toward dental PPOs because other managed care plans, such as dental health maintenance organizations, have such limited networks.

"In a tight employment market, employers are more likely to offer a benefit that has some cost savings but also allow employees more of a choice among the providers they see. The last year we had double-digit growth in a dental HMO was in 1997," Ms. Ireland said.

Conversely, she pointed out, dental PPOs have seen double-digit growth since 1996.

The PPO portion of the dental care market is now roughly double that of HMOs, Ms. Ireland said. "It's at about 31% for PPOs, and it's just under 18% for HMOs. And I think we'll see that grow even more this year," she said.

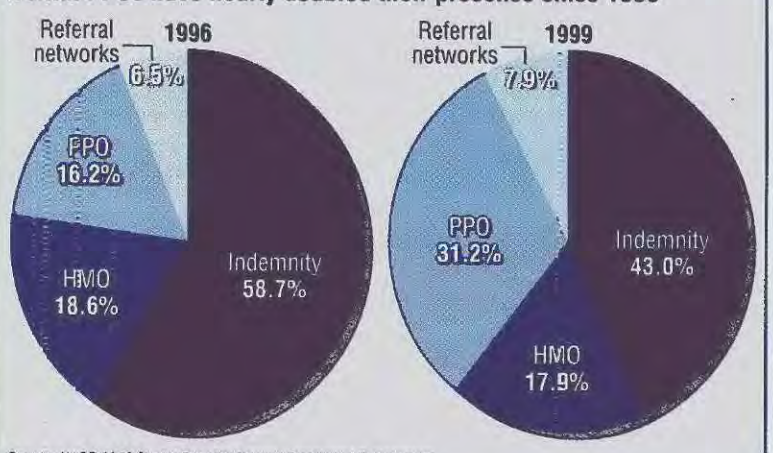
Dr. Alan J. Vogel, vp and national dental director with Metropolitan Life Insurance Co. in New York, said that employers favor dental PPOs for their greater accessibility. A key difference between PPO and HMO networks is the number of providers in each, he said.

"Over the last number of years, the problems that came up with access and quality really became some issues that have caused the DHMO trend to slow down and stop, almost to the point of going

See **Dental** *on page 6*

Biting into market share

Dental PPOs have nearly doubled their presence since 1996



Source: NADP 2000 Dental Benefits Report: Enrollment & Networks

GRAPHIC BY ADAM DOI

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PBMs still effective in controlling prescription costs page 14

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Spotlight Editor: Michael Prince

Managed

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panacea for rising health care costs, are beginning to look a lot more like PPOs, which many employers had hoped to use as steppingstones to move employees into the more-restrictive managed care plans.

"As you look at the distinction between (HMOs and PPOs), the differences are starting to blend," said Brad Fluegel, health sector market leader for Tillinghast-Towers Perrin in New York.

HMOs have eliminated or curbed specialist referral requirements, expanded their drug formularies and are doing less capitation in their contracts with providers, industry observers say.

HMOs also experienced significant financial losses over the past few years and are now playing catch-up.

"The rate increases in prior years were well below medical trends," Mr. Fluegel said. "Plans were more growth-oriented than profit-oriented and were aggressive on price in order to get the business."

But that approach backfired. Lower premiums, coupled with higher prescription drug costs and less management, have put many HMOs in the hole, he said, and now they have to raise rates substantially to return to their former levels of profitability.

Furthermore, now the majority of plans are for-profit and have shareholders to answer to, said Blaine Bos, principal at William M. Mercer Inc. in Chicago.

As health plans consolidate and become publicly traded, "shareholders are demanding that more attention be paid to the bottom line," Mr. Bos said. "Shareholders want better returns on their investment, so HMOs have to raise prices to improve profitability."

'The doctors are more sophisticated in how they negotiate contracts. They've discovered how much power they have,' says Blaine Bos of William M. Mercer.

Increased provider clout also is making it harder for HMOs to negotiate good discounts, which also is adding to the plans' overhead, consultants point out, and the more they have to pay their doctors, the more they have to charge in premiums.

"The doctors are more sophisticated in how they negotiate contracts," Mr. Bos said. "They've discovered how much power they have."

But while managed care may be hitting some obstacles today, it did have a significant impact on health care costs over the past 10 years, almost everyone agrees.

"It has delivered on the cost promise," said Ken Sperling, health care practice leader at Hewitt Associates L.L.C. in Norwalk, Conn.

"The discounts are real. It's still cheaper to deliver care in an HMO with a $5 copayment than in an indemnity plan with a $400 deductible," Mr. Sperling said.

"I think what happened is when companies changed to managed care plans, they had a one-time decline in their costs because of the discounts they were getting and case management and everything these managed care plans were doing to control costs," said Mike Pikelny, corporate actuary and employee benefits consultant at Hartmarx Corp. in Chicago.

"But now that all those programs are in place, I think the increases for all the plans are going up at the same rate," Mr. Pikelny said.

"It's just that management care plans started from a lower level, and that one-time savings is gone," he said.

Despite these trends, managed care plans will always cost less than indemnity plans will, Mr. Pikelny and others say.

"HMOs squeezed a lot of fat out of the system," agreed Mr. Bos. "They've gotten rid of a lot of administrative inefficiencies, and now it's getting hard."

To survive, managed care will have to shift its focus, many say.

For example, rather than just offering discounts, plans will tout quality, use evidence-based medicine and institute new technology and procedures to eliminate medical errors, all of which have been shown to reduce cost over the long run, Mr. Bos said.

"But that's a more-expensive and difficult proposition," he acknowledged.

This is where the newest trend, the so-called "consumer-driven health care model," will likely come into play, observers say.

"They say the way to focus on quality is to get the consumer involved," Mr. Bos said. "But that's a tough proposition too, because it means educating employees so they look at health care in a new way."

And, "the return on investment will be much, much lower than in the beginning of managed care," Mr. Bos predicted. He added that "the employer and the employee are going to pay for the transition."

"I expect to see some pretty healthy increases for the next two to three years, as plans rebuild reserves and reinvent themselves," Mr. Fluegel said.

And "there will be higher levels of cost-sharing with employees," he said.

But "we're certainly not going to go back to a world of fee-for-service medicine," Mr. Fluegel said.

"It's kind of like the stock market in a way," he said. "We've been in a bull market for several years, and people have forgotten that the market goes up and it goes down—it vacillates. The same holds for health care premiums."

"There used to be a five-year cycle, but that's been moderated somewhat because of the advent of managed care," Mr. Fluegel said. "But the underlying issues haven't gone away."

"Managed care in its current form has hit the wall," said Hewitt's Mr. Sperling.

"We've changed the intercept," he said, "but not the slope."

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What can we do to help you?

Dental

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in a negative direction," Dr. Vogel said.

Gary D. Radine, the San Francisco-based president and chief executive officer of Delta Dental Plan of California, Pennsylvania and aligned states, said that although dental HMOs are not the most popular choice in managed care, he cannot foresee a day when they disappear completely.

"These kinds of programs tend to have cycles with the overall economy and what the purchasers are facing," Mr. Radine said.

The dental care marketplace has been unsuccessful in managing dental costs because most dentists will not join dental HMOs, said Dr. Robert J. Leaf, a principal with American Dental Consultants in New York.

This may help explain why only 153 million people, or 56% of the U.S. population, have dental benefits, Ms. Ireland said.

Although at one time dental HMOs were growing in popularity and used to be considered "sexy," Dr. Leaf said that employers aren't interested in networks that allow their employees a choice among only 5% of the dentists in a community.

Dr. Leaf attributes the popularity of dental PPOs to their larger networks.

"Employers did not realize that employees had a fair amount of loyalty to their own dentists and were unwilling to switch," he said.

"When companies like IBM and AT&T offered the DHMO networks and they only got 5% to 10% of their employees to use it, they realized that that wasn't going to help them very much," Dr. Leaf said. "If you have a program that costs 10% as much as their medical program and you only get 10% of your employees to use it—even if it saves half, it's such a small number and a lot of work that it wasn't worth the effort."

'Employers did not realize that employees had a fair amount of loyalty to their own dentists,' says Dr. Robert J. Leaf.

Mr. Radine said that the dental care marketplace only recently has become relatively successful at containing cost increases, although perhaps more so than its medical industry counterpart.

"The cost has been relatively stable, in the 6%, 7% and 8% level," he said.

Mr. Radine explained, though, that dental services aren't as technology-driven as are medical services. "Dental hasn't really had to cope with the high costs associated with technology as the medical industry," he said.

According to the Towers Perrin 1999 Health Plan Performance Benchmarking Study of Fortune 500 Companies, the average annual employee contribution is $192 for dental indemnity plans, $137 for dental PPOs and only $112 for dental HMOs.

Although Ms. Ireland said that a reduction of about 5% to 6% in the indemnity market is being seen annually—and it's mostly migration to PPOs—Ralph Kimmich, the director of benefits and compensation for Southwest Airlines Co. in Dallas, said that Southwest's employees seem happy with that company's indemnity program.

Mr. Kimmich said Southwest chose its indemnity plan some 25 years ago, "before things like HMOs and PPOs were in anyone's mind." And while the company has re-examined its plan over the past few years, it sees no reason to switch, he said.

"The amount of savings wasn't worth the change to a PPO or an HMO," Mr. Kimmich said.

Additionally, he said, many of the national networks seem to be weak in some geographic areas and the net gain from switching to a network would be too nominal to bother.

A technology company benefit manager who asked to remain anonymous said that, in 2000, her company had a basic compensatory dental plan as well as a nondeductible dental plan with a copayment. Employees did not have to choose their dentists from a network.

This year, though, the company added a dental PPO. She said the company wanted to save money and wanted each employee to use his or her annual dental maximum benefit of $1,500 more efficiently.

"It's a two-pronged approach—we're saving money on both ends," the benefit manager said, referring to savings by both employer and employee, "and there's not too much of a change for the employees."

She said her company plans someday to switch completely to a PPO to realize cost savings; the networks, though "are too weak at this point."

Scott E. Ziemba, a Chicago-based senior consultant with Watson Wyatt Worldwide, said that as much as employers would prefer a more managed approach, the lack of continuity of care and access prohibits many employers from adopting network-only benefits.

"When we work with an employer, they will typically offer a network-based benefit structure, but they will also offer a fee-for-service program along with it and make a differentiation in the pricing structure to employees as far as which one they take," Mr. Ziemba said.

Much of the reason for that, Mr. Ziemba said, is that people are more in tune with their benefits overall, whether medical or dental.

"Employees are making sure that they use every benefit that their employer is providing them to their maximum benefit," he said.

In the event of an economic downturn, Ms. Ireland said, employers that offer dental benefits are not likely to eliminate the benefit. While an employer can't really rescind a benefit once it's out there, she said, it can alter the way in which it is offered.

Ms. Ireland suggested that employers might simply opt to pay less making employees responsible for more out-of-pocket costs.

Dr. Vogel said it is almost impossible to predict the future of dental coverage, because "there are two functions that have to be evaluated—how the employers look at structuring their funding for these benefits and how the economy is going."

Finding the right balance is the key to success for employers when determining the types of dental coverage to offer, Mr. Radine said.

Employers, he said, "are trying to find out what their employees want and strike the right balance."

"That's where I see it going—more freedom of choice for people," Mr. Radine said. "People would rather have choices."

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OPINIONS

Approve pension reform

WILL PENSION REFORM legislation ever be enacted?

That is a reasonable question in the wake of years of failure—despite overwhelming support in Congress—to win final approval of such a measure.

That failure certainly wasn't due to lack of trying. Several times during the prior administration, Congress sent President Clinton tax or budget bills that included pension reform provisions. But the broader bills were vetoed, killing with it the pension provisions.

Last year, though, a different outcome appeared likely, at least for a while. First, the House, by a 401-25 margin, passed a pension reform package proposed by Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md., as a stand-alone bill. Shortly thereafter, the Senate Finance Committee unanimously approved a very similar bill.

At that point, final passage of a measure along the lines of the Portman-Cardin bill seemed likely, if not inevitable. What wasn't known then was the political maneuvering that would unfold.

Senate Republicans decided to attach the pension bill to a tax bill that President Clinton opposed. Ostensibly, that action was taken because Republicans feared that the popular pension bill would become a magnet for other measures they opposed. Probably closer to the mark was that Republicans believed Democrats would be blamed for the defeat of a popular measure if President Clinton vetoed the tax bill and with it the pension reform package. Ultimately, Republicans decided not to seek a final vote on the tax bill after the administration sent out signals that the measure would be vetoed.

We would hope that this time around, when it comes to pension reform, the past is not prologue. Clearly, the lesson of the past is that pension reform legislation should not be part of broader, controversial bills but should be considered as a freestanding measure. The conventional wisdom used to be that the only chance of Congress passing pension reform measures was to have those measures attached to broader bills. Assuming that ever was true, recent history suggests that such an attachment only decreases the chances of pension reform being enacted, and benefit lobbyists should press legislators to see that such an attachment does not occur.

As to the Portman-Cardin bill itself, we would hope that

Congress quickly approves it and President Bush signs it. In brief, the bill would, in a modest but welcome way, undo some of the damage that legislators inflicted on pension plans during the mid-1980s when the plans were viewed as revenue targets rather than a source of retirement income.

For example, the measure would allow employees to put more money into 401(k) plans, while allowing employers to provide bigger benefits through both defined benefit and defined contribution plans.

In addition, the measure would eliminate rules whose rationale defies common sense. To take one example, it is beyond us why an employee who moves from the private to the nonprofit sector can't roll over funds from a 401(k) plan to a 403(b) plan rather than maintain two savings plan accounts.

While recognizing that nondiscrimination tests are necessary to ensure that plans don't favor higher-paid employees, we believe those tests should be simplified, which the legislation would do.

We hope this bill receives the approval it has long deserved.

Arbitration isn't only tool

THE SUPREME COURT handed employers a welcome victory late last month when it upheld their right to require that employees submit work-related disputes to arbitration.

Indeed, had but one justice voted to uphold the 9th U.S. Circuit Court of Appeals' interpretation of the Federal Arbitration Act of 1925 in *Circuit City Stores Inc. vs. Saint Clair Adams*, employment arbitration agreements could have become unenforceable. Employers would have lost a critical tool in reducing costs and avoiding litigation.

The Supreme Court's 5-4 decision guarantees that, except in those circumstances specifically exempted by the Federal Arbitration Act, employers can still count on that tool. And the decision seems likely to boost the popularity of an already popular way to settle disputes. But that doesn't meant that this tool is always the right one for the task.

As a number of legal experts pointed out in last week's issue, there are cases where an employment arbitration requirement can work against an employer's best interests. Employers have to be careful not to let their justified and understandable distaste for litigation sour them on taking certain matters to the courts. Employment law experts point out that there are times when less-than-meritorious employment cases that would have been rejected by juries end up in some gain for the complainants when arbitrators decide to split the difference. There can also be a temptation for disgruntled employees to take every dispute, no matter how minor, to the arbitrator.

These caveats don't mean that the decision wasn't a victory for employers. After all, they were but one vote from losing the use of a tool that has saved them a considerable amount of time and money. But now that the high court has ruled that arbitration can be brought on employment-related matters under most circumstances, employers should remember that even the best of tools doesn't necessarily mean it's the right tool for every job.

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SPOTLIGHT REPORT

Provider clout leads to higher health plan costs

By ROBERTO CENICEROS

Medical providers wielding increased clout in negotiations with health plans will continue to add to benefit cost increases, several experts say.

Hospital groups in particular, and some specialty physician groups, are winning considerable gains, sometimes through aggressive standoffs and threats to abandon their participation in health plans.

Just a few years ago, they readily accepted the compensation and terms dictated by managed care companies. But not anymore, the experts say.

"The pattern really built to where we have seen confrontation played out in the media and there are holdouts and the threat of termination," said a spokesman for Blue Cross of California.

To stem the problem of employees being left without access to health care providers as a result of contract disputes, some employers are demanding that both health plans and hospitals agree to continue providing service even if their contract negotiations break down.

In the long term, direct communication between providers and employers could eventually help the latter manage the resulting benefit cost increases, some observers believe. But they note that success stories have yet to be found.

There has been a shift in the balance of power nationwide, said Paul Ginsburg, the president of the Washington-based Center for Studying Health Care System Change. The center is an independent research organization funded entirely by the Robert Wood Johnson Foundation.

Medical providers have greater clout, Mr. Ginsburg said. In part, he said, that's because managed care companies have reduced their practice of restricting participation in their provider networks, Mr. Ginsburg said.

Increased consolidation among hospital companies has also meant that health plans have had little choice but to accept the hospitals' terms if they are to offer a network in many communities, several observers say.

"There are more situations where a hospital has realized it's a must that plans have to have them in their network," Mr. Hastings said. Additionally, more hospitals have probably realized that, in the earlier days of managed care, they accepted health plan conditions too readily because of an unfounded fear that they would be dropped from networks.

"So, part of it is a contrast with a situation where (hospitals) might have gotten less (in the past) than they could have gotten," he said.

Hospitals also have grown more aggressive because of the 1997 Balanced Budget Act, which cut Medicare spending and left them with few funding alternatives other than shifting costs onto the private sector, others say.

Several observers see increases in reimbursements to medical providers as necessary to keep them afloat and keep networks stable. As proof that reimbursements sank too low under managed care, they cite the bankruptcy of several large doctor groups in California, as well as the shutdowns of hospital emergency rooms and cuts in nursing staffs.

"The claim by providers that they are being squeezed unreasonably on reimbursement is probably a fair statement," said Glenn Smith, a senior health care consultant in San Francisco for Watson Wyatt Worldwide.

Some health industry participants argue that poor management has been just as much a factor in the failure of many doctor groups. But the Sacramento-based California Medical Assn. cites a PricewaterhouseCoopers study that found capitation rates for California doctors dropped from between $40 and $45 per member per month in 1993 to a range of $29 to $36 in 1999. Adjusted for the cost of living, the rates dropped 55% in seven years, according to the CMA.

Under capitation arrangements, providers are paid a set fee per plan member per month, regardless of whether that member actually seeks medical care.

The CMA argues that, while employers in California—where capitation has made the greatest inroads—have been paying higher health plan premiums, those increases are not being passed on to doctors.

Hospitals have been more successful than have doctors in winning negotiation demands, said Michael Eberhard, the chairman of Medical Pathways, a Cerritos, Calif.-based manager of doctor groups in California and Texas. "The doctors are still fragmented, and they don't have the negotiating leverage," Mr. Eberhard said.

But some specialists who band together have been able to exert considerable leverage in negotiations, Mr. Ginsburg said.

Hospitals, for their part, have focused on winning greater payment amounts and abandoning capitation-type reimbursement in favor of per diem charges. In doing so, they are forcing health plans to take back the risks that previously had been pushed onto the providers by the health plans (*BI*, Nov. 20, 2000). The hospitals no longer want to bear the risk of costly and complex treatments such as organ transplants.

But the doctor groups that previously embraced capitation are not giving up on that means of reimbursement. They are narrowing the risks they will take on, though, and they are demanding greater capitation payments.

Provider groups that say they have not been paid adequately have cut off their relations with health plans, sometimes in the middle of negotiations. In October, for example, Partners HealthCare Systems

Continued on next page

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Inc., a Boston-based provider group, announced it would not renew its contract with the Waltham, Mass.-based Tufts Health Plan (*BI*, Nov. 20, 2000).

When negotiations broke down earlier this year between Blue Cross of California and Sacramento, Calif.-based Sutter Health, plan members had to forgo treatment at Sutter's hospital facilities and find care elsewhere, the Blue Cross spokesman said. That disruption lasted for about a month. In February, the two companies reached an agreement and issued a joint statement saying they regretted the disturbance in service.

"Many of the other health plans just went ahead and agreed to the higher level of reimbursement," Mr. Smith said. They didn't put up the fight that Blue Shield did.

Employers are growing increasingly concerned about their employees being caught in the middle of disruptions such as that caused by Sutter and Blue Shield's impasse, said Peter V. Lee, president and CEO of Pacific Business Group on Health, a San Francisco-based employer purchasing coalition. To ease employer concerns, hospital groups and health plans are now agreeing to extend employee care until an employer's next open enrollment even if their contract ends and they do not sign a new agreement before the employer's next enrollment.

In other cases, such "continuity agreements" are set for six months beyond the termination of a contract between a health plan and hospital group, Mr. Lee said. The agreements are the result of purchaser pressure, he added.

Meanwhile, large employers are enduring health care cost increases, but they rarely, if ever, communicate directly with the medical providers whose demands are seen as adding to those increases.

'Health benefit costs still are not as much a concern to employers as they were in the early '90s,' says Paul Ginsburg.

That type of communication could help employers manage benefit costs, said Doug A. Hastings, a senior member of the national health law practice for Epstein Becker & Green P.C. in Washington. Such a dialogue would require the cooperation of health plans and would likely result in employers learning which doctors and hospitals provide the best care at the best prices.

Employers could then pass that information on to their employees.

"That is really, if we can get there, the next generation of health care beyond managed care," Mr. Hastings said.

But, so far, employers have hardly even spoken up about whether their health plans should negotiate in favor of paying a premium in return for wide-open provider networks or should tighten up their networks in order to reduce costs, said Kirby Bosley. Ms. Bosley is the head of William M. Mercer Inc.'s Los Angeles health care and group benefits consulting practice.

"By and large, health plans are getting no direction from employers," Ms. Bosley said. "So, in many cases, they are operating under the assumption that employers want them to keep the largest network possible at any cost. They are operating under that assumption because they are not hearing otherwise."

While employers have taken some small measures to reduce their health care costs, such as increasing copayments and deductibles for prescriptions, they have yet to pursue any larger structural changes, Mr. Ginsburg said. A tight labor market and good economic times have worked against that.

"Health benefit costs still are not as much a concern to employers as they were in the early '90s, when the rapid shift to managed care started," Mr. Ginsburg said. But that, he said, could change in an economic slowdown. BI

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Medicare

Continued from page 3
Unable to earn a profit, HMOs over the last two years have exited the Medicare market en masse. As recently as 1999, there were 309 Medicare HMOs; as of last month, the number had fallen to just 178, according to the Health Care Financing Administration, the federal agency that administers Medicare.

"There has been a massive retrenchment around the country," said Greger Vigen, a consultant in the Los Angeles office of William M. Mercer Inc.

As HMOs exited markets, hundreds of thousands of retirees and other Medicare-eligible individuals scrambled to find coverage from other HMOs or returned to the traditional Medicare program. Indeed, over the last year, enrollment in Medicare HMOs tumbled to about 5.6 million from 6.3 million.

The pullout of HMOs from the Medicare market has had an impact on employers that had encouraged retired workers—through financial incentives and communications programs—to enroll in Medicare HMOs.

For example, at Bethlehem Steel Corp. in Bethlehem, Pa., the proportion of retirees enrolled in Medicare HMOs has dropped sharply over the last few years, to 15% from 25%. "This has been bad public relations for us," said Jack Romeo, Bethlehem's director of health care systems.

In other cases, the withdrawal of HMOs from the Medicare market has curtailed interest among employers that had considered offering such a plan.

"We have retirees all over the country. There wasn't one HMO that could cover all the retirees, and we wouldn't have wanted to deal with multiple HMOs," said Michael Pikelny, corporate actuary and employee benefit consultant at Hartmarx Corp. in Chicago.

Contending that they have been squeezed by inadequate government reimbursements and escalating costs, those HMOs remaining in the Medicare market have raised premiums and cut benefits.

For example, in 1998, all of the Medicare HMOs offered by Florida Blue Cross & Blue Shield were zero-premium plans. Today, monthly premiums—ranging from about $25 to $80—are charged in 11 of the 13 counties where Florida BC/BS offers Medicare HMOs, while prescription drug coverage in many cases has been cut by

See **Medicare** *on next page*

Future of Medicare HMOs

Reasons given by employers for discontinuing Medicare HMOs	
HMOs not available	65%
Health plan disruption	32%
Too expensive	21%
Administrative burdens	14%
Concern over government policy	9%
Other	5%

Source: Hewitt Associates L.L.C.

Employers' plans for Medicare HMOs*	
Not currently offering and do not intend to start	68%
Keep existing Medicare HMOs	21%
Offer Medicare HMOs in new markets	11%
Discontinue offering Medicare HMOs in selected markets	3%
Offer only Medicare HMOs to retirees	2%
Other	2%

*Strategies for Medicare HMOs 2001-2003

Medicare

Continued from previous page
half.

In California—the state with the greatest number of beneficiaries in Medicare HMOs—premiums now typically range from $500 to $800 per year, according to Mercer's Mr. Vigen. That marks a big change from three years ago, when plans required small premiums or none at all, he said.

In the wake of the plunge in the number of Medicare HMOs, Congress—amid heavy lobbying from the HMO industry—last year took a few steps aimed at stabilizing the market. Among other things, legislators guaranteed that all Medicare HMOs would receive a minimum rate increase this year of 3% rather than 2%.

In addition, last year's changes set a new minimum monthly payment rate of $525 for enrollees who reside in counties in metropolitan areas with a population of at least 250,000, and a minimum monthly payment rate of $475 for enrollees residing in rural areas. The prior minimum monthly rate was $415.01 for both. The new payment rates took effect March 1.

In all, the changes will pump more than $6 billion in additional direct federal payments over the next five years to Medicare HMOs, according to the Washington-based American Assn. of Health Plans, a managed care trade group.

Already, the changes in payment rates have had an effect. PacifiCare Health Systems Inc. said the payment increase allowed it to remain in markets it might have otherwise exited. PacifiCare's Secure Horizons unit is the nation's largest Medicare HMO, with just over 1 million enrollees.

In addition, Blue Cross & Blue Shield of Massachusetts, which has about 40,000 enrollees in its Medicare HMOs, said the additional federal payments allowed it to reduce premiums in some of the counties in which it offers coverage.

And following last year's legislative action, HMOs in two counties in New Mexico, five counties in central New York and one county in Illinois decided to re-enter the Medicare market, while two HMOs—AmCare Health Plans of Texas Inc. and SelectCare of Texas Inc.—notified HCFA that they intend to expand into Houston and other parts of Texas.

Indeed, HMOs describe last year's changes as a good first step toward stemming the exodus of HMOs from the Medicare market. But, they say, more needs to be done.

"Perhaps we are seeing some stabilization in the program, but it would be naïve to think the problem has been solved," said an AAHP spokeswoman.

One area HMOs consider ripe for change is the methodology HCFA uses to set payment rates. Currently, payment rates are based on a blend of Medicare costs in counties in which enrollees reside and national costs.

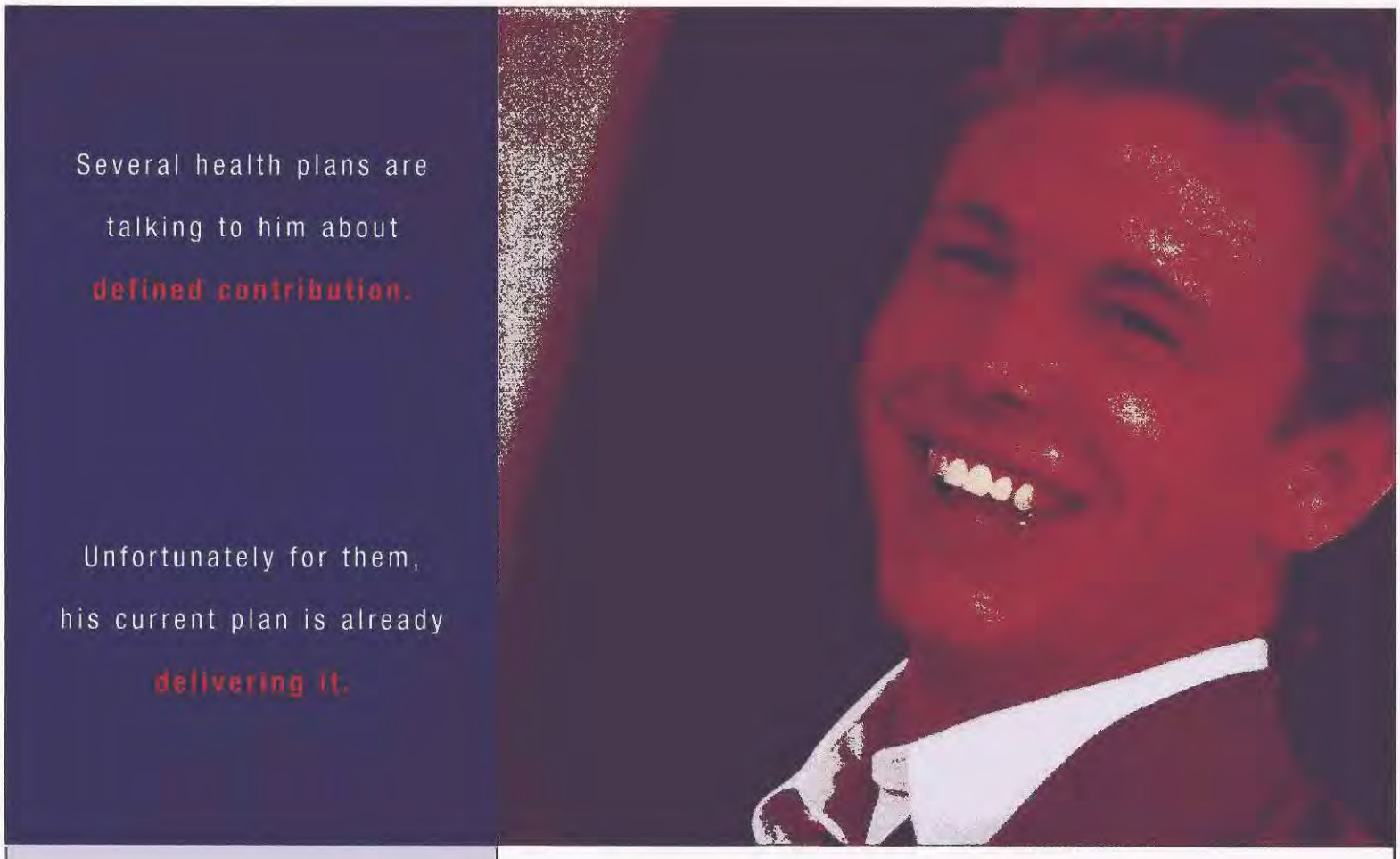
Such a payment structure, HMOs maintain, is especially damaging to plans with enrollees in suburbs. Medical costs are much lower in the suburbs than in nearby major urban areas, and the payment rates are set accordingly. However, suburban enrollees often receive their care in the city, and the payment rates do not entirely reflect those higher costs.

For example, in New York, the federal payment rate is about $200 a month less for enrollees in Suffolk County, which is on Long Island, than for enrollees living in Manhattan. "Seniors get care in high-cost academic centers in Manhattan, yet the reimbursement is based on where they live, where the costs and payment rates are lower," said a spokeswoman for Empire Blue Cross & Blue Shield, which has about 60,000 Medicare HMO enrollees.

"You can't do business that way," she said, adding that Congress needs to change the payment methodology so that payment rates more closely reflect HMOs' actual costs.

Others say that, without further changes, Medicare HMOs will wither away.

See **Medicare** *on page 14*



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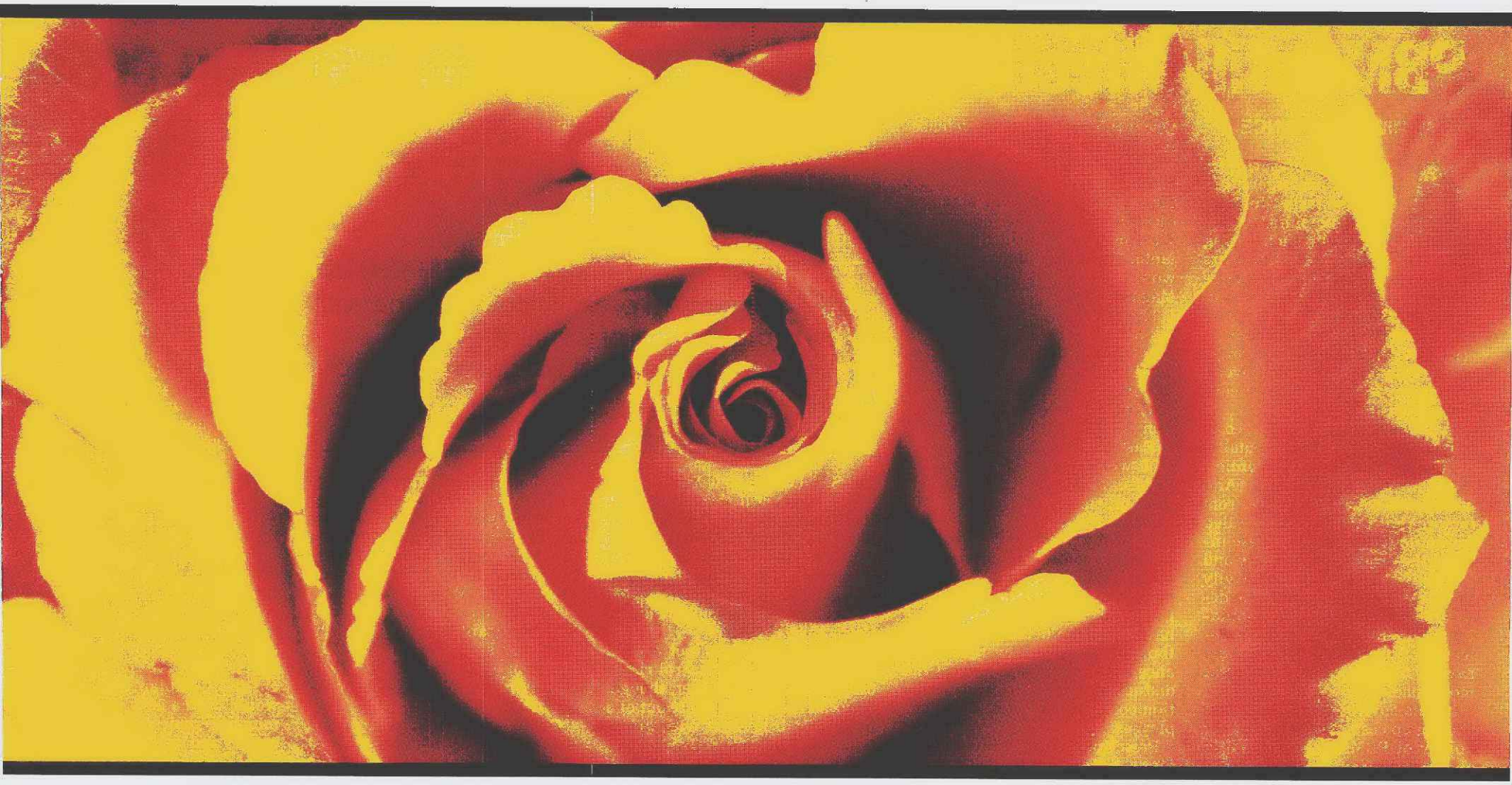

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Medicare

Continued from page 12

Unless there is reform, "This industry is going to disappear," said Charles Scott, a vp with Blue Cross & Blue Shield of Florida in Jacksonville, which has about 150,000 Medicare HMOs enrollees.

Right now, it is unclear how soon lawmakers will act, though health maintenance organizations are optimistic that congressional action is in the offing.

"The reason to be optimistic is that there are so many members of Congress that understand the importance of this program and how important it is to beneficiaries," the AAHP spokeswoman said.

The uncertainty in the Medicare HMO market, though, unquestionably has cooled employer interest in offering the plans to their retirees.

"If an employer doesn't offer a plan now, it probably is going to wait until the current uncertainty ends," said Steve Coppock, a consultant in the Norwalk, Conn., office of Hewitt Associates L.L.C.

"Employers may not be discontinuing Medicare HMOs...but they no longer think that the plans are the only answer to control retiree health care costs," said Jonathan Nemeth, a senior vp in the Somerset, N.J., office of Aon Consulting Inc.

'If an employer doesn't offer a plan now, it probably is going to wait until the uncertainty ends,' says Steve Coppock.

Still, despite drastic premium increases in the last year—some as high as 50%—Medicare HMOs can be much less expensive for employers and offer better benefits than Medicare supplemental plans.

"Even if an HMO is charging $70 or $80 a month, that still is likely to be a lot less than an employer's cost for its indemnity plan. There are still opportunities to use Medicare HMOs, save money and offer choice," said Mr. Coppock.

"The dollar differences between Medicare HMOs and traditional plans are still significant: There can be a 20% to 25% differential. That is enough for an employer to pay attention," said Ms. Helke of Watson Wyatt.

In addition, while the wave of Medicare HMO withdrawals has captured national attention, most major urban markets still are served by the plans, pointed out Mary Case, a principal with Unifi Network, a unit of Pricewaterhouse Coopers L.L.P. in New York. BI

PBMs still effective in reducing employers' drug costs

By MICHAEL PRINCE

Although prescription benefit managers are an easy target for employers looking to cast blame for their rising drug costs, employers themselves perhaps have not done enough to keep those costs in check, often because of a reluctance to limit employees' choice.

But that has begun to change, consultants say, with employers' willingness to impose stricter controls growing.

In the past few years, drug costs have risen 15% to 20% annually, studies show, with no drop anticipated in the near future. And much of the increase stems from factors that cannot be controlled by employers or PBMs. These include the development of new and expensive drugs that are heavily promoted by drug makers; the demographic aging of the population, which creates greater demand for drugs; and the wider array of drugs available to treat more conditions.

In this environment, the forces driving up costs "far outstrip" the ability of PBMs to hold them in check, said Howard Tarre, a director of the Unifi Network in Teaneck, N.J., a unit of PricewaterhouseCoopers.

With all the forces pushing up drug costs, PBMs "are as effective as they can be" in controlling costs, said Jody Hunter, director of health and welfare benefits for Georgia-Pacific Corp. in Atlanta. Without PBMs, Mr. Hunter said, "we would be a lot more defenseless than we are now."

While PBMs may not be perfect, having one is a lot better than not having one, said Sean Maguire, director of client development for Watson Wyatt Worldwide in Atlanta. "If PBMs didn't exist, costs would be a lot higher," Mr. Maguire said.

The alternative to a PBM is to go without the management of prescription drugs or to rely on health plans for such services, said Allan Zimmerman, senior executive vp for National Prescription Administrators Inc., a PBM in East Hanover, N.J.

"I would suggest to you the PBM is more effective" than either of those alternatives, Mr. Zimmerman said.

Typically, PBMs have a variety of tools to control employers' drug costs, and managing costs is a matter of employers permitting the use of such tools. Employers have been reluctant to do so, though, because they must balance any cost savings against the disturbance that strict prescription controls can cause their employees.

Prescription drug strategies fall along a continuum, with strict controls and cost containment at one end and total employee freedom at the other. It's up to the employer to pick its place on this scale and, essentially, to choose how much it will pay for its employees' freedom, experts say.

In the past few years, employers have, in general, favored giving employees more choices and, consequently, have paid more. But the trend has started to change in the past year.

"Employers have been unwilling to take the necessary steps (to cut costs), although now they are willing," said Ed Kaplan, vp with The Segal Co. in New York.

'You don't want a prescription drug benefit to be a big source of conflict with employees,' says Sean Maguire of Watson Wyatt Worldwide.

Employers still want to provide their employees with choices, but now they are asking PBMs, "What can you tell us about managing these costs?" said John Jones, vp of legal and regulatory affairs for Prescription Solutions, a PBM in Costa Mesa, Calif.

Individually, each tool a PBM possesses can help control rising drug costs. Used together, though, they can really take a bite out of a program's drug costs, with reductions that range from 10% to 25%, Mr. Zimmerman said.

Clinical programs, which are designed to reduce or even eliminate unnecessary prescriptions, are perhaps the most effective strategy, Mr. Zimmerman said. He estimates that 25% to 30% of all prescriptions are inappropriate—meaning that they are for the wrong drug, are for an incorrect dose or can cause adverse reactions with other drugs that patients are taking. Clinical programs vary, but, in general, all review prescriptions to determine whether a more appropriate drug or lower-cost option—such as a generic equivalent—exists.

But employees may object to such reviews, viewing them as interfering with the doctor/patient relationship. "You don't want a prescription drug benefit to be a big source of conflict with employees," Mr. Maguire said.

To reduce employee resistance, it's important to first pave the way with an intensive education program, said Michael Meredith, senior vp with Willis North America Inc. in Atlanta.

Once employees understand that generic equivalents are just as good as name-brand drugs, they will more readily accept a program that encourages use of generics, he said. Also, as part of that education, Mr. Meredith said, it's important to tell employees that increases in drug benefit premiums mean lower salaries for them, thus increasing their incentive to buy generic drugs.

While strong clinical programs can help, Mr. Meredith said, not all PBMs have them. Such programs vary greatly from one PBM to the next, and an employer should investigate the capabilities of the individual program under consideration, he added.

PBMs differ in other respects as well. Many do very little to help employers control drug costs and act merely as middlemen between employers and drug makers. But the better PBMs have the clout to obtain good deals from drug manufacturers and the necessary systems in place to perform clinical drug reviews, experts say.

But even good PBMs have their critics. Mr. Kaplan gives PBMs a generally poor grade for controlling costs. He said that because PBMs receive a significant percentage of their revenues from drug manufacturers—in the form of rebates when the manufacturers' drugs are sold—they are not inclined to lean on drug makers in order to get the best deals possible.

While admitting that they get rebates, PBMs deny that the rebates influence their efforts to get the best drug prices for employers. Mr. Zimmerman of National Prescription Administrators said that the rebate money is discussed with an employer and becomes a part of the negotiations when arriving at a price for a PBM's services.

Regardless of its PBM arrangements, another way an employer can attack rising costs is by redesigning its drug benefit plan. The past few years have seen the rise of three-tier programs, which require participants to pay a higher copayment for a brand-name drug and to pay even more for a brand-name drug that is not on an approved formulary. But such an approach is yesterday's news, experts say.

The latest design charges employees a percentage of the drug's cost, rather than a fixed amount, with the percentage varying by the type of drug.

For example, a plan might require a 20% copayment for major-therapy drugs, such as those for controlling high cholesterol. Often, this 20% copayment is lower than the fixed copayment employees currently are charged, said Segal's Mr. Kaplan. The next level would have a 50% copayment for minor therapies, such as those for coughs and colds. And, finally, the third level would have a 50% copayment—with an annual maximum benefit of $1,000—for so-called "lifestyle drugs," such as the impotence drug Viagra, he said.

Such a plan design offers employees a richer overall benefit while reducing the amount of money spent for numerous drug classes, Mr. Kaplan said. In addition, it creates a more equitable distribution of money for prescriptions.

"There will be some winners and some losers," he said.

Such plans are also part of a larger benefit strategy, adopted by many employers, to create a consumer mentality among their employees. By paying a percentage of drug costs, the theory goes, employees will learn the true costs of their prescriptions and will opt for the most cost-effective treatments.

This year, Georgia-Pacific adopted a new cost-sharing program, with employees paying 20% copayments for generics and brand-name drugs without generic alternatives, and 40% copayments for brand-name drugs when generics exist, Mr. Hunter said.

In addition, an employee now must pay the entire cost up front and submit a claim for reimbursement; that, he said, forces employees to learn the true cost of the drugs.

So far, employee reaction has been positive, Mr. Hunter said, adding that the change has helped the company foster a consumerist mentality toward its health benefits. BI

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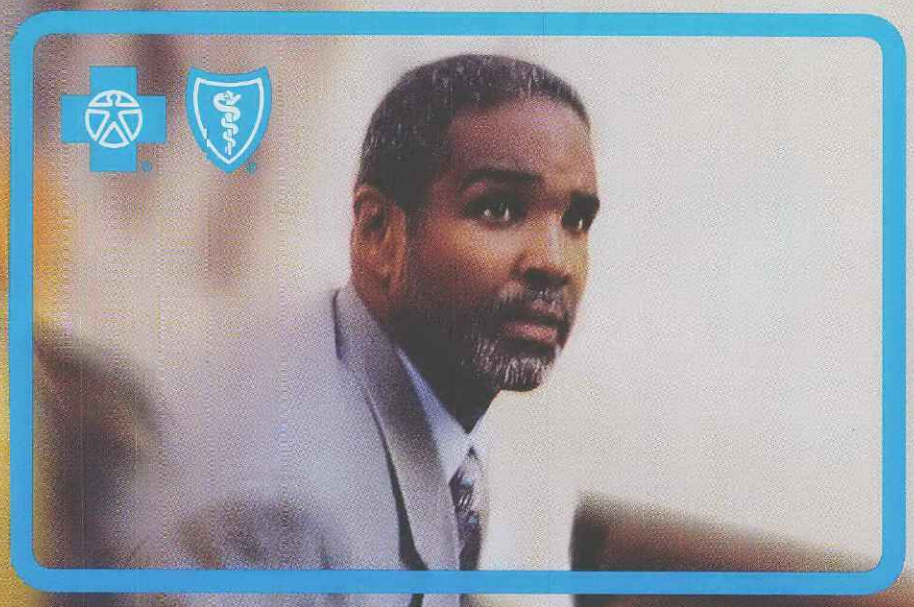

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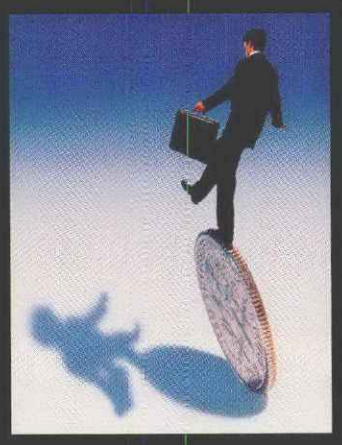

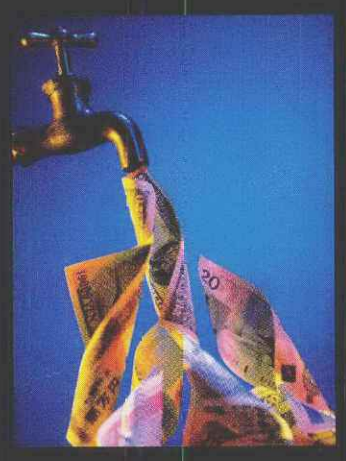

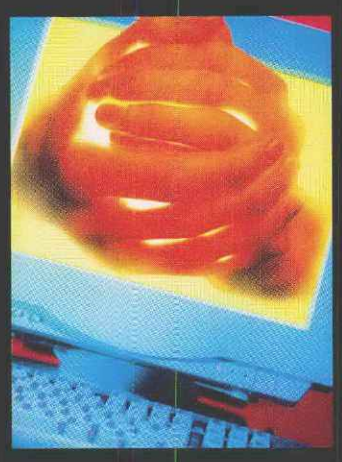

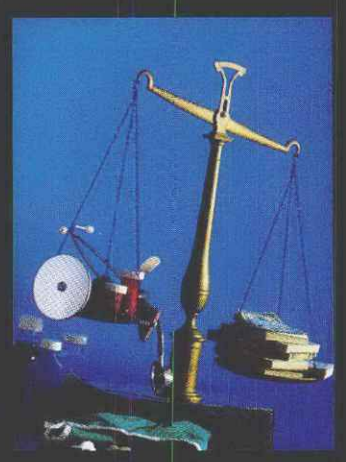

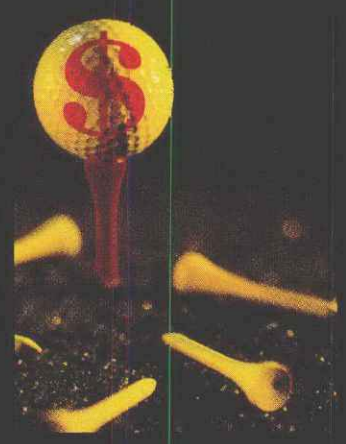

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Agent/BrokerTopics

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AGENCY/ INSURER RELATIONS

Both sides seek mutual benefits

INSIDE:

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Agency stock programs raise questions on conflict of interest page 16D

High-profile fraud case inspires congressional action on data sharing page 16F

Former commissioner opposes federal charter for insurance companies page 16G

Some see progress made toward SEMCI

By MICHAEL BRADFORD

Agents continue their decades-long push for a single-entry technology that will allow them to streamline their electronic communications with insurers.

Nor is the end of the long road to develop a broad-based single-entry, multiple-company interface—SEMCI, for short—in sight. Agents and insurers have yet to agree on how such technology would operate to allow an agent to key policy quoting and issuance information into a computer once and transmit it to a number of locations.

Hope springs eternal among many intermediaries, though, as some forms of SEMCI are appearing and efforts to create one broad interface move along. Some argue that SEMCI could become a reality in short order if agents, insurers and vendors regained their focus and stopped the political maneuvering that has slowed the development of a system.

"It has nothing to do with technology and everything to do with politics," said Virginia M. Bates, president of VMB Associates Inc., an agency consultant in Melrose, Mass. Too many insurers are interested only in establishing proprietary systems, she said, which means that the agents who use them must make separate data entries for individual companies.

"Companies that want to, do it," Ms. Bates said of SEMCI technology. "Those who don't say it's hard." She questions the motives of insurers that don't advocate the establishment of a SEMCI platform, charging that "the harder they make it, the easier it will be for them to become a direct writer."

"It's been a long-ranging battle," agreed Mark Parrish, president of Ajasent Inc., a West Monroe, La., application service provider for agents. "My personal opinion is that it's more political than technical," he said of the struggle to establish a SEMCI interface.

"I think, for years, the technology has existed," Mr. Parrish remarked. But SEMCI won't be widespread "until you get the politics out, no matter how great the technology is."

Some are growing weary of the battle, sources point out, and as it continues, alternatives to SEMCI are appearing.

"People have gotten frustrated," said Edgar J. Higgins, chairman of the Agents Council for Technology, a 2-year-old group formed by the Independent Insurance Agents of America Inc. of Alexandria, Va. "Technology has progressed to a degree where achievement of SEMCI is very close. Yet there are many who say we may never get to SEMCI: They're saying, 'Stop worrying about it and get to the solutions that work.' "

Mr. Higgins, who owns Thousand Islands Agency in Clayton, N.Y., said single-entry interfaces are available that work for some agents. "While it is great to endorse and support these single-entry models, it is important to recognize that SEMCI is still a viable concept—it's just taken a long time for the technology to get there. The concern is that a lot of people will give up on SEMCI because there are other technology alternatives."

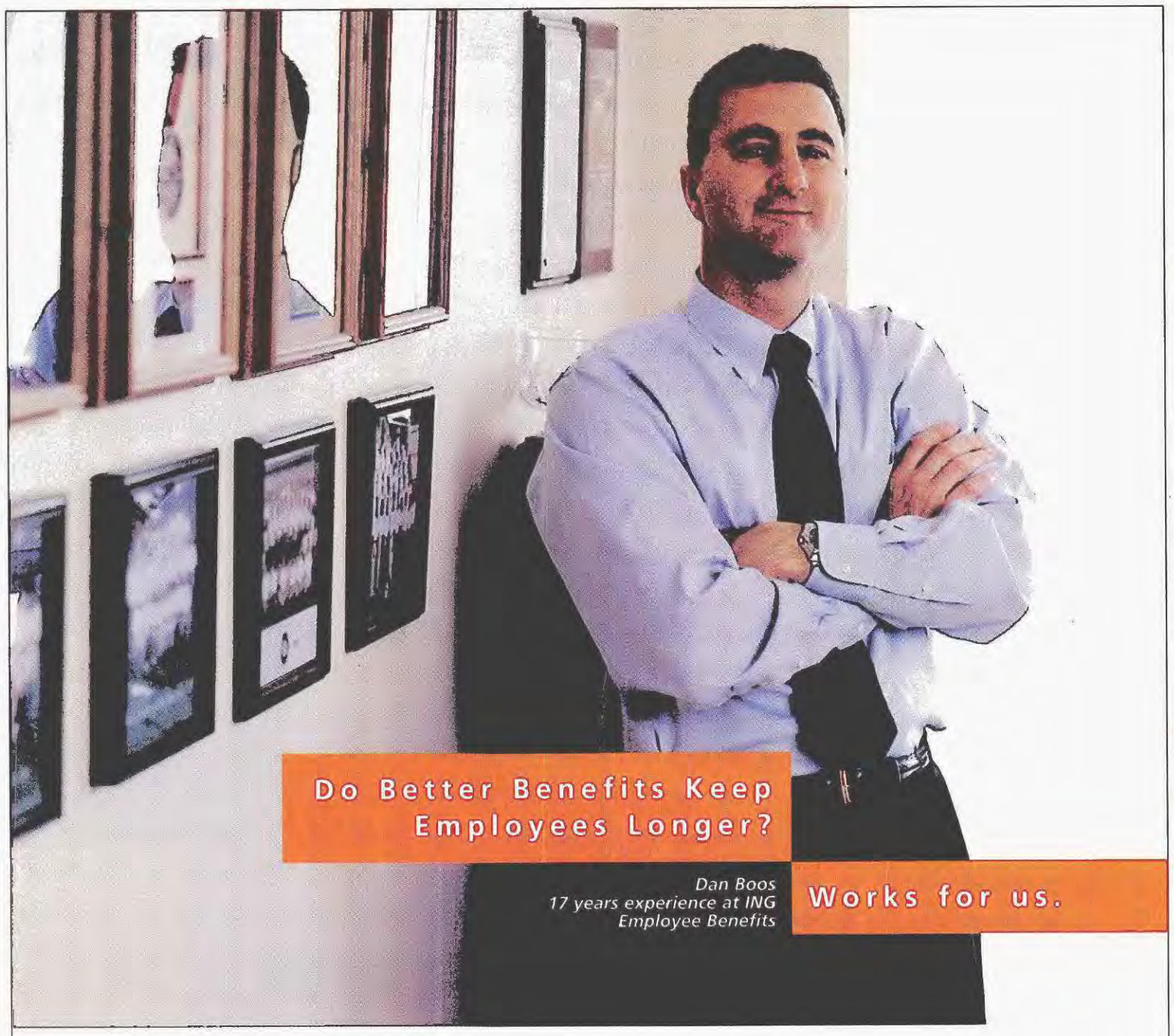
Ms. Bates said single-entry alternatives are popping up all over. "More agents that I visit are actually running real-life single-entry systems with multiple companies."

She explained that, using such a setup, an agency can to enter information into its management system, transmit it to an insurer, add a few bits of information from another company and transmit the data again to the next insurer without re-entering the original policy information. "It works just fine," she said.

It's not difficult for insurers to participate in such systems, Ms. Bates said. She said, though, that many apparently want to keep agents locked into insurers' proprietary systems. "People complicate something simply because they have a political agenda," she said.

Mr. Higgins said single-entry solutions that involve a few insurers here and there are working, but a broad-based SEMCI

See **SEMCI** *on page 16L*



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SEMCI

Continued from page 16B

platform adopted by agents and insurers could make things easier on everyone. "The Internet has created the opportunity for single-entry solutions, and that is where some folks have migrated. It creates opportunities for those who are more aggressive to work on short-term solutions while the work continues on a long-term solution."

A spokesman for ACORD, the Pearl River, N.Y.-based nonprofit association that promotes communications standards, said the SEMCI concept is defined in several ways. "Some say that simply being able to upload and download in a batch format represents SEMCI," he said. "To some, it doesn't."

One insurer that is encouraging a SEMCI approach is Travelers Insurance Co. Working with a platform developed by Applied Systems Inc. of University Park, Ill., Travelers allows agents to use their agency management systems to key in information needed to receive quotes on small commercial lines business, explained Patrick Gee, vp of operations for small commercial and personal lines at the Hartford, Conn.-based insurer.

The interface will permit agencies to transmit the data to other insurers as well—as soon as other insurers sign up, Mr. Gee said. "Other carriers are working on it," he said, but he noted that "it's difficult to predict when other carriers will come online."

If other insurers do join Travelers on the platform, an agency will have only to rerun a quote request through individual company editing processes before retransmitting. "It minimizes the amount of redundant keying," Mr. Gee said. "The agent gets a quote back in real time."

The Travelers system gives agents the choice of using the SEMCI approach or sticking with the insurer's proprietary system, he said.

In addition to providing quotes, the system eventually will allow the issuing of policies, Mr. Gee said. "Because it's tied to our proprietary system, an agent will be able to just hot-key over and enter the information that will issue the policy."

At some point, policy issuance may be available in the SEMCI mode alone, he said.

Agents want the technology because they believe it will save them time and money, reducing the amount of work necessary to get quotes and policies.

In the traditional mode, "the agent tends be the one doing the extra work, not the carrier," Mr. Parrish said. "The idea of single entry is terribly attractive to agents."

"If we do this right," Mr. Gee said, and establish an "agent/carrier partnership, it will certainly save costs."

> *'Some say that simply being able to upload and download in a batch format represents SEMCI. To some, it doesn't."*
>
> — ACORD spokesman

When a SEMCI platform will become widely available is hard to predict, Mr. Higgins said, but it could be relatively soon. "With the rapid progression that is taking place, I wouldn't be surprised if it's 12 to 24 months," he said.

Mr. Higgins said that, in order for SEMCI to become a reality, those who are interested must regain their focus and concentrate on getting the job done. That can happen, he said, through the efforts of the Agents Council for Technology.

"One of the key factors that makes us optimistic is ACT," Mr. Higgins said. "It was founded by agents but engages all the major players who have an interest in this. It allows us to have a forum where people can come together."

ACORD, meanwhile, has its sights set beyond SEMCI, to an interface it calls "straight-through processing."

While SEMCI is largely an interface between agents and insurers, straight-through processing would allow information to be entered once by anyone—an agent, a risk manager or another participant—and then transmitted seamlessly along the distribution chain to brokers, insurers, reinsurers and others. A user who needs access to the data could add information and send it to the next recipient.

"It really is a concept of having data and information entered once from start to finish," the ACORD spokesman said. Users would never have to re-enter the original information, he said.

The hurdle for ACORD is establishing data standards that would allow all users to participate. Some version of SEMCI must be available before straight-through processing can work, the spokesman said. "SEMCI is a valuable goal to shoot for and one that a lot of organizations and people are working toward," he said. "ACORD is concerned with SEMCI as well and how it fits into the STP vision." BI

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Insurers offering agents stock

Observers say competitive forces, not stock, will sway agents

By LEE FLETCHER

In an effort to strengthen ties with their producers, some insurers are offering agents a vested interest in the company's success, providing incentives for them to buy stock.

Although such an arrangement would seem to tempt agents to favor those insurers in which they have a financial stake, some consultants say that competition remains the driving force in where agents place coverage.

In addition, one consultant notes that, in most cases, agents' holdings in insurers are not significant enough to influence their decisions.

It's not unusual for an insurer to offer company stock to agents, said Paige K. Proctor, president of agency consulting company Paige Proctor Consulting Inc. in Carlock, Ill.

Just as they would like their own employees to have some ownership in the company, insurers think "it's healthy for agents" to hold a financial stake, Mr. Proctor said.

He estimated that 5% to 10% of insurers offer stock incentives to agents.

Birmingham, Ala.-based Vesta Insurance Group Inc. earlier this year announced that it was developing a stock incentive plan for agents, which it planned to launch this year. Vesta, however, declined to comment on the particulars of the program, saying that the details were not yet finalized.

Mr. Proctor noted that, in some cases, an insurer will allow agents to set aside a portion of their commission to be invested in the insurer's stock.

"If the agent has $2,000 of commission coming, and the agent has said, 'Yes, take $300 a month out of my commission and invest it in company stock,' they will do so," Mr. Proctor said. In addition, he said, insurers often provide incentives for agents to purchase stock in the company, such as discounted prices or matching shares.

> *Because finding the best coverage at the best price is still the most important driver for agents' decisions, the stock arrangements do not create a conflict of interest.*
>
> — Paige K. Proctor

Because finding the best coverage at the best price is still the most important driver for agents' decisions, the stock arrangements do not create a conflict of interest, Mr. Proctor said.

"It sounds like the agent is favoring one company over another, but again, the competitive forces today really dictate where that insurance is written," Mr. Proctor said.

"You've got to remember that it's usually a combination of price and coverage, and for that agent to constantly choose a company that he may have some stock in—but has the highest price and poorest coverage—he's not going to write much insurance, because the customer is going to go elsewhere," Mr. Proctor said.

Chris Burand, president of agency consulting firm Burand & Associates L.L.C. in Pueblo, Colo., said agent ownership of insurer stock "without a doubt" appears on its face to create a conflict of interest. But, agents' stockholdings in insurers are "so minor that it really isn't material, except maybe in a few cases," Mr. Burand said.

"For the most part, we're literally talking about an agent owning a hundred or a couple hundred dollars' worth of company stock," he said.

In addition, he noted, most agents would simply prefer to receive cash commission rather than company stock.

"Unless the price was steeply discounted and the terms were very, very favorable and they could immediately cash (in) the stock for a higher dollar value—they just want the money," Mr. Burand said. BI

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Frankel inspires Congress to step up anti-fraud efforts

By MARK A. HOFMANN

Advocates of greater cooperation in anti-fraud efforts among insurance, banking and securities regulators can thank an unusual benefactor if Congress enacts legislation enhancing regulators' ability to share data across industry lines.

That benefactor is Martin Frankel, an accused swindler who is currently in federal custody. Mr. Frankel—who was banned from the securities industry before getting involved in the life insurance business—fled to Germany after swindling more than $200 million from life insurance companies he controlled, federal investigators allege.

His activities have spurred Congress to begin examining ways to improve the sharing of fraud information among regulators overseeing the industries covered by the 1999 Gramm-Leach-Bliley Financial Services Modernization Act.

Insurance companies, brokers, agents, banks and securities dealers had all hailed Gramm-Leach-Bliley for lowering the barriers that had separated the three industries since the 1930s. Proponents say the act allows U.S. financial services entities to operate more efficiently in the domestic and global marketplaces, to better serve the needs of customers and to streamline the expensive and duplicative process of multistate agent and broker licensing.

But, as the charges pending against Mr. Frankel demonstrate, the potential for cross-industry swindling pre-dated the breakdown of the regulatory barriers. The House of Representatives has responded to that challenge by seeking ways to improve how regulators in the three industries share information about criminal fraud.

"This was inspired by the Martin Frankel episode," said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

"I think while there were many breakdowns in the regulatory process associated with Frankel, probably the most inexcusable was (that) he had already been banned from the securities industry and then waltzed right into the insurance business. There is a glaring flaw in the regulatory process that fails to allow state insurance commissioners to have commensurate access to federal databases," Mr. Wood said.

"If (swindlers) tried to go to another industry, at least people would know," said Nicole Allen, the Council's director-state affairs. She said that the measure would benefit regulators and the regulated entities alike.

The effort to promote more efficient sharing of information among regulators formally began with a joint March 6 hearing of two House Financial Services Committee subcommittees.

> *'Any legislation ultimately developed must truly streamline and coordinate fraud efforts....What it should not do is create a new bureaucratic regime.'*
>
> — Kenneth Schloman

Members of the Financial Services Committee's Subcommittee on Oversight and Investigations and Subcommittee on Financial Institutions and Consumer Credit heard that creating a system for sharing fraud data provided by regulators overseeing each of the industries would not be an easy task.

As Financial Services Committee Chairman Mike Oxley, R-Ohio, noted in a statement issued before the hearing in Washington began, more than 200 different departments and agencies have some role in combating fraud, and each has its own records system. The banking and securities sectors generally answer to federal regulators, while insurers, agents and brokers are subject to state oversight.

"We must ensure that regulators have all the tools they need," said Oversight and Investigations Subcommittee Chairwoman Sue Kelly, R-N.Y., as she opened the hearing. She noted that Mr. Frankel had managed to evade his past by crossing industry lines.

"After being permanently banned from the securities industry, he migrated to the insurance industry," she said.

Rep. Kelly's counterpart on the Financial Institutions and Consumer Credit panel—Rep. Spencer Bachus, R-Ala.—called Mr. Frankel a "high-profile poster boy" for the need for cooperation. Rep. Oxley told the panel that even if a coordinated effort caught "only one Martin Frankel," it would have paid for itself many times over.

But as witnesses addressed the panel, the problems in creating a unified approach became evident. One concern, cited by witnesses and lawmakers alike, is privacy. Regulators would have to ensure that their efforts did not violate state and local law. They would also have to make sure that inaccurate and possibly damaging information was not disseminated.

Designing an approach to sharing information also raises the question of whether a new system must be built from the ground up, or whether existing systems should be linked. Iowa Insurance Commissioner Terri Vaughan, speaking as vp of the National Assn. of Insurance Commissioners, stressed her belief that linking was preferable. Every party involved already has its databases, she said.

The very role of the NAIC causes some concern to insurers. Robert Dibblee, senior vp-government affairs for the National Assn. of Independent Insurers, did not testify in person before the joint hearing, but he sent a letter to the chairs and ranking members of each panel. In an interview after the hearing, Mr. Dibblee said NAII member companies want to know, "What role, if any, will the NAIC have in this process?"

"Our members get leery when we start talking about giving more authority to the NAIC," he said. Because the NAIC is a trade group consisting of regulators rather than a regulator itself, he said, NAII would prefer individual state regulators retain the authority for conducting background checks by accessing FBI files.

"This is a concept. We wanted to put on the record a series of questions we would ask those who are pushing this idea as they move it forward. We understand there's a need to share financial data among the different regulators, and we want to make sure it's done in the most cost-effective and privacy-respective way and easiest for those who need the data," he said.

Mr. Wood of the Council called the current system of licensing producers a "cumbersome" and "duplicative" process that is "replete with literally hundreds, if not thousands, of varied requirements for agents and brokers to jump through. This is one piece that should at least to a certain degree weed out those persons who have been involved in fraudulent activities at the onset of the licensing process."

Kenneth Schloman, Washington counsel for the Alliance of American Insurers, stressed the need for efficiency in whatever shape legislation takes.

"Any legislation ultimately developed must truly streamline and coordinate fraud efforts, ideally eliminating duplicative information requests by regulators. What it should not do is create a new bureaucratic regime," he said before the hearing began. BI

Ex-commissioner opposes federal insurance charter

By MARK A. HOFMANN

Sen. Ben Nelson, D-Neb., isn't straying from his past when it comes to federal involvement in insurance regulation.

The former Nebraska insurance director and one-time executive vp of the National Assn. of Insurance Commissioners said during an appearance at the Commercial Insurance Legislative Summit in Washington last month that he remains opposed to optional federal charters for insurance companies.

Sen. Nelson added, though, that he is "sympathetic to people who are tired of dealing with the patchwork quilt" of state regulation.

The freshman senator and former Nebraska governor also said he opposes federal solvency regulation, but he promised to "try to keep an open mind" on the matter.

In another matter of concern to insurance agents, Sen. Nelson told his audience that he supports the repeal of the federal estate tax.

Many small-business people, including owners of insurance agencies, have sought reform of the tax because it makes it difficult to keep a family business within a family upon the death of its founder. The estate tax will "be reformed at a level that will meet most people's expectations" within a few months, he predicted.

Another key lawmaker—House Financial Services Committee Chairman Mike Oxley, R-Ohio—said that the committee will pursue a "very aggressive agenda" to build upon the Gramm-Leach-Bliley Financial Services Modernization Act. That act lowered the Depression-era barriers that separated the insurance, banking and securities industries.

Rep. Oxley, whose new committee has express jurisdiction over insurance, praised the Council of Insurance Agents & Brokers for ensuring that the Gramm-Leach-Bliley Act contained a provision that would create a National Assn. of Registered Agents & Brokers—or NARAB—if a sufficient number of states failed to harmonize their agent/broker licensing laws.

He said that NARAB had given a new sense of urgency to the effort to create licensing uniformity or reciprocity among the states.

The committee seeks, in addition to uniformity, the sharing of data among banking, insurance and securities regulators as a means of combating fraud (see story, page 16F).

Rep. Oxley also called for increasing the speed with which new insurance products may go to market; currently, new products often languish for months while awaiting regulatory approval.

"We've got an opportunity to keep insurance regulators' feet to the fire," thanks to Gramm-Leach-Bliley, he said. "We're not anti-regulation; we're for meaningful regulation.

"Not only is there a new sheriff in town—we've got a whole new set of laws to work with," Rep. Oxley said.

The Commercial Insurance Legislative Summit was held jointly by the CIAB, the American Insurance Assn. and the Reinsurance Assn. of America. Members of the three trade groups met to hear legislators and policymakers and to visit lawmakers to voice their concerns.

This was the second annual joint summit of the three groups. BI

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InsuranceNoodle now doing business in 34 states

CHICAGO—InsuranceNoodle, an online quoting and insurance e-brokerage specializing in small business, recently received a license to sell insurance in California.

With the addition of California, InsuranceNoodle now conducts business in nine of the 10 largest states and 34 states in total, said Robert Rudy, chairman and co-founder of the Chicago-based brokerage. "Over 82% of small businesses in the U.S. now have access to tailored business insurance solutions through our network of independent insurance agencies or directly online," Mr. Rudy said in a statement.

Rick Madock, vice chairman and co-founder, added in the statement that "traditional agencies are joining our 'Noodle Network' to obtain streamlined access to a broad product portfolio. This allows them to provide clients an extensive range of products from insurers they might not otherwise be able to offer."

Insurance companies including American International Group Inc., The Hartford Financial Services Group Inc., The St. Paul Cos. Inc. and Zurich U.S. have teamed up with Insurance Noodle.

For more information, visit *www.insurancenoodle.com.*

A/BT BRIEFS

YouZoom expands

SAN DIEGO—YouZoom.com recently expanded its online insurance offerings to Texas.

Launched in 1999, YouZoom is building a network of independent agent and broker Web sites where consumers can compare prices, purchase insurance and manage many aspects of their insurance policies online. With the addition of Texas, the San Diego-based affiliate of Arrowhead General Insurance Agency Inc. sells personal auto and property insurance through 10 insurers in five states, with plans to enter five additional states by midyear.

CNA Life program

NASHVILLE, Tenn.—CNA Life, which provides life, long-term care and variable insurance products and services, recently introduced its Agent Affinity Group program.

Through the Nashville, Tenn.-based company's program, licensed CNA producers and their agency employees can enjoy discounted premiums for their own long-term care coverage.

In addition to allowing members to purchase policies at discounted rates, the program lets extended family members receive the discounted rates. Extended family members include spouses, parents, grandparents, adult children and parents and grandparents-in-law.

Qualified members receive a 20% discount on premiums on LTC policies. For further information regarding CNA long-term care insurance products, visit *www.cnaltc.com.*

Selective technology

BRANCHVILLE, N.J.—Selective Insurance Group Inc. has implemented two technology initiatives—a service center and a mobile claim system—for insurance agents and customers.

Selective's service center, located in Richmond, Va., helps the company's independent insurance agents serve their small-business customers. Through the center, licensed individuals use technology to respond by e-mail, phone or fax to customer inquiries about such matters as insurance coverage or billing. Initially, the Selective Service Center will handle small-business accounts from participating agents in Virginia. Additional states will be added during the year.

Branchville, N.J.-based Selective's mobile claim system is used by the company's claims agents to serve agents and customers while in the field.

The system is designed to reduce time spent on back-office paperwork, freeing claims specialists to spend more time with customers and agents, handling claims and assisting with claims mitigation.

It is being implemented in the company's Southern region, with introduction to other regions scheduled for later this year.

Health insurance access

LOS ANGELES—HealthInsurance.com, a Los Angeles-based company providing small businesses with greater access to health insurance, recently announced a business partnership with Seabury & Smith Inc.

Under the terms of the agreement, HealthInsurance.com will be paid an undisclosed fee to develop and implement the technology necessary to put on the Web Seabury & Smith's affinity group services' individual major medical insurance operations. Those operations are based in Park Ridge, Ill.

In the first phase of this project, which went live in February, HealthInsurance.com provided the technology for Seabury & Smith's online quoting and servicing for its individual health insurance products in 21 states. Other states will be added throughout 2001.

As part of the partnership, HealthInsurance.com also will be the exclusive provider of small-business health insurance services to more than 300 association clients of Seabury & Smith, which is a division of Marsh Inc.

HealthInsurance.com offers small-business coverage from and is an authorized agent for such health plans as Blue Cross of California, PacifiCare Health Systems Inc., Blue Shield of California, HealthNet Inc., Kaiser Permanente in California and Universal Care Inc. The site currently provides real-time quotes and service online in California, and it covers 46 states through offline quoting. HealthInsurance.com will soon begin adding additional states to its online service.

Using HealthInsurance.com's Web-based service, Seabury & Smith will provide real-time quotes for leading health insurers. Customers will be able to receive customized quotes online and receive applications and forms electronically. BI

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A

AmeriScript Inc.

4301 Darrow Road,
Stow, Ohio 44224;
330-686-7010; fax: 330-686-7011
www.chandler-group.com

2000 revenues
Total gross revenues $880,556
PBM services $880,556
Unbundled PBM services $880,556
PBM clients
Total 837
Employee/group plans with direct service ... 837
Lives covered
Total 204,646
Retail network
Pharmacy locations 40,000
Staff
Total 40
Professionals 38
Registered pharmacists 2

PBM services since: 1986.
Parent: The Chandler Group of Managed Care Cos.; primary business: HMO/PPO.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: mail-order drug distribution, pharmaceutical claims processing, online Rx claims adjudication, disease management, retrospective Rx utilization review, Rx formulary management review, concurrent Rx utilization review, physician prescribing practices monitoring and management.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Arthur W. Chandler, chairman/CEO; Michelle Swigonski, president.
Contact: Michelle Swigonski; miches@chandler-group.com.

C

Caremark Rx

2211 Sanders Road,
Northbrook, Ill. 60062;
847-559-4700; fax: 847-559-4981
www.caremark.com

2000 revenues
Total gross revenues $4,430,000,000
PBM services $3,827,000,000
PBM clients
Total 1,200
Employee/group plans with direct service ... 1,092
Lives covered
Total 20,000,000
Active group health plan 20,000,000
Retail network
Pharmacy locations 52,000
Mail-order services
Percentage of prescription volume 50%
Generic usage
Percentage of prescription volume 38%
Staff
Total 2,661
Registered pharmacists 505

PBM services since: 1985.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Mac Crawford, chairman/CEO; James H. Dickerson Jr., president/COO; Howard A. McClure, executive vp/CFO.
Contact: Bruce Lyons, vp-sales; 847-559-4809; bruce.lyons@caremark.com.

CLAIMSPRO Management Services Inc.

24370 Northwestern Highway, Suite 200,
Southfield, Mich. 48075;
248-352-2852; fax: 248-352-7475
www.claimspro.com

2000 revenues
Total gross revenues $16,520,000
PBM services $16,400,000
Unbundled PBM services $16,400,000
PBM clients
Total 2,000*
Employee/group plans with direct service ... 1,710
Retail network
Pharmacy locations 55,000*
Staff
Total 75
Professionals 41
Registered pharmacists 2

PBM services since: 1989.
Parent: PharmaCare; primary business: PBM.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: Bruce Liebowitz, president; Ron Klein, executive vp.
Contact: Ron Klein; 877-208-9306; rjklein@claimspro.com.
**Estimated*

E

Express Scripts Inc.

13900 Riverport Drive,
Maryland Heights, Mo. 63043;
800-281-0712; fax: 314-702-7059
www.express-scripts.com

2000 revenues
Total gross revenues $6,800,000,000
PBM services $6,700,000,000
Lives covered
Total 43,500,000
Retail network
Pharmacy locations 55,000
Staff
Total 5,000

PBM services since: 1986.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff, independent panel.
Service area: nationwide, Canada, U.S. territories.
Billing method: fee per claim.
Officers: Barrett Toan, chairman/CEO; David Lowenberg, COO; Stuart Bascomb, executive vp.
Contact: Larry Zarin; lzarin@express-scripts.com.

F

First Health Services Corp.

4300 Cox Road,
Glen Allen, Va. 23060;
804-965-7400; fax: 804-527-6849
www.fhsc.com

2000 revenues
Total gross revenues $119,400,000
PBM services $46,300,000
PBM clients
Total 23
Employee/group plans with direct service 23
Lives covered
Total 11,400,000
Active group health plan 11,400,000
Active workers compensation 640,000
Retail network
Pharmacy locations 51,356
Mail-order services
Percentage of prescription volume 3%
Generic usage
Percentage of prescription volume 48%
Staff
Total 1,042
Professionals 384
Registered pharmacists 62

PBM services since: 1968.
Parent: First Health Group Corp; primary business: drug manufacturer.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management.
Subcontracted services: mail-order drug distribution.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim, shared cost savings.
Officers: Teresa Dimarco, president; Pete Quinn, vp-account management; Tom Graves, vp-sales.
Contact: info@fhsc.com.

I

The Inteq Group Inc.

5445 La Sierra Drive, Suite 400,
Dallas, Texas 75231;
800-324-7799; fax: 214-739-7979
www.inteqrx.com

2000 revenues
PBM services $8,000,000
PBM clients
Total 2,500
Employee/group plans with direct service ... 750
Lives covered
Total 1,800,000
Active group health plan 1,800,000
Active workers compensation 300,000
Retail network
Pharmacy locations 48,000
Mail-order services
Percentage of prescription volume 45%
Generic usage
Percentage of prescription volume 44%
Staff
Total 55
Professionals 50
Registered pharmacists 2

PBM services since: 1993.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: mail-order drug distribution.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: Andrew Fisk, president; Jerry Hosler, executive vp-finance and administration; John Teichgraeber, executive vp-sales and marketing.
Contact: sales@inteqrx.com.

N

National Medical Health Card Systems Inc.

26 Harbor Park Drive,
Port Washington, N.Y. 11050;
800-251-3883; fax: 516-621-4793
www.nmhc.com

2000 revenues
Total gross revenues $210,000,000
PBM services $206,000,000
PBM clients
Total 320
Employee/group plans with direct service 7
Lives covered
Total 515,000
Retail network
Pharmacy locations 52,000
Mail-order services
Percentage of prescription volume 10%
Generic usage
Percentage of prescription volume 4%
Staff
Total 100
Professionals 85
Registered pharmacists 15

PBM services since: 1981.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Bert Brodsky, CEO; Jim Bigi, president; James Thompson, senior vp-sales and marketing.
Contact: Kathleen Tilden; 800-251-3883, ext. 2242; ktilden@nmhc.com.

P

Pharmaceutical Technologies Inc.

14301 First National Bank Parkway,
Suite 200,
Omaha, Neb. 68154;
402-964-4030; fax: 402-964-9004
www.pti-nps.com

2000 revenues
Total gross revenues $120,000,000
PBM services $99,000,000
Unbundled PBM services $99,000,000
PBM clients
Total 2,200
Employee/group plans with direct service ... 2,200
Lives covered
Total 1,100,000
Active group health plan 365,000
Active workers compensation 10,000
Retail network
Pharmacy locations 51,000
Mail-order services
Percentage of prescription volume 10%
Generic usage
Percentage of prescription volume 49%
Staff
Total 26
Professionals 20
Registered pharmacists 6

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim, percentage of savings.
Officers: Douglas M. Pick, president/CEO; Angella Pieper, CFO; Shellie Shoening, vp-clinical programs.
Contact: Douglas M. Pick; pti-dpick@cccorp.com.

Pharmacy Services Group

1100 N.E. 51st St.,
Oakland Park, Fla. 33334;
954-938-9980; fax: 954-938-7984
www.rxuniverse.com

2000 revenues
Total gross revenues $33,000,000
PBM services $26,500,000
Unbundled PBM services $3,800,000
PBM clients
Total 650
Employee/group plans with direct service ... 200
Lives covered
Total 1,000,000
Active group health plan 680,000
Active workers compensation 320,000
Retail network
Pharmacy locations 68,000
Mail-order services
Percentage of prescription volume 25%
Generic usage
Percentage of prescription volume 42%
Staff
Total 54
Professionals 17
Registered pharmacists 9

PBM services since: 1983.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Ken Sack, CEO.

Prescription Solutions

3515 Harbor Blvd.,
Costa Mesa, Calif. 92679;
714-825-3700; fax: 714-825-3898
www.rxsolutions.com

2000 revenues
Total gross revenues $260,208,000
PBM services $35,665,000
Unbundled PBM services $1,448,380
PBM clients
Total 31
Employee/group plans with direct service 19
Lives covered
Total 4,853,196
Retail network
Pharmacy locations 51,000
Mail-order services
Percentage of prescription volume 17%
Generic usage
Percentage of prescription volume 51.7%
Staff
Total 621
Professionals 215
Registered pharmacists 97

PBM services since: 1989.
Parent: PacifiCare Health Systems Inc.; primary business: HMO/PPO.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Ed Feaver, president; Paul Miller, vp-finance/CFO; Randy Radcliff, vp-sales and marketing.

R

RxAmerica

369 Billy Mitchell Road,
Salt Lake City, Utah 84116;
800-770-8014; fax: 801-961-6008
www.rxamerica.com

2000 revenues
Total gross revenues $431,756,017
PBM services $298,158,256
PBM clients
Total 420
Employee/group plans with direct service ... 365

Continued on next page

Terms used in this directory

The seventh annual *Business Insurance* directory of prescription benefit managers lists organizations that provide general prescription benefit management services in an integrated package designed to control the types and distribution methods of prescriptions used by plan participants.

The package of services must include several of the following elements: pharmaceutical benefit design consulting, disease management of participants, prescription educational services for users or physicians, utilization review and claims processing. The PBM services must be provided on an unbundled basis and must be available to corporate and institutional employer clients other than third-party vendors.

Listings begin with the company name, address, phone number, fax number and Web site address. The category **2000 revenues** includes total gross revenues, gross revenues generated from all PBM services and gross revenues from unbundled PBM services.

The **PBM clients** section specifies the total number of clients, as well as the number of employer/group plans that contracted directly with the PBM in 2000.

Lives covered includes total group health plan lives, both eligible and active. Active enrollees are those participants who actually received prescriptions through the plan. Active group health enrollees and active workers compensation enrollees in 2000 are also provided.

Retail network information lists the number of pharmacies that participate in the PBM's network. The percentage of prescriptions filled through **mail-order services** and the percentage of prescriptions filled with **generic** equivalents are listed next.

Staff information, given in full-time equivalents for 2000, details the total number of staff members assigned to prescription benefit management services. The total number of professional staff members is also provided, including the number of registered pharmacists on staff.

PBM **services** and **subcontracted services** offered by the company are listed next. The **reports** provided to the client along with the **service area** are followed by the **billing methods** and the **dispute resolutions** offered. Principal **officers** and a **contact person** for readers seeking more information complete the listings.

Listings are generated through responses to a *Business Insurance* questionnaire. The directory is published as an editorial service; there is no charge to be included. Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.

If your company would like to be included in next year's directory of prescription benefit managers, please contact the *Business Insurance* Directory Department at 312-649-5313.

Continued from previous page

Lives covered
Total 6,400,000
Active group health plan 3,900,000
Retail network
Pharmacy locations 47,800
Mail-order services
Percentage of prescription volume 4%
Generic usage
Percentage of prescription volume 54%
Staff
Total 300
Professionals 290
Registered pharmacists 34

PBM services since: 1994.
Parent: Albertson's Inc. and Longs Drug Stores Corp.; primary business: retail food and drug stores, respectively.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: John Gardynik, general manager; Joseph C. LaPine, vp-sales and marketing; David Salemi, director-operations.
Contact: Brook Boggess, director-marketing; 801-961-6051; marketing@rxamerica.com.

S

Scrip Pharmacy Solutions

100 Clearbrook Road,
Elmsford, N.Y. 10523;
888-818-3939; fax: 914-460-1660
www.mimhp.com

2000 revenues
PBM services $369,800,000
Lives covered
Total 5,100,000
Retail network
Pharmacy locations 50,000
Mail-order services
Percentage of prescription volume 6%
Generic usage
Percentage of prescription volume 48%
Staff
Total 245
Professionals 220
Registered pharmacists 32

PBM services since: 1993.
Parent: MIM Corp.; primary business: PBM.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: Richard H. Friedman, chairman/CEO; Recie B. Bomar, president; Edward J. Sitar, CFO.
Contact: Mark Leaper; mleaper@mimhp.com.

U

USI Prescription Benefits Management dba USI Rx

665-675 Foxon Road, Suite 204,
East Haven, Conn. 06513;
203-468-8367; fax: 203-468-8416
www.usi-rx.com

2000 revenues
PBM services $53,000,000
PBM clients
Total 120
Employee/group plans with direct service 100
Lives covered
Total 250,000
Active group health plan 125,000
Active workers compensation 1,500
Retail network
Pharmacy locations 50,900
Mail-order services
Percentage of prescription volume 6.4%
Generic usage
Percentage of prescription volume 39%
Staff
Total 22
Professionals 8
Registered pharmacists 4

PBM services since: 1995.
Parent: USI Insurance Services; primary business: brokerage/TPA.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: disease management, mail-order drug distribution.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: James Pennington, chairman/CEO; James Santella, president; Timothy J. Humphreys, COO.
Contact: Lauren Cornelio, 203-468-8367, ext. 2130, lcornelio@usi-rx.com; Michael Hajdun, 203-468-8367, ext. 2129, mhajdun@usi-rx.com.

United Drugs

7227 N. 16th St., Suite 160,
Phoenix, Ariz. 85020-5256;
602-678-1179; fax: 602-678-0772
www.uniteddrugs.com

2000 revenues
Total gross revenues $8,000,000
PBM services $1,000,000
Unbundled PBM services $200,000
PBM clients
Total 25
Employee/group plans with direct service 4
Lives covered
Total 60,000
Active group health plan 40,000
Retail network
Pharmacy locations 20,000
Mail-order services
Percentage of prescription volume 2%
Generic usage
Percentage of prescription volume 60%
Staff
Total 36
Professionals 8
Registered pharmacists 2

PBM services since: 1990.
Parent: American Associated Druggists Inc.; primary business: pharmacy cooperative.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management.
Subcontracted services: claims processing.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Service area: nationwide.
Billing method: fee per claim.
Officers: Michael Huston, CEO; Bruce Semingson, vp-managed care sales; Elizabeth Schrader, vp-operations and finance.
Contact: Elizabeth Schrader; eschrader@uniteddrugs.com.

W

Walgreens Health Initiatives

520 Lake Cook Road, Suite 400,
Deerfield, Ill. 60015;
847-374-2640; fax: 847-374-2645
www.whphi.com

2000 revenues
Total gross revenues $763,760,214
PBM services $8,388,886
PBM clients
Total 526
Employee/group plans with direct service 487
Lives covered
Total 1,920,000
Retail network
Pharmacy locations 48,046
Generic usage
Percentage of prescription volume 43%
Staff
Total 225
Professionals 32
Registered pharmacists 9,000

PBM services since: 1995.
Parent: Walgreen Co.; primary business: retail pharmacy.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: Rx formulary management/review.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide, Puerto Rico, United States Virgin Islands.
Billing method: fee per claim, fee for service.
Officers: Robert H. Halaska, president; David W. Bernauer, Edward H. King, vps.

Wausau Pharmacy Benefits

115 W. Wausau Ave.,
Wausau, Wis. 54401-2875;
888-459-3015; fax: 715-841-3195
www.wausaupharmacybenefits.com

2000 revenues
Total gross revenues $63,600,000
PBM services $1,000,000
Unbundled PBM services $1,000,000
PBM clients
Total 135
Employee/group plans with direct service 135
Lives covered
Total 175,000
Active group health plan 90,000
Retail network
Pharmacy locations 46,000
Mail-order services
Percentage of prescription volume 3%
Generic usage
Percentage of prescription volume 41%
Staff
Total 9
Professionals 9
Registered pharmacists 1

Parent: Wausau Benefits Inc.; primary business: TPA.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, retrospective Rx utilization review, benefit design consulting, formulary management/review, patient education.
Subcontracted services: claims processing, mail-order drug distribution.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: independent panel.
Service area: nationwide.
Billing method: fee per claim.
Officers: Alfred Moore, president; Bryan Troyer, vp-operations and account services; Mark Campbell, director-pharmacy benefits operations.
Contact: Mark Campbell; P.O. Box 8046, Wausau, Wis. 54402-8046. BI

Upcoming *BI* Directories

401(k) Plan Administrators
Issue date May 21
Deadline April 20

EAP/Dependent Care Resources*
Issue date June 25
Deadline May 18

Agents & Brokers*
Issue date July 16
Deadline May 21

Risk Management Consultants*
Issue date July 30
Deadline May 28

For more information or to receive a questionnaire for inclusion in any of the directories, please contact Kevin Edison, directory editor, at 312-649-5279 or print a questionnaire from the directory area of *BI*'s web site, *www.businessinsurance.com.*

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Many causes of slowdown in M&A activity

By JUDY GREENWALD

Fear of what may be lurking in the balance sheets of acquisition candidates, difficulty in achieving economic savings and exorbitant asking prices are among the factors behind the current slow pace of merger and acquisition activity in the property/casualty insurance industry, observers say.

Although there have been some high-profile deals in recent months—such as American International Group Inc.'s purchase of HSB Group, the parent company of Hartford Steam Boiler Inspection & Insurance Co.—the overall pace has been significantly slower than it was several years ago. Some say it may pick up later this year, though.

"There are some natural obstacles to consolidation in this business," said Jay Cohen, an analyst with Merrill Lynch & Co. in New York. "Specifically, when you merge two insurance companies, you don't get a tremendous amount of savings, because a significant portion of your expenses, you can't do much about."

"You still have to pay claims" as well as commissions, for instance, Mr. Cohen said. "It doesn't leave you with a lot of cuttable expenses."

Michael Smith, an analyst with Bear, Stearns & Co. in New York, said: "The economics don't work, because, when you get right down to it, there is very little in the way of meaningful expense savings to actually be taken. And, in many cases, those expense savings are offset by increased loss costs, especially resulting from catastrophes," he said.

"But in the current environment, also, I think that potential buyers are going to be very uneasy about buying somebody else's troubles. You're looking at a bunch of used cars out there with 100,000 miles on them. Get halfway down the street and the motor falls out—they're not a lot of fun," he said.

Mr. Cohen agreed. "There is some uncertainty in the balance sheet of an insurance company" when it is purchased, he said. "You're not only buying future business prospects; you're also buying probably some past business as well, in the form of loss reserves, and evaluation of those loss reserves has certainly been a deal-breaker in many circumstances."

Brian Meredith, senior property/casualty insurance analyst with Banc of America Securities in New York, said: "The larger commercial insurance companies that have the capability to do an acquisition right now don't want to, because they've already seen the benefits" of improved pricing. These companies, he said, "don't want to take the risk of an acquisition impeding earnings going forward."

In addition, Mr. Meredith said, to the extent that lesser-quality companies may be available, the higher-quality companies believe they will win market share away from them anyway. "So why buy them?"

Another factor that has slowed acquisition activity is the stock market. "Valuations were so low over the last couple of years that most companies didn't have an adequate currency to buy other companies," said Adam Klauber, director of investment research at Chicago-based Cochran, Caronia & Co.

'I think that potential buyers are going to be very uneasy about buying somebody else's troubles,' says Michael Smith.

Asking prices have been a factor as well. Michael Lewis, senior insurance analyst with Warburg Dillon Read in New York, said that, in addition to a dearth of candidates, "I think the companies who are targeted as possible sale candidates are asking too high a price. And the Europeans, I think, were nervous about how their investors viewed the U.S. nonlife market, specifically regarding unacceptable profit margins and unacceptable returns on invested capital."

Matthew Coyle, director at Standard & Poor's Corp. in New York, also pointed to the industry's slow growth and low profitability.

Companies both within and outside the insurance industry "have elected to put their money into life or annuities," Mr. Coyle said. He pointed out that the annuities market has been growing at a double-digit pace for the last several years.

"There's not a lot of demand from the larger financial institutions and companies around the world for a pure property/casualty company," Mr. Cohen said. "It seems they have a bigger interest in life insurance or asset management."

Some observers, however, say there may be a few deals this year. "I don't think there'll be any kind of a rush to make these deals, but I wouldn't be surprised to see one or two deals announced" over the next 12 to 18 months, Mr. Lewis said.

"I still believe that the commercial lines sector is the most fragmented of any sector in the industry," he said.

Personal lines, reinsurance and even brokers "are distinctly more consolidated than the commercial lines players, so I think the trend has to be fewer, better-run and better-capitalized companies," Mr. Lewis said.

Right now, insurers are focused on organic growth and "getting their own houses in order," said Judy Blades, executive vp-business insurance at The Hartford Financial Services Group Inc. There are, however, "some M&A opportunities out there, and I think we'll see some more fallout from that," she said.

Mr. Coyle said that as rate hikes slow, "I think companies will again look at consolidation in order to improve top- and bottom-line margins."

But while there may be some deals, activity will not occur at the same pace of several years ago, said Michael Paisan, vp at Keefe, Bruyette & Woods in New York.

At that time, "there was a lot of defensive maneuvering," he said. "I think a lot of companies wanted to stay independent," and because they were worried about European incursions, they made domestic acquisitions as a defensive move.

Mr. Paisan also said that many recent mergers are now viewed as unsuccessful, with Bermuda-based ACE Ltd.'s 1999 acquisition of the CIGNA property/casualty operations a notable exception. Some companies, he said, "simply are very inept at integrating acquisitions." BI

Network

Continued from page 1

"The two (companies) have been doing business together for about 10 years," Mr. Margrett said. "This formalizes a business relationship they have had for some time."

The two companies will each own 50% of the network, which will include a Guernsey-based shell company. Among other things, the Guernsey company will enforce the service charter and standards to which HLA Global local member companies must adhere, Mr. Margrett said.

An executive committee, bringing together one representative from each of the network's five operating regions—North America, South and Central America, Europe, Middle East and Africa, and Australia and Far East—will help craft overall strategy for the network.

'It's not any accident that Heath Lambert and Acordia are doing a joint venture together because we both have a similar philosophy,' says Frank C. Witthun.

For Acordia and Heath Lambert, the joint venture represents a teaming of similar companies, in terms of revenues, employees and philosophy.

Acordia, which is in the process of being acquired by Wells Fargo & Co. where it will function as a division of Wells Fargo's insurance operation (*BI*, March 12), had 2000 revenues of $410 million, with 3,800 insurance professionals on staff in more than 100 North American offices. Heath Lambert Group, meanwhile, posted 2000 revenues of nearly $400 million and has 4,000 employees in 88 offices in 43 countries.

Based on 1999 brokerage revenues, Heath Lambert and Acordia are the world's sixth- and seventh-largest brokers, respectively.

"It's not any accident that Heath Lambert and Acordia are doing a joint venture together because we both have a similar philosophy to serving clients and doing business," Mr. Witthun said.

Mr. Margrett noted that rather than representing a merger of the two companies, the global network venture "is really a partnership on international business."

"This is much more driven by providing service to our multinational clients on a global basis in a consistent fashion," he said.

And, he emphasized, the network agreement is primarily a retail move. "Our wholesale side, obviously, is unaffected by this," Mr. Margrett said.

The two CEOs estimated the combined brokerage business of the HLA Group network partners at $1.0 billion.

"We have a number of joint initiatives for the development of our business," Mr. Margrett said. "If you look at both of our organizations and our businesses, you'll find that we've both been involved in growing business throughout our careers."

Going forward, the companies intend to bring other partners into the network to meet clients' needs in various parts of the world. "There are areas of the world where we want representation," Mr. Margrett said, noting that sometimes that representation will be achieved through acquisition and in other cases by bringing new partners into the network.

Mr. Margrett emphasized that despite the formation of the network, Heath Lambert will maintain existing brokering relationships with other U.S. companies.

"Occasionally, you come up with a client that has a very strong relationship with someone in a particular territory, and to try to force them into a shape might not make the most sense," he said.

Mr. Witthun agreed that non-exclusive network arrangements are the best approach to providing good client service. "If you're a client-focused company, it really has to be non-exclusive," he said.

As the new network moves forward, the two companies plan to invest in a significant marketing effort.

In terms of technology or communications investments, Mr. Margrett said, "We both have existing arrangements that work quite well."

There will be no attempt to actually fuse Acordia's and Heath Lambert Group's information technology systems, he said, though "Clearly there will be a Web site and all the rest of it in due course." BI

DATEBOOK

APRIL 17. Internet Health Care Fraud Issues Training Program in Chicago, sponsored by National Healthcare Anti-Fraud Assn.; $325 for members and $500 for non-members. Laurie Leonard, 1255 23rd St. N.W., Washington, D.C. 20037-1174; 202-452-1508; fax: 202-785-6764.

APRIL 18-20. Civil/Criminal Investigations Academy in Chicago, sponsored by National Healthcare Anti-Fraud Assn.; $450 for members and $625 for non-members. Laurie Leonard, 1255 23rd St. N.W., Washington, D.C. 20037-1174; 202-452-1508; fax: 202-785-6764.

APRIL 18-19. National Council on Compensation Insurance Annual Issues Symposium in Orlando, Fla.; $575. NCCI, 901 Peninsula Corporate Circle, Boca Raton, Fla. 33487; *www.ncci.com.*

APRIL 18-20. Product Management Skills and Technologies Seminar in Chicago, sponsored by Dorman Consulting Services. Also **May 2-4** in Orlando, Fla., and **June 6-8** in Boston; $995. Richard Dorman, One Haverhill Court, Beachwood, Ohio 44122; 216-464-5678; fax: 216-464-2727; *www.dormanconsulting.com.*

APRIL 19. I-Day Annual Convention in Pittsburgh, sponsored by Insurance Club of Pittsburgh. ICP, Renee Revtai, 1719 Investment Building, Pittsburgh, Pa. 15222; 412-471-7488; *insclubpgh@aol.com.*

APRIL 22-25. AMS Users Group 25th Annual Conference in Nashville, Tenn.; $409 for members and $509 for non-members. AMSUG, 8615 Freeport Parkway, Suite 250, Irving, Texas 75063; 972-929-8803; *www.amsug.org.*

APRIL 23-24. Pricing and Rate Making in Plain English Seminar in Chicago, sponsored by Dorman Consulting Services; $895. Also **May 7-8** in Orlando, Fla., and **June 11-12** in Boston. Richard Dorman, 1 Haverhill Court, Beachwod, Ohio 44122; 216-464-5678; fax: 216-464-2727; *www.dormanconsulting.com.*

APRIL 25. Annual Statement Investment Seminar in Chicago, sponsored by the National Assn. of Insurance Commissioners; $195 for government employees and $295 for others. NAIC, Monica Horvat, 2301 McGee, Suite 800, Kansas City, Mo. 64108; 816-783-8200; *www.naic.org.*

APRIL 29-May 1. Alliance of American Insurers Annual Meeting in San Francisco, sponsored by Alliance of American Insurers; $775 for members and $1,275 for non-members. AAI, Thomas O'Dowd, 3025 Highland Parkway, Suite 800, Downers Grove, Ill. 60515; 630-724-2100; *www.allianceai.org.*

APRIL 29-MAY 3. The Risk & Insurance Management Society Inc.'s 39th Annual Conference and Exposition in Atlanta; $745 for members and $1,045 for non-members. RIMS, 655 Third Ave., New York, N.Y. 10017; 800-713-7467; fax: 212-986-9716; *www.rims.org.*

May

MAY 2-4. Personal Lines Underwriting Seminar in Chicago, sponsored by National Assn. of Mutual Insurance Cos.; $199 for members and $249 for non-members before April 19, $249 for members and $299 for non-members after April 19. Nancy Griffith, 317-875-5250; fax: 317-879-8408; *ngriffith@namic.org.*

MAY 3-5. National Assn. of Independent Life Brokering Agency Annual Meeting in Dallas. NAILBA, Jennifer Payne, 8201 Greensboro Drive, Suite 300, McLean, Va. 22102; 703-610-9020; *www.nailba.org.*

MAY 6-8. Intermediaries & Reinsurance Conference in Amelia Island, Fla., sponsored by Intermediaries & Reinsurance Underwriters Assn. $595. Guy Benthin, 971 Route 202 North, Branchburg, N.J. 08876; 908-203-0211; fax: 908-203-0213.

MAY 6-9. E-Regulation Conference in Kansas City, Mo., sponsored by National Assn. of Insurance Commissioners and National Insurance Producer Registry; $275 for regulators and $375 for non-regulators. NAIC, 2301 McGee St., Suite 800, Kansas City, Mo. 64108; *www.naic.org.*

MAY 6-9. National Assn. of Surety Bond Producers Annual Meeting in Colorado Springs, Colo. NASBP, Susan Ostrader, 5225 Wisconsin Ave. N.W., Suite 450, Washington, D.C.; 202-686-3700; *nasbp@nasbp.com.*

MAY 6-9. Assn. for Advanced Life Underwriting Annual Meeting in Washington, D.C. AALU, 2901 Telstar Court, Falls Church, Va. 22040-1205; 703-641-9400; *www.aalu.org.*

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The Datebook is compiled from notices sent to Business Insurance. Notices for meetings should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the cost, if any, to attend the meeting and information on registration for interested readers. *Business Insurance* reserves the right to select those meetings of greatest interest to its readers and cannot guarantee that notices will be printed. Datebook listings also are available on the World Wide Web at *www.businessinsurance.com.*

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GLOBAL BRIEFS

French mutual insurers, despite their dominant position in the domestic nonlife market, need to adapt to the challenge of a more dynamic and competitive environment, Moody's Investors Service Ltd. warns. In a commentary released last Thursday, Moody's says that while the sector benefits from a low-risk profile, good underwriting quality and improving financial fundamentals, it may face increased competition. Other long-term challenges include mutual insurers' "relatively heavy bias toward nonlife insurance and their geographical diversity and financial flexibility." To meet these challenges, Moody's says mutuals "will have to consider increased cooperation, partnerships and alliances—both in-market or with other providers of financial services—in order to leverage their strong competitive positions and organizational strengths."...Rebus iS, a London-based provider of information technology services to the global insurance market, has developed **Claims Liability Management**, a system designed to speed up claims management and incorporate legal firms more smoothly into the processing cycle. The system incorporates fully automated claims processing, tracking and recording and can immediately show the potential liability that a facility or underwriter may have, "thus allowing the legal practice to alert them of their claims position in real time."...**Chubb Europe**, the Belgian-registered unit of Chubb Corp., has transferred its European administrative office and several support operations to London. Chubb said the move to Cottons Building, London Bridge, London, effective August 2001, is prompted by the growth of Chubb Europe's business and the "significant" savings by moving some operations out of the City of London, the central financial district. Chubb's United Kingdom and Ireland headquarters will remain on Fenchurch Street, in the City of London...The **Assn. of British Insurers and the Law Society of England and Wales** have agreed to jointly sponsor negotiations aimed at reaching agreement on the recoverability of legal costs under the Access to Justice Act. Currently, views differ as to what constitutes reasonable costs and when it is reasonable to pay them, which has led to a number of court cases. The negotiations, expected to take three months, are seeking to reach an agreement among all the parties involved, not impose a ruling....Factory Mutual Insurance Co. Ltd. of Johnston, R.I., which does business as **FM Global** and specializes in property protection and risk management, has opened offices in Milan and Turin, Italy. FM Global said customers in Italy will now receive local delivery of its full range of products and services...Global actuarial, benefits and human resources consultant **Watson Wyatt Worldwide** has set up an insurance and financial services consulting presence in Delhi, India. Watson Wyatt has been involved in insurance projects in India since the mid-1990s, but these have been undertaken mainly by its consultants based in Singapore....Marsh & McLennan Cos. Inc. has received a license to run the new **"Managing Risk" course in Britain** planned by the Institution of Occupational Safety and Health and the Institute of Risk Management. Marsh will be one of the first providers of the new course aimed at raising awareness of risk management and helping organizations meet their duties under new corporate governance requirements.

Lloyd's posts loss for 1998

By SARAH VEYSEY

LONDON—In line with analysts' predictions, Lloyd's of London posted a loss of £1.06 billion ($1.58 billion) for the 1998 year of account, noting that things are likely to get worse before they get better.

In announcing its results for 1998, the most recent year to close under Lloyd's three-year accounting system, Lloyd's said Tuesday that it would likely record an even larger loss for 1999 when that year closes.

The last year for which Lloyd's saw a loss of more than £1 billion was 1992, when the market, still reeling from long-tail losses that had plagued it since the mid-1980s, recorded a £1.19 billion ($1.87 billion) loss. That was followed by several profitable years, but 1997 saw another downturn, with Lloyd's posting a £176 million ($284 million) deficit.

"The loss for 1999 is currently projected to be £1.11 billion ($1.66 billion) —however, this figure will continue to develop, and the projection is likely to deteriorate further over the next 12 months," Lloyd's said in a statement.

Lloyd's Chairman Sax Riley said the 1998 and 1999 years marked the bottom of the insurance cycle. "The continuing deterioration of 1998 and 1999 comes as no surprise. It is a factor we have highlighted regularly. It is also entirely consistent with the results of the rest of the nonlife insurance industry over the last three years," Mr. Riley said in the Lloyd's statement.

Both Standard & Poor's Corp. and Moody's Investors Service Ltd. had earlier predicted that Lloyd's would post a loss of at least £1 billion for 1998, and both forecast even larger losses for 1999. In spite of the expected losses, S&P last September affirmed its A+ insurer financial strength rating for the market (*BI*, Sept. 25, 2000).

Lloyd's reports results for the market as whole and does not analyze precisely where the losses occur. But it said that several key factors had contributed to the losses for 1998 and 1999. "Both years have proved to have very high levels of catastrophe claims," the Lloyd's statement said. "While Lloyd's principal exposures are in the U.S. and Caribbean, where Hurricane Georges struck in 1998, the European storms Lothar and Martin, which occurred in December 1999, continue to have an impact."

For 1998 and 1999, many syndicates almost doubled their provisions for bad debt, in the wake of concerns about the security of some reinsurers, Lloyd's noted. "This is a prudent move following the failure of a number of reinsurers," the statement said.

Lloyd's also said that 1998 and 1999 had seen a rise in directors and officers liability claims linked to an increase in corporate merger and acquisition activity. "Subsequent reappraisals of the value of these transactions triggered a wave of

See **Lloyd's** *on next page*

Aviation market analysis

Buyers told to expect more price increases

By EDWIN UNSWORTH

LONDON—Aviation insurance buyers should brace for further rate hikes, according a leading figure in the London aviation market.

There was a "long-overdue correction" in the aviation market's last round of renewals, after four years in which claims have outstripped premiums, according to Graham Nichols, chairman of the Aviation Insurance Offices' Assn. He added that further rate increases will follow.

"The market has realized that it has to charge realistic prices...and that is happening now," Mr. Nichols said at a Wednesday press conference following the association's annual meeting. The AIOA represents the company aviation insurance market in London, which underwrites approximately 60% of business placed in London, with the other 40% going to Lloyd's of London.

The AIOA reported that in 2000, aviation claims paid by its members totaled £490 million ($731.6 million), against premiums received of only £408 million ($609.2 million). Last year was the fourth straight in which claims exceeded premiums.

Mr. Nichols, who is also chief executive officer of Westminster Aviation Insurance Group, said that although underwriters realize rates need to harden, it will take "at least 24 months to get trading to a proper level."

Although Mr. Nichols said rates began hardening in the last renewal period, he declined to comment specifically on the level of increases achieved. Instead, he noted that worldwide aviation premiums total around $2 billion annually, whereas to achieve profitability, they should be in the range of $3 billion to $4 billion.

Mr. Nichols said deductibles on aviation policies are also "clearly overdue for a revision," noting that the value of aircraft has risen dramatically since deductibles were last changed in 1984.

Westminster Aviation has discussed

See **Aviation** *on next page*

PHOTO: AFP

Belgian trains collide

BRUSSELS, Belgium—The Belgian government has blamed human error for the March 27 train crash in Pecrot, Belgium, in which at least eight people died. The crash occurred when an empty train passed a red warning light onto the wrong track and collided with another train carrying approximately 80 passengers. The Societe Nationale des Chemins de Fer Belges, the state railway, operated both trains. Among the dead were the engineers of both trains, and two other SNCB employees traveling in the cabs of the trains. Rescue workers at the site, 15 miles east of Brussels, said the death toll could rise.

An SNCB spokesman said that to trigger both trains' emergency brakes, signal operators cut off power to the line when they saw the empty train on the wrong track. But the braking came too late to stop the collision. Information on insurance coverage was not immediately available.

Oil rig sinking may mean rate hikes

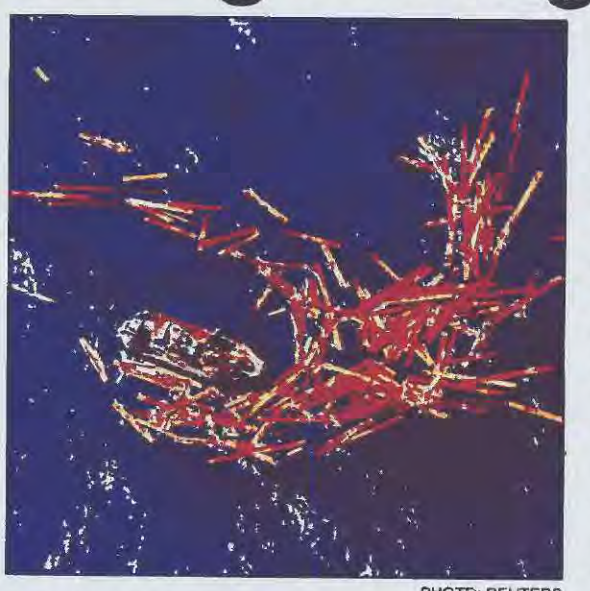

PHOTO: REUTERS

A rescue ship collects wreckage from the P-36 oil rig that sank off the coast of Rio de Janeiro, Brazil, on March 20, five days after 10 workers died when powerful blasts rocked the structure.

By EDWIN UNSWORTH

LONDON—The insured loss from the recent sinking of the Brazilian offshore P-36 oil rig could reach $700 million and will force up offshore energy rates, a Lloyd's of London underwriting agency says.

Wellington Underwriting P.L.C. said a total loss in the region of $700 million would nearly equal the entire global premium volume for offshore energy business and would represent the equivalent of the market's total profits for the last 10 years. "This is clearly going to have a very significant effect on offshore energy (insurance) prices." the agency said in a recent newsletter.

Wellington adds that while it is too early to estimate the offshore energy rate increases, "they will be sizable."

The Petroleo Brasileiro S.A. oil rig, the world's largest offshore platform, sank March 20 after a series of explosions. The rig was insured for $500 million under a policy led in Brazil by Bradesco Seguros S.A. Only 0.9% of this was retained by the insurer, though, with most of the risk reinsured into global energy markets.

Wellington says the rig policy was written by 15 underwriting operations, some of which purchased facultative reinsurance, and almost all underwriters on the risk will have marine excess-of-loss protections.

"Thus, a very large proportion of this loss will be transferred to the first-tier marine reinsurance market," the Wellington newsletter says. It also says that because there was relatively little retrocessional capacity available to protect first-tier reinsurers for 2001, Wellington does not expect a recurrence of the excess-of-loss spiral that followed the 1988 Piper Alpha oil rig explosion. That disaster cost insurers about $1.4 billion.

Wellington says an additional $200 million in insured losses from P-36 are likely to result from expenses for rectification attempts prior to the sinking, wreck removal and sue-and-labor claims.

The rig's protection and indemnity coverage, underwritten by Assuranceforeningen Gard of Norway, has a $400 million limit. In addition, to cover the pollution liability resulting from the sinking, a civil liability policy was purchased with a limit of $50 million,

See **Oil rig** *on next page*

Lloyd's

Continued from previous page
claims some of which may prove to be spurious, but nevertheless need to be reserved for," Lloyd's said.

Syndicates that have now ceased underwriting were responsible for losses of £514 million ($767.5 million) in 1998 and predicted losses of £409 million ($610.7 million) in 1999. Those amounts represent 50% and 37%, respectively, of the marketwide losses, Lloyd's said.

Lloyd's said its campaign to elevate market standards will continue. It said the poor forecasting and consistent losses that several syndicates produced had resulted in so-called "capital loadings," whereby the syndicate or managing agent is forced to increase its capital for the following underwriting year. Lloyd's added that some syndicates had been deregistered due to consistently poor performance, and it stressed that "this rigorous approach to dealing with potential threats to the Lloyd's franchise will continue." BI

Aviation

Continued from previous page
with clients the need for changes in the deductible level, explaining that if policyholders want coverage for aircraft maintenance, "we must load the cost," Mr. Nichols said.

"Other markets, I suspect, are doing the same," he said.

Citing figures from London-based Airclaims Ltd., which compiles aviation safety statistics, AIOA said 23 Western-built jet aircraft were lost last year—the same as in 1999—and that the estimated cost of major hull losses, including partial losses, was $848 million, down from $997 million in 1999. Passenger fatalities, however, surged to 726 in 2000 from 299 in 1999.

Mr. Nichols said this represented "an average bad year." He added, however, that "if these figures are translated into estimated costs, including potential liability costs, the total far exceeds the premium generated—and that was only for an average loss-cost year."

Commenting on the space market, he said the trend has been similar to that in the aviation market, in that rates are too low, claims are exceeding premiums and many insurers are locked into long-term programs.

"A lot more realism has crept into the (space) market during 2000," and insurers are raising rates in the face of a tougher reinsurance environment and some withdrawal of capacity, Mr. Nicholson said BI

Oil rig

Continued from previous page
with the excess of that coming under the P&I policy, Wellington said.

Wellington's syndicate 2020 declined to underwrite the physical damage policy on the rig but could be involved on the liability side through its line on the P&I Club protections if liability claims exceed $5 million. So far, the newsletter says, liability losses have not reached this layer.

Marlborough Underwriting Agency Ltd.'s syndicate 62 had about a 2.5% share of the rig's reinsurance, said Managing Director Tom Bolt. But he said Marlborough, a Berkshire Hathaway Inc. unit, did not lead the coverage at Lloyd's, as some sources have reported.

Tom Bradley, senior vp-finance at The St. Paul Cos. of St. Paul, Minn., said that, net of reinsurance and other recoveries, the insurer's losses from the accident are expected to be approximately $5 million.

Petrobras, meanwhile, faced a more than sixfold premium increase in renewing its property coverage March 31.

The Rio de Janeiro-based oil giant will pay $48.3 million to cover property worth $20.9 billion, a spokesman said. In 2000, Petrobras paid only a $7.5 million premium for its property coverage. The new policy will be for 14 months rather than 12, so that Petrobras can harmonize all its insurance coverages in 2002, he said.

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Gavin Souter contributed to this report.

Doing more for one's self

Surveys show increases in self-insurance, risk manager duties

By SARAH VEYSEY

Most U.K. risk managers expect their organizations to increase self-insurance and risk retention levels in the next two years, and many risk professionals are taking on additional responsibilities, two recent surveys have found.

Both surveys were conducted earlier this year by the London-based Assn. of Insurance & Risk Managers. The first survey, done at the beginning of this year, took a broad look at self-insurance and risk retention, among other topics. The second survey, completed later, explored those topics, as well as that of risk managers' expenditures and responsibilities, in greater depth.

Of 47 respondents to the first survey, 82.2% said they expect self-insurance and risk retention levels to increase in the next two years in their risk management programs while the rest said they expect those amounts to stay the same. No respondents expected those levels to decrease.

The first survey also revealed that, in the last two years, 80% of risk managers said their organizations have undertaken additional risk assessments, while 20% said that number has not changed.

Of the 134 respondents to the second survey, 23 said their risk retention in the next two years will be between 26% and 50% of total spending, 20 said their retention will be between 51% and 75%, and 15 said it will be between 76% and 100%.

The second survey also found that, from 1998 to 2000, 70% of respondents have seen their job responsibilities grow. Just three respondents said there has been a decrease in their responsibilities, while 23% reported no change.

About two-thirds of the respondents expect to take on more responsibilities over the next two years, while four respondents expect a decrease, and 29% expect no change.

"Our research shows that more than 65% of our members appear to be reporting significant growth in the scope and nature of their work role, with very, very few—3%—expecting their responsibilities to reduce in the future," said Alan Fleming, chairman of AIRMIC and risk manager for U.K. rail operator Railtrack P.L.C.

"From our results, it is clear that the role of the risk manager in the U.K. today is growing and continuing to evolve in difficult insurance market circumstances," he said. "Allied to this, the value of professional risk management within U.K. businesses is gaining recognition."

AIRMIC said it believes the recent introduction of the Turnbull rules on internal controls and the increased need to publicly demonstrate good corporate governance are also contributing to this trend.

"Faced with a market offering poorer service and signs that premiums are set to rise, decision-makers within companies are looking elsewhere to resolve their risk concerns—and increasingly turning to their in-house risk management functions, supported by external broking and consultancy services, for solutions," Mr. Fleming said.

The first AIRMIC survey revealed that 75.6% of risk managers expected property and business interruption premiums to rise in the next two years. Just 24.4% thought premiums would remain at their current levels, while no respondents said they believed premiums would decrease. More than 70% thought casualty premiums would increase in the next two years, with 26.7% expecting them to remain at current levels and just 2.2% expecting a decrease.

For other classes of insurance, 66.7% of respondents expected an increase in premiums in the next two years, while 33.3% expected premiums to remain the same, and none predicted a decrease.

About 40% of respondents to the first survey said major brokers' service levels had decreased over the past two years. More than 42% expected those levels to remain unchanged over the next two years, while 24.4% expected them to decrease.

Less than 3% of respondents to the second survey said they did not use brokers, while 47% said they used just one. Thirty-nine percent used two or three brokers, and 8% used four or more.

Thirty-eight percent of respondents said that brokerage fees had increased between 1998 and 2000, but about 30% said fees had decreased and 26% reported no change. For 2000-2002, 39% thought brokerage fees would increase, while 37% expected no change and 18% predicted a decrease.

The first survey revealed that many insurance buyers believed that service from insurers was declining. Half of the respondents said that the level of service provided by insurers had decreased over the past two years, with just 13.6% reporting an increase and 36.4% saying the level had not changed. For the next two years, 45.9% expect service by insurers to stay the same, with 29.7% predicting an improvement and 24.3% a deterioration in service.

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Advance copies of the survey results are available to preregistered attendees, exhibitors and sponsors of the AIRMIC conference to be held June 4-6 in Birmingham, England. Nonmembers of AIRMIC may purchase copies at the conference. For more information, contact AIRMIC at 44-207-480-7610 or at enquiries@airmic.co.uk.

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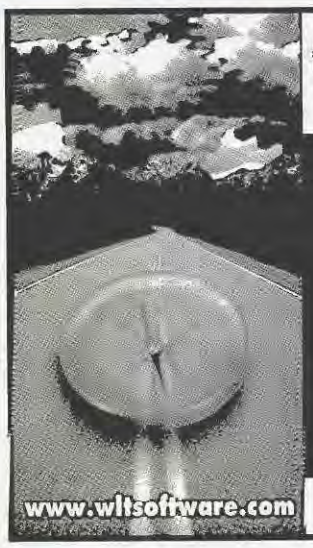

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LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF AMERICAN HEALTH CARE PROVIDERS, INC.
00 CH 01689

NOTICE OF EXTENSION OF CLAIM FILING DEADLINE

PLEASE TAKE NOTICE, that on May, 11, 2000, the Circuit Court of Cook County, Illinois, entered an Order of Liquidation With a Finding of Insolvency and Injunctive Relief against American Health Care Providers, Inc. ("AHCP"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of AHCP ("Liquidator").

TAKE FURTHER NOTICE, that on March 8, 2001, the Circuit Court of Cook County, Illinois, entered an Order Extending the Claim Filing Deadline ("Extension Order"). Pursuant to the Extension Order, all persons, companies or entities who have, or may have claims against AHCP, its property or assets, or against an enrollee or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before November 12, 2001 at 4:30 p.m., Central Time.

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with and may be obtained from, the Liquidator of AHCP, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to AHCP upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST AHCP, ITS PROPERTY OR ASSETS, OR AGAINST AN AHCP ENROLLEE OR POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATION ON OR BEFORE NOVEMBER 12, 2001 AT 4:30 P.M., CENTRAL TIME.

Cathleen M. Travis
Special Deputy Receiver

LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF ILLINOIS HEALTH CARE INSURANCE COMPANY
00 CH 09775

NOTICE OF EXTENSION OF CLAIM FILING DEADLINE

PLEASE TAKE NOTICE, that on June 30, 2000, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against Illinois Health Care Insurance Company ("ILLINOIS HEALTH"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of ILLINOIS HEALTH ("Liquidator").

TAKE FURTHER NOTICE, that on March 8, 2001, the Circuit Court of Cook County, Illinois, entered an Order Extending the Claim Filing Deadline ("Extension Order"). Pursuant to the Extension Order, all persons, companies or entities who have, or may have claims against ILLINOIS HEALTH, its property or assets, or against a policyholder of ILLINOIS HEALTH, shall have the right to present and file with the Liquidator proper proofs of claim on or before December 28, 2001 at 4:30 p.m., Central Time.

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of ILLINOIS HEALTH, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to ILLINOIS HEALTH upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST ILLINOIS HEALTH, ITS PROPERTY OR ASSETS, OR AGAINST AN ILLINOIS HEALTH POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATION ON OR BEFORE DECEMBER 28, 2001 AT 4:30 P.M., CENTRAL TIME.

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LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION
OF BACK OF THE YARDS NEIGHBORHOOD
COUNCIL RISK MANAGEMENT ASSOCIATION, INC.
99 CH 06024

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on January 22, 2001, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against Back of the Yards Neighborhood Council Risk Management Association, Inc. ("BYRMA"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of BYRMA ("Liquidator").

TAKE FURTHER NOTICE, that on March 7, 2001, 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 BYRMA and its policyholders, members, creditors and all other persons interested in its property or assets, are fixed as of January 22, 2001, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims against BYRMA, its property or assets, or against a BYRMA policyholder or member, shall have the right to present and file with the Liquidator proper proofs of claim on or before January 22, 2002 at 4:30 p.m., Central Standard Time ("C.S.T.").

TAKE FURTHER NOTICE, that pursuant to Section 209(4) of the Illinois Insurance Code, 215 ILCS 5/209(4), any insured under an insurance policy issued by BYRMA shall have the right to present the Liquidator with a proof of claim setting forth a contingent claim, subject to the claim filing deadline of January 22, 2002 at 4:30 p.m. (C.S.T.). The final date by which evidence supporting the liquidation of any such contingent claim may be received by the Liquidator shall be January 22, 2003 at 4:30 p.m. (C.S.T.). No such contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the class"d" priority level, 215 ILCS 5/205(1)(d), unless such claim has been liquidated and the insured claimant has presented evidence of payment of such claim to the Liquidator on or before January 22, 2003 at 4:30 p.m. (C.S.T.).

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of BYRMA, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to BYRMA upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST BYRMA, ITS PROPERTY OR ASSETS, OR AGAINST A BYRMA POLICYHOLDER OR MEMBER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE JANUARY 22, 2002 AT 4:30 P.M. (C.S.T.)

Cathleen M. Travis
Special Deputy Receiver

LEGAL NOTICES

NOTICE OF SANCTION OF SCHEME OF ARRANGEMENT

IN THE HIGH COURT OF JUSTICE (IN ENGLAND) No. 7686 of 2000
CHANCERY DIVISION
COMPANIES COURT

IN THE MATTER OF

CHESTER STREET INSURANCE HOLDINGS LIMITED
(formerly Iron Trades Holdings Limited)
and
IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an Order dated 28 February 2001 made in the High Court of Justice in the matter of Chester Street Insurance Holdings Limited (the "Company"), the Scheme of Arrangement proposed to be made between the Company and its Scheme Creditors (as defined in the Scheme) pursuant to section 425 of the Companies Act 1985 (the "Scheme"), which was voted on and approved by Scheme Creditors during meetings held on 5 February 2001, was sanctioned. A copy of the Scheme was lodged with the registrar of companies on 5 March 2001, and the Scheme became effective on that date.

NOTICE OF THE DECLARATION OF A TRIGGER EVENT UNDER THE SCHEME

On 8 March 2001 and pursuant to the provisions of the Scheme, the directors of the Company (the "Directors") gave notice to Dan Schwarzmann and Colin Bird of PricewaterhouseCoopers (the "Scheme Administrators"), The Chester Street Employers Association Limited, the Policyholders Protection Board, the Law Debenture Trust Corporation plc and the Creditors' Committee (as defined in, and formed pursuant to, the Scheme), that they had concluded that:

(a) the value of the Company's assets is less than its liabilities taking into account its contingent and prospective liabilities; and

(b) without the occurrence of a Trigger Event (as defined in the Scheme) and the operation of the Scheme in accordance with its terms thereafter, there is no reasonable prospect that the Company would avoid going into insolvent liquidation.

By virtue of that notice, the Directors declared a Trigger Event (as defined in the Scheme). Following this Trigger Event, the Scheme Administrators are empowered to supervise and ensure the carrying out of the Scheme, including the setting and, where appropriate, payment of a Payment Percentage (as defined in the Scheme).

Should you have any questions regarding this Notice, please address them to the Scheme Administrators at:

Dan Schwarzmann
PricewaterhouseCoopers
Plumtree Court
London EC4A 4HT, England
Telephone: 020 7583 5000
Facsimile: 020 7804 4578

LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF
AMERICAN UNIFIED LIFE AND HEALTH INSURANCE COMPANY
00 CH 01689

NOTICE OF EXTENSION OF CLAIM FILING DEADLINE

PLEASE TAKE NOTICE, that on June 27, 2000, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against American Unified Life and Health Insurance Company ("AMERICAN UNIFIED"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of AMERICAN UNIFIED ("Liquidator").

TAKE FURTHER NOTICE, that on March 8, 2001, the Circuit Court of Cook County, Illinois, entered an Order Extending the Claim Filing Deadline ("Extension Order"). Pursuant to the Extension Order, all persons, companies or entities who have, or may have claims against AMERICAN UNIFIED, its property or assets, or against any policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before December 27, 2001 at 4:30 p.m., Central Time.

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of AMERICAN UNIFIED, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to AMERICAN UNIFIED upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST AMERICAN UNIFIED, ITS PROPERTY OR ASSETS, OR AGAINST AN AMERICAN UNIFIED POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 27, 2001 AT 4:30 P.M., CENTRAL TIME.

Cathleen M. Travis
Special Deputy Receiver

LEGAL NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION)
OF AGORA SYNDICATE, INC.) NO: 00 CH 13471

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on November 15, 2000, the Circuit Court of Cook County, Illinois, entered an Order of Liquidation With a Finding of Insolvency against Agora Syndicate, Inc. ("Agora Syndicate"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Agora Syndicate ("Liquidator").

TAKE FURTHER NOTICE, that on March 20, 2001 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 Agora Syndicate and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of November 15, 2000, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims, against Agora Syndicate, its property or assets, or against an Agora Syndicate insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before November 15, 2001 at 4:30 p.m. (C.S.T.).

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by Agora Syndicate shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before November 15, 2001 at 4:30 p.m. (C.S.T.). No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before November 15, 2002 at 4:30 p.m. (C.S.T.). Any contingent claim for which a proper proof of claim is filed on or before November 15, 2001 at 4:30 p.m. (C.S.T.), but which is not liquidated on or before November 15, 2002 at 4:30 p.m. (C.S.T.), may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the court.

TAKE FURTHER NOTICE, that the form and required content of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of Agora Syndicate, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to Agora Syndicate relating to all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST AGORA SYNDICATE, ITS PROPERTY OR ASSETS, OR AGAINST AN AGORA SYNDICATE POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE NOVEMBER 15, 2001 AT 4:30 P.M. (C.S.T.)

Cathleen Travis
Special Deputy Receiver

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Largest U.S. reinsurers' year-end 2000 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurer	Net reinsurance premiums written 2000	Net reinsurance premiums written 1999	Policyholders surplus (reinsurers only)	Net income (loss) 2000	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 2000	Combined ratio 1999
1. Berkshire Hathaway	$4,724,000	$2,410,000	N/A	N/A	$4,766,000	101.3%	$114,000	2.4%	103.7%	110.7%
2. Employers Reinsurance Group	3,996,052	3,509,319	5,195,832	431,903	2,956,756	78.7	1,331,114	33.3	112.0	114.5
3. General Re Group [1]	3,516,783	2,800,684	4,494,569	384,749	2,928,948	86.4	889,430	25.3	111.7	119.9
4. American Re-Insurance Co.	3,165,479	2,821,261	2,165,369	(96,688)	2,752,721	85.8	991,155	31.3	117.1	115.3
5. Swiss Reinsurance America Corp.	1,758,729	1,046,400	1,537,044	28,381	1,367,672	87.7	592,323	33.7	121.4	109.5
6. Transatlantic Re/Putnam Re	1,533,345	1,391,798	1,531,876	177,025	1,114,706	73.9	406,972	26.5	100.4	106.4
7. St. Paul Re * [2]	1,251,493	1,056,401	N/A	N/A	1,006,182	79.2	435,689	34.8	114.0	100.2
8. Everest Reinsurance Co.	1,211,773	1,108,070	1,272,689	165,254	890,590	75.8	336,850	27.8	103.6	103.3
9. Zurich Reinsurance (N.A.) Inc.	959,759	967,313	858,653	99,332	865,552	82.9	324,645	33.8	116.7	107.6
10. CNA Re *	951,200	1,274,800	N/A	N/A	888,100	81.6	261,700	27.5	109.1	116.4
11. Gerling Global Reinsurance	897,568	800,874	536,371	(26,253)	747,925	84.3	274,889	30.6	114.9	106.8
12. Hartford Re Co.	825,879	702,961	N/A	N/A	624,352	77.1	262,118	31.7	108.8	107.2
13. Odyssey Re Corp./Odyssey Amer Re [3]	609,251	551,039	853,008	95,026	441,842	72.8	220,025	36.1	108.9	122.5
14. Berkley Insurance Co. [4]	444,684	399,372	615,384	19,143	329,722	75.1	146,573	33.0	108.1	108.5
15. SCOR U.S. Group [5]	426,937	664,935	336,456	(20,687)	508,700	96.1	162,190	38.0	134.1	112.8
16. PartnerRe US [6]	369,264	267,946	356,150	21,380	291,596	85.4	121,265	32.8	118.2	117.1
17. Folksamerica Reinsurance Co. [7]	332,691	214,552	443,928	(20,051)	255,298	81.7	121,765	36.6	118.3	112.6
18. Underwriters Reinsurance Co.	308389	429,259	464,393	(162,855)	493,875	154.0	74,427	24.2	178.2	102.2
19. American Agricultural Insurance	304,278	223,746	293,935	22,393	210,332	75.3	62,478	20.5	95.8	113.9
20. AXA Corporate Solutions Reinsurance Co.	275,768	134,686	285,821	(862)	152,470	68.9	107,727	39.1	108.0	116.2
Totals for Top 20	**27,863,322**	**22,775,416**	**21,241,478**	**1,117,190**	**23,593,339**	**85.9%**	**7,237,335**	**26.0%**	**111.9%**	**111.1%**
Totals for all companies [8]	**24,853,859**	**21,212,749**	**24,477,775**	**1,062,875**	**20,264,985**	**83.2%**	**7,692,820**	**31.0%**	**114.2%**	**113.8%**

* Results include combined U.S. and non-U.S. affiliate operations.
1. All data presented on a North American Combined Statutory Basis for the General Re Group. Excludes other affiliates from the Berkshire Hathaway Group Inc. 2. Excludes corporate aggregate excess cover. 3.Includes results of Odyssey America Re Corp. and Odyssey Reinsurance Corp. 4. Formerly Signet Star Reinsurance Co. 5. Includes the effects of reinsurance credits. 6. Includes the combined results for Partner Reinsurance Co. of the U.S. and its subsidiary PartnerRe Insurance Co. of New York. 7. Income figures included herein reflect the reinsurance business acquisition of Risk Capital Reinsurance Co. on 5/5/2000. 8. Excludes results of Berkshire Hathaway Group Inc.

Sources: Reinsurance Assn. of America and *Business Insurance*

Reinsurers

Continued from page 1

111.1% combined for 1999. This includes the results of the Berkshire Hathaway Group, which is not an RAA member.

The reinsurers as a group posted a 17.2% increase in net reinsurance premiums written from 1999, for a total last year of $24.85 billion. The top 20 reinsurers reported an increase of 22.3%, for a total of $27.86 billion.

The poor results were expected, observers say. "I don't think there are any surprises there," said Mark Lescault, Armonk, N.Y.-based head of the divisional underwriting office for the Swiss Re Americas division, referring to the RAA report.

Mr. Lescault said the results reflected deteriorating fundamentals, excess capacity, rising loss costs, declining prices in every year since 1995 and broadened terms and conditions. All those factors have "come to full fruition in the year 2000," he said.

"It was what we had expected," said Elizabeth Farrell, assistant vp at Oldwick, N.J.-based A.M. Best Co. Ms. Farrell also pointed to deteriorating fundamentals, as well as growth in some proportional programs and declining reserve redundancies. Results were also dampened by adverse development in reserves for 1999 and prior years, she said.

"Obviously, what had been predicted in fact came to reality, which is that the final quarter of the year showed that the reinsurance industry really had a horrible year," said Jerome Karter, vice chairman of SCOR U.S. Group in New York. Mr. Karter pointed out that the reinsurance industry's combined ratio deteriorated from the 112.4% reported by the RAA in the first quarter, to 114.2% by year end.

Individual companies' resolve that "enough is enough" started to come through with the 2001 renewals, with reinsurers simply letting business go if they could not get adequate pricing, Mr. Karter said.

The results are "evidence of another difficult year," said David Robb, president of reinsurance operations for The Hartford Financial Services Group Inc. in Hartford, Conn.

"The RAA results for 2000 were a bit like a scary movie, as evidenced by the composite combined ratio of 114.2%," said Ken Zuckerberg, vp in equity research at Dresdner Kleinwort Wasserstein in New York.

There was a large increase in premiums "but a big increase in claims, too, so the combined ratio is essentially unchanged from what was reported a year ago," said Michael Smith, an analyst with Bear, Stearns & Co. in New York.

Todd Bault, a research analyst at Sanford Bernstein & Co. in New York, said that the existence of premium growth, combined with little change in combined ratio, indicates "that most of the premium growth wasn't price—it was more exposure getting into the reinsurance market."

Although there will be some improvement this year, it is not expected to be dramatic.

If reinsurers get price hikes of 10% to 20%, as is likely, but reserves remain inadequate, "you might not see a lot of improvement in the combined ratio," which will be "flat to slightly better but probably not a lot better," Mr. Bault said.

"I'm not sure that the underwriting results are going to improve that dramatically too soon," Mr. Smith said. Reinsurers' shift several years ago into writing more quota-share business means they "are only going to hear about the losses from the ceding companies," and the ceding companies have been underestimating their reserves, Mr. Smith said.

Rick Smith, president and chief executive officer of P&C Re Americas, a unit of Overland Park, Kan.-based Employers Reinsurance Corp., said: "I think it's going to be an improving process. The question is how firm prices will become." This year will be the "start of the road to recovery for the industry," he said.

Hartford Re's Mr. Robb said, "From a combined ratio standpoint, in the absence of any abnormal catastrophes, I would think there would be some modest improvement."

But because most of the premiums that will be earned this year will still reflect business written in previous years, "I think any improvement will take place in the latter part of the year and will be gradual rather than dramatic," Mr. Robb said.

"I don't think it's great," SCOR Re's Mr. Karter said about the outlook for reinsurers. The underpricing of the past few years will tend to "drift through a lot longer" for reinsurers than it will for primary insurers, "and we'll see that development continue at least through this year," he said.

"The real question is whether people have put up enough reserves to reflect that, and I'm not so sure that everyone's gotten the full message on that. That's going to be the real issue for 2001," Mr. Karter said.

"But I do think that our position on it certainly is that we are not going to take any business just to feed the top line. We want our profit on it, and I have a feeling that the majority of...reinsurers are finally seeing it the same way. If you look at the results, they can't be sustained.

"And, particularly in this environment, with the financial markets and all the uncertainty and unpredictability of that compared to the last three, four years—that's not something any company's going to fall back on," Mr. Karter said.

Mr. Lescault said there is no question that the disciplined underwriting and improved pricing now being introduced will continue throughout the year. "But I think it must continue into 2002 and 2003 at least," he said, "to get things working through to the bottom line."

Mike Schell, president and chief operating officer of the New York-based global reinsurance operations of St. Paul Re, agreed that it will take reinsurers more than one year to recover from the soft market.

"Despite the improvement in insurance pricing on the underlying product and despite better rates and terms on the reinsurance product, there are many classes where the rate and term improvements are just a first step. And, just like the clients need to be selective and do a good job underwriting the original risk, reinsurance companies need to do similarly with their reinsurance clients," Mr. Schell said.

Meanwhile, most observers do not necessarily see any long-term implications behind planned changes at two reinsurers.

Zurich Financial Services has said it will spin off Zurich Re, which will be renamed and operate as a fully independent and separately listed reinsurer (*BI*, March 26). In addition, Toronto-based Fairfax Financial Holdings Ltd. announced that Odyssey Re Holdings Corp., its wholly owned subsidiary, has filed a registration statement with the U.S. Securities and Exchange Commission relating to a proposed initial public offering.

"I think different companies, based on their own situations, have different ways of managing their capital—that's probably more pertinent in the case of Odyssey—or have different strategic objectives, and that's probably more the case of Zurich Financial Services. But I don't think there's any particular significance to it. I don't think it has any effect on the reinsurance business," Mr. Schell said. BI

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COMMENTARY

Claims padding and fair treatment

People have good reason to pad their insurance claims, a couple of readers have suggested in response to one of my columns last month.

People filing claims suspect insurers won't fairly settle an honest claim in the first place, and their fears are well founded, readers told me.

Sorry to say, I suspect these readers are more right than wrong in their assessment, especially in the personal lines market. Everyone has a horror story about dealing with an insurance company claims adjuster, except those who have never filed a claim.

"In my 53 years of active work in the business, including my small amount of retirement consulting, I have encountered literally hundreds of cases of unfair, overly restrictive and downright fraudulent attempts by insurance companies to 'improve underwriting results through the claim department,'" wrote a retired industry professional.

"In 18-plus years of risk management and some brokering, out of approximately 2,000 auto claims and 35 property claims that I have dealt with, I can only recall approximately 20 of the former and five of the latter where the insureds received a satisfactory or better-than-anticipated settlement from the insurer," wrote a free-lance risk manager. "By 'satisfactory' I mean not the emotional reaction of the insured, but the conclusion arrived at after a reasoned discussion or review of the outcome of the claim."

The risk manager noted, "I have worked mostly in the New York area, which is not truly representative of the country as a whole." But that's still a very sorry record, I must say.

Kathryn J. McIntyre

As for claims padding by policyholders, the risk manager wrote: "I can only recall two circumstances where any of the above claims involved fraudulent and unjustified padding by the claimants."

Cases of "padding," the risk manager wrote, "are merely feeble attempts to fill some of the gaps left behind by the mostly cavalier and inadequate claims-handling procedures that we seem to have become accustomed to. Whatever 'padding's' cumulative cost, I'm sure it's just a tiny fraction of the shortfall in compensation practiced by our industry."

I doubt there is any way to determine just how much insurers "save" by unfairly underpaying claims, but no doubt insurers try. The risk manager's e-mail reminded me that our Associate Editor Mike Bradford had to fight to get a fair payment some years ago when his brand-new Mazda RX7 was stolen from the Dallas airport. His insurer tried to lowball Mike on what it was going to pay. Mike, being a tenacious reporter, went through want ads and made calls to determine what it would cost him to replace the car. He also was smart enough to ask for another adjuster on the claim. Armed with his facts and talking to a new adjuster, Mike finally got the claim settled to his satisfaction. But what if he weren't so knowledgeable and tenacious?

So when I suggested that insurers need to better communicate with policyholders on what is fair in filing a claim, I surely was remiss in not observing that too often, insurers aren't fair with their policyholders.

As the risk manager wrote me: "I, for one, can only apologize on behalf of the industry whenever another egregious claim scenario arises, scratch my balding head for a solution, contain my anger when dealing with the claims reps, and flip out when references such as your column remind me about the whole sorry matter."

In addition to failing to take insurers to task for those times they are less than fair with policyholders, I also was less than clear on what I consider fair in settling a claim. The retired insurance professional wrote: "If to properly repair the car damaged by an earthquake you have to also fix a dent that was there before, is it appropriate to reduce the claim settlement as you suggest?"

The answer is no, and that is not what I intended to suggest. I was speculating that if the survey of consumer attitudes toward filing claims was correct, there could be claims for damages allegedly caused by the Seattle earthquake that had nothing to do with the temblor.

While I still don't condone padding insurance claims, given the respective expertise of claims adjusters and personal lines policyholders, I agree that more often than not, the insurer could treat the consumer more fairly. Indeed, the New York-based risk manager has some sage advice for insurers: "If insurers revised their practices with regard to their handling of small claims, albeit with a significant increase in costs in this area, they would gain tremendous support from the general public in the fight to reduce the big awards. I'm no actuary, but it seems the net result would be a big gain for the insurers, not to mention the increased goodwill. As it stands, the small-claims handling process seems to be poisoning a very wide breadth of water."

Publishing Director Kathryn J. McIntyre's commentary appears fortnightly and online at www.businessinsurance.com. *She can be reached at kmcintyre@crain.com.*

NAIC

Continued from page 2

changes without legislative approval. Other pro-reform factors could include a state legislature that previously passed similar deregulation legislation, is considering such legislation or has a sufficiently long session in which to do so, he said.

The deregulation initiative aims to have states implement "informational filing" of rates and "file and use" for forms, according to the working group's discussions last week at the NAIC's spring quarterly meeting in Nashville, Tenn.

State requirements that insurers follow to gain approval for their rates and forms for various lines of coverage typically vary significantly, ranging from prior approval to no filing requirements at all. The NAIC's project is designed to reduce requirements in many states, though state-specific definitions of the terms vary.

Yet, greater uniformity in definitions may result from regulators adopting the definitions contained in the NAIC's Speed To Market Working Group Report from last December.

Essentially, the project seeks to have an insurer file for informational purposes—but not regulatory approval—such items as rates and rating manuals as well as an explanatory memorandum about the new product or revisions to an existing product. An insurer, however, could be required to provide additional supporting information should regulators order a market conduct examination in the future.

Meanwhile, implementing a "file and use" system for forms means that an insurer is typically permitted to use the forms after filing them with the appropriate statue insurance departments. Some states also have a specified waiting period before the insurer can use the forms.

The new initiative is drawing wide support.

The New York-based Risk & Insurance Management Society Inc. "is pleased" that the NAIC is instituting this effort to get commercial lines deregulation enacted, said Daniel Barry, RIMS' director of government affairs. "Of all the initiatives the NAIC is considering, this has the most direct and positive impact on risk managers," he said, adding that he plans to contact the NAIC to find out how RIMS can help.

In addition, the project's goals may be furthered by the fact that 19 states have thus far passed commercial lines deregulation laws based, at least in part, on a National Conference of Insurance Legislators' model law, said Robert Mackin, NCOIL's Albany, N.Y.-based executive director. Although he is unfamiliar with the specifics of this project, he said NCOIL and the NAIC have a "superlative" working arrangement,

The NAIC is looking for more help in creating 'efficient, market-oriented regulation,' says Kathleen Sebelius.

primarily due to joint efforts to enact more uniform agent licensing laws nationwide.

Meanwhile, the other working group focusing on "Speed to Market" programs—the Coordinated Advertising Rate & Form Review Authority Working Group—is seeking comment on the latest draft of national standards for life/health-related products, which will be included in a 10-state pilot program beginning May 1. Those products are an individual term life policy; an individual flexible premium deferred annuity contract; as well as the individual or group Medicare supplement form.

Speeding products to market is only one of several goals the NAIC has made progress in achieving since regulators unanimously signed on to the organization's "Statement of Intent" to modernize regulation a year ago.

Most representatives of insurance-related trade groups—including the NAII, the Alliance of American Insurers and the American Insurance Assn.—generally agree that the NAIC has made substantial progress in addressing these issues, though they have not always agreed with the final versions of the proposals.

The NAIC has made "tremendous progress" thus far but is looking for more help from the states to implement the NAIC's promise of creating "efficient, market-oriented regulation of the business of insurance," said NAIC President Kathleen Sebelius, the Kansas insurance commissioner.

Regulators are especially concerned with meeting some impending deadlines.

For example, regulators have until July to exercise their authority to implement tougher consumer privacy protections for insurers under the Gramm-Leach-Bliley financial services modernization act.

Following two closed-door sessions at the NAIC meeting, Ms. Sebelius estimated that 45 states are expected to enact protections for consumer financial information that meet or exceed the requirements of the federal law. In addition, about 36 states are expected to consider enacting protections for consumer health information, she said.

In Kansas, legislation (H.B. 2480) that would expand her authority to administratively adopt health-related consumer protections—in addition to financial protections the Legislature previously authorized her to implement—has passed the House and is expected to be considered by the state Senate soon. The governor is expected to approve the measure, she said.

Regulators also face a deadline of November 2002 for at least 29 jurisdictions to implement reciprocal agent licensing laws to forestall creation of the National Assn. of Registered Agents & Brokers, which would reduce state regulators' authority over such licensing. According to the NAIC, nine states are now NARAB-compliant and similar bills are pending in about 33 states. Legislative action also is anticipated in several more states.

In addition, the NAIC has launched a National Insurance Producer Registry to create a single point of licensing for agents nationwide. BI

Unifi

Continued from page 1

employers about how to solve a business problem without actually putting your hands on it and helping do it," Mr. Keller said.

This hands-on approach requires a huge financial investment in technology. While Unifi is, as Mr. Keller puts it, "prepared to compete up and down the line," as a unit of a partnership it lacks the same ability to raise capital that publicly held firms enjoy.

Moving beyond providing advice and actually building and running services for clients poses other issues for Unifi as well. Its parent, PwC, conducts audits and does accounting work for about 35% of the nation's largest companies. Increasingly, the U.S. Securities and Exchange Commission, to ensure the objectivity of financial statements, has taken a tough line on accountants and auditors providing to their clients other services in which they have a financial interest.

The possible changes at Unifi come amid years of growth. Through acquisitions and organic growth, PwC has emerged as one of the nation's largest benefit consultants.

In 1990, Coopers & Lybrand ranked as the ninth-largest benefit consultant, with a little more than $115 million in benefit consulting revenues. PwC is now the fourth-largest benefit consultant, according to *Business Insurance*'s annual ranking, with benefit consulting revenues last year of $885 million.

That figure includes about $400 million in revenues from Unifi, which has about 3,500 employees. Unifi's revenues rose by more than 30% last year.

Acquisitions and mergers have played a key role in the growth of PwC's benefit consulting business. In 1997, Coopers & Lybrand acquired Kwasha Lipton, a venerable consultant based in Fort Lee, N.J. While relatively small at about $80 million in consulting revenues, Kwasha Lipton was known in the industry for innovation—it developed, for example, the nation's first cash balance pension plan—top talent, highly regarded outsourcing services and a prized client list, which included such companies as Bank of America Corp.

"Tremendous assets came with Kwasha Lipton," Mr. Keller said.

In 1998, Coopers & Lybrand merged with the accounting firm Price Waterhouse, which had a benefit consulting practice that, while relatively small, had been very successful in recruiting top employee benefit staffers from the Internal Revenue Service and the congressional Joint Committee on Taxation.

The developments at PwC come amid changes, or potential changes, at other benefit consultants. Last month, Hewitt Associates L.L.C., the nation's largest benefit consultant, disclosed that it is considering an initial public offering of shares, which some outsiders say would allow Hewitt to invest more in its benefit outsourcing operations.

And last year, Watson Wyatt & Co. and its employees raised just over $80 million through the sale of 6.4 million shares of stock; about half the shares were sold by the company and half by its employees. Watson Wyatt President and Chief Executive Officer John C. Haley said one reason for the company's IPO was to make funds available should an attractive acquisition present itself.

At the same time, consolidation has swept the industry. Last year, for example, Aon Corp. acquired Actuarial Science Associates, a former unit of AT&T Corp. that had more than $100 million in benefit consulting revenues, much of it coming from the telecommunications industry.

Other benefit consultants were taken over when their parent companies were acquired. Marsh & McLennan Cos. Inc.'s 1998 and 1997 acquisitions of, Sedgwick Group P.L.C. and Johnson & Higgins, respectively, resulted in two big benefit consultants—Sedgwick Noble Lowndes and A. Foster Higgins & Co. Inc.—being folded into Marsh's benefit consulting unit, William M. Mercer Inc.

Also in 1997, Aon acquired Alexander & Alexander Services Inc.'s benefit consulting unit as part of its purchase of A&A, while Mellon Bank acquired Buck Consultants Inc. BI

Standard

Continued from page 1
workers compensation.

Shortly after President Bush signed the legislation rescinding the OSHA rule, a bipartisan group of senators, led by Sen. John Breaux, D-La., introduced new legislation—S. 598—that would direct the secretary of the Department of Labor to begin work on a new ergonomics rule (*BI*, March 26). Sen. Breaux was one of six Democrats who joined their unanimous GOP colleagues in voting to revoke the rule.

Sen. Breaux was one of six Democrats who joined their unanimous GOP colleagues in voting to revoke the rule.

If the Breaux bill becomes law, the secretary of Labor would have to issue an ergonomics rule within two years of the measure's enactment, with the final rule taking effect within 90 days of the regulation's issuance.

The bill, which is less than three pages long, spells out what the standard can and cannot cover. According to the bill, the new ergonomics rule would not apply to "non-work-related musculoskeletal disorders that occur outside the workplace or non-work-related musculoskeletal disorders that are aggravated by work." But the bill provides no guidance about how such determinations should be made.

In addition, the rule must "set forth in clear terms" the situations in which an employer must address an ergonomic hazard, the measures required to do so, and the employer's "compliance obligations."

Furthermore, the secretary of Labor must develop information and training materials and implement an outreach program to provide compliance assistance for employers and employees.

But the provision of the bill that is generating perhaps the most interest reads, "In issuing a new rule under this subsection, the secretary of Labor shall ensure that nothing in the rule expands the application of state workers' compensation laws."

"I wish it would say it will not 'supersede or expand'—you're talking about two different issues," said Billie Fae Fuschi, vice chair of the Risk & Insurance Management Society Inc.'s External Affairs Team and director-workers compensation for Methodist Healthcare in Memphis, Tenn. Nevertheless, Ms. Fuschi called the proposed workers comp carve-out "a good thing."

"We're happy that the bill would direct the secretary that there is no expansion of workers compensation," said Julie Gackenbach, director-government relations in Washington for the Des Plaines, Ill.-based National Assn. of Independent Insurers. "We want everyone to read that this means no separate system."

"I think, at this point, we have no position on the Breaux bill, nor do we have an opinion at this moment about whether a new rule should be issued," said John Savercool, vp-federal affairs for the American Insurance Assn. in Washington. "We think that the secretary of Labor should have an opportunity to express her opinion as to whether a new rule should be issued."

"Having said that, we appreciate the intent that we believe Sen. Breaux has in ensuring that a new rule, as mandated by his legislation, would not adversely affect workers compensation and violate the (1970 Occupational Safety and Health Act.) We will work not only with him and the bill's co-sponsors, but also members of the Senate Health, Education, Labor and Pensions Committee, to assure that that intent is written clearly into any law that moves in that committee," Mr. Savercool said.

'There will be no means of developing a rule. . . that is going to stand the test of time forever,' says Keith Lessner.

Jim Green, the chair of RIMS' External Affairs Team, called the measure "an unknown quantity."

Although the bill instructs OSHA to develop a standard, the measure "does put some limitations on that, very measured limitations. OSHA should seize this opportunity to use their resources to partner with the academic community, as well as the business and manufacturing community, to conduct real-world, practical research into the causes and possible prevention of ergonomics-related MSDs," said Mr. Green, who is also the risk manager for Acme Building Brands Inc. in Fort Worth, Texas.

Ms. Fuschi called the bill "broad," and she added: "I know this is kind of a judge's guidance to the jury. On the other hand, it's so broad that it mirrors what was out before."

"We need to be on top of it and make sure that, when we do 'RIMS on the Hill,' we let our senators know what we expect of them," Ms. Fuschi said, referring to RIMS' annual legislative conference and visit to lawmakers, scheduled for late June.

'We feel it's more important to get it right than to get it done quickly,' says the NAII's Julie Gackenbach.

Keith Lessner, vp-safety and environment for the Alliance of American Insurers in Downers Grove, Ill., said that "overall, it's a good idea," but he added that he sees several possible problems.

The first is that the Bush administration hasn't made clear that it intends to pursue ergonomics rulemaking. "A bill like this may push the administration to move farther than it would have," Mr. Lessner said. But the "real issue," he said, is the extent to which OSHA "can carve out an approach to the problem that doesn't rely on workplace rules—whether it can be done with assistance, suggestions and awareness."

"From our perspective, a lot can be done through these voluntary programs—that's a pretty cost-effective route," he said

"There will be no means of developing a rule this year or in two years that is going to stand the test of time forever. A big part of the game is what can we do based upon what we know will work," Mr. Lessner said. He said that it would be best to "leave the stuff we don't know about" until more is learned.

Mr. Lessner's second concern is the difficulty inherent in trying to determine whether an MSD is work-related.

"Ultimately, it's going to be a long, long time before technology will determine" exactly what caused an MSD. Consequently, he said, "in terms of common sense, we're going to be forced to look at conditions the workplace."

Ms. Gackenbach of the NAII said the insurer group "would prefer not to have an arbitrary time limit" placed on the Labor Department as it seeks to draft a new rule.

"We feel it's more important to get it right than to get it done quickly," she said. BI

ACORD broadens standards effort

PEARL RIVER, N.Y.—ACORD, an organization dedicated to developing data standards for the insurance industry and related sectors, has broadened its efforts with the formation of a global standards strategy committee.

The committee will give ACORD the flexibility to respond to increasing interest in standards on the part of risk managers, reinsurers, statistical agencies and other organizations around the world, according to a statement by John Leonard, chairman of Pearl River, N.Y.-based ACORD.

The new committee will provide leadership that will establish "a foundation for achieving standards convergence across all industry sectors," Mr. Leonard said in the statement.

Peter Nance, senior vp at General Re Corp., has been named chairman of the new committee.

Mr. Nance said the committee will be an important part of ACORD's effort to achieve "straight-through processing"—a technology that would allow insurance information to be entered once and transmitted to all parties throughout a distribution network without rekeying.

The committee's first action was the establishment of a property/casualty steering committee that will concentrate on broadening the acceptance of extensible markup language —or XML—data standards. In addition, the ACORD committee established a life steering committee that will focus on developing standards for the life insurance business.

—By Michael Bradford

UPDATES

Britain sets rail safety deadline

LONDON—A government-backed inquiry into train protection systems has reported that an automatic system to prevent trains from passing red signals must be implemented by 2008.

The joint inquiry into train protection systems, set up by the Health and Safety Commission in the wake of the 1997 Southall and 1999 Ladbroke Grove rail disasters, recommends a "tight timetable" to improve rail safety. Both accidents occurred when train engineers passed red warning lights.

The inquiry was carried out by Lord Cullen, who headed the Ladbroke investigation; and John Uff, a professor of engineering law at London's King College, who headed the Southall investigation. Their joint report recommended that the so-called European Train Control System be brought in on high-speed lines. The ETCS makes use of radio technology that sends messages to the train's engineer, telling the engineer when and within what distance to stop.

But before the ETCS can be installed on U.K. railway lines, trials of the system must be performed. A series of trials is scheduled for next year.

The report also recommended that, after 2010, no train be allowed to travel faster than 100 mph unless its line has been fitted with the ETCS.

Until the ETCS can be installed, the network must use the Train Protection Warning System, which the joint inquiry described as "far from ideal" and which is thought to be less effective on high-speed trains. Railtrack P.L.C., the United Kingdom's railroad operator, has pledged to install the TPWS nationwide by the start of 2003.

The Health and Safety Commission welcomed the report of the joint inquiry and said it would check on the progress of the implementation of its recommendations in September.

"No one should underestimate the substantial challenge for all parts of the rail industry," said HSC Chairman Bill Callaghan. "This involves not just installing the most modern automatic train protection systems on a busy network, but continued vigilance by railway management and staff and delivery, day after day, of high standards and safety performance."

Stake in Odyssey Re for sale

TORONTO—Fairfax Financial Holdings Ltd. announced last week that it plans to sell a minority stake in its Odyssey Re Holdings Corp. unit in an initial public offering.

Fairfax did not specify how many Odyssey Re shares it intends to sell or the offering price of the shares. In a filing with the U.S. Securities and Exchange Commission, though, Odyssey Re said that it will continue to be controlled by Toronto-based Fairfax after the offering and that its current management will remain in place.

Odyssey Re will turn over some of the proceeds of the offering to Fairfax subsidiaries that will control the reinsurer and will use the balance for general corporate purposes, possibly including a contribution to the capital of its Odyssey America unit and the payment of dividends.

Odyssey Re's U.S. business expanded significantly in recent years with its 1996 acquisition of Skandia America Reinsurance Corp. and its 1999 takeover of TIG Reinsurance Co. Odyssey Re generated $862.2 million in gross written premiums in 2000, with $677.6 million, or 78.6%, produced in the United States, according to SEC filings.

Employers Re buys CyberComp

LAWRENCEVILLE, N.J.—Employers Reinsurance Corp. has bought CyberComp, an Internet-based workers compensation insurance system that was one of the few remaining profitable operations of Reliance Insurance Co.

ERC will reactivate the CyberComp Web site, which was shut down last year, and take on 25 employees of the Lawrenceville, N.J.-based company. Terms of the sale were not disclosed.

CyberComp, which uses online technology to quote and bind workers compensation policies for small employers, will offer coverage written by Westport Insurance Corp., an ERC subsidiary. Westport will accept new business and consider renewals but will not assume any existing liabilities, according to an ERC statement.

CyberComp, which was launched in 1996, has been used to issue more than 25,000 policies. It had been a profitable unit of New York-based Reliance before the troubled insurer shut its doors last year.

Employers owed comp refunds

AUSTIN, Texas—The Texas Department of Insurance is looking for 29,000 employers that are owed around $15 million in refunds from workers compensation insurers.

The refunds, which average more than $500, are for surcharges that employers were billed to pay off $300 million in bonds used in 1991 to capitalize the state's insurer of last resort, the Texas Workers' Compensation Insurance Fund. The state Legislature in 1999 ordered the refunds after the state fund had amassed a large enough surplus to retire the bonds early.

The 29,000 employers are ones that the Texas Insurance Department has been unable to locate. Their names will be listed on the department's Web site at *www.tdi.state.tx.us* and updated periodically.

Refunds are owed to policyholders that bought workers comp coverage between June 1, 1992 and May 31, 1998.

FOR THE RECORD

Excerpts from *BI*'s Daily Online Updates, March 26 - 30, 2001

PHOTO: BUSINESS WIRE

Taco Bell bought a policy that would have been triggered had Mir hit this target, which was part of a promotional campaign.

NO CLAIMS FROM MIR Insurers and reinsurers appear to be off the hook to both the Russian space agency and U.S. fast-food chain Taco Bell after the space station Mir splashed safely into the Pacific Ocean. The 130-ton space station returned to Earth late last month over the South Pacific, littering a 125-square mile area of ocean with fragments. Lloyd's of London confirmed that a reinsurance policy valued at $200 million had been placed with its syndicates and international markets on behalf of Russian space authorities. London-based broker Heath Lambert Group placed the coverage. A spokesman for Lloyd's said the policy reinsured coverage written by three Russian insurers. Taco Bell, a unit of Louisville, Ky.-based Tricon Global Restaurants Inc., had offered to give free-taco coupons to every American if the main section of Mir landed on a 40-foot-by-40-foot target in the Pacific Ocean off Australia. Taco Bell confirmed that it had purchased insurance that would be triggered by a hit to its target, but did not release coverage details.

HUB POSTS DOUBLE-DIGIT GAINS Acquisitions completed during 2000 not only expanded Hub International Ltd.'s presence in the United States but also helped boost year-end results at the Canadian insurance brokerage. Toronto-based Hub International reported total revenue last year of $150.3 million Canadian ($100.3 million), an increase of 76% from the amount recorded in 1999. Net income for 2000 was $9.7 million Canadian ($6.5 million), up 64% from the year before. One of the companies Hub International bought in 2000 was Kaye Group Inc., a New York-based holding company with both brokerage and underwriting operations. Kaye Group was the 30th-largest broker of U.S. business in *Business Insurance*'s 2000 ranking, based on 1999 brokerage revenues of $47.2 million. Other U.S. brokerage acquisitions by Hub International include Chicago-based Mack & Parker Inc. and Boston-based C.J. McCarthy Insurance Agency Inc.

QBE BUYING HIH RIGHTS QBE Insurance Ltd. will buy the renewal rights to the corporate insurance business of former rival HIH Insurance Ltd., instead of proceeding with a previously announced plan to form a joint venture with the now-defunct HIH. In addition to the Australian corporate business of Sydney-based HIH, which went into provisional liquidation last month, QBE will offer renewals to HIH's travel insurance policyholders in Australia and New Zealand and its professional liability policyholders in Asia, QBE announced. QBE will assume only HIH's liabilities for travel policies. The price for the rights was "consistent with the transaction previously announced," a QBE statement said. Under that deal, QBE and HIH would have established a joint venture for corporate coverage in which QBE would own 60% and HIH, 40%. QBE would have provided $140 million Australian ($69.5 million) of the venture's $200 million Australian ($99.3 million) in capital. Less than two weeks after the deal's announcement, HIH entered provisional liquidation and said it expected to report a half-year loss of $800 million Australian ($397.1 million).

MARSH, MERCER USING BENEFITPOINT William M. Mercer Inc. and Marsh Inc. will make an unspecified investment in BenefitPoint Inc. and incorporate BenefitPoint's technology into their benefit consulting operations. San Francisco-based BenefitPoint, a privately held technology company, provides an online infrastructure linking insurers, brokers, employers and employees, allowing them to exchange information about virtually every type of group benefit. With this investment, Mercer and Marsh, units of Marsh & McLennan Cos. Inc., join other large brokers and consultants that have contracted for the BenefitPoint online platform. Others include Arthur J. Gallagher & Co., which is also an investor; Aon Consulting Inc. and Willis Group Ltd.

ALLIANZ MULLS BANK BUY Allianz A.G. Holding last week confirmed it is in talks to acquire Dresdner Bank, which would create Germany's first bancassurance group. Responding to rumors that have circulated for more than a month, the Munich-based insurance giant said the talks are at "an advanced stage" and, if successful, would lead to the creation of "a leading integrated financial services provider for insurance, investment and banking products." Allianz already holds a 21.4% stake in Dresdner, Germany's third-largest bank. A merger would create Europe's largest financial group, with combined assets of approximately 103 billion euros ($91.30 billion). As part of its plans to acquire Dresdner Bank, Allianz will trade its minority stake in Bayerische HypoVereins Bank with Munich Reinsurance Co. in exchange for a minority stake in Dresdner Bank now held by Munich Re. Terms of the proposed takeover were not revealed.

PHOTO: AFP

The Baltic Carrier spilled more than half a million gallons of crude oil into the Baltic Sea after colliding with another vessel last week.

OIL SPILLED IN SHIP COLLISION Coast guard and environmental protection ships from Denmark, Germany and Sweden last week worked to contain oil slicks that threatened the Danish coast following collision of two ships in the Baltic Sea. The incident involved a tanker, the Baltic Carrier, and a freighter, the Tern. Both ships remained afloat late last week and seemed to be in no danger of sinking, although the tanker, registered in the Marshall Islands, suffered a hull breach and appeared to have spilled more than half a million gallons of its cargo of nearly 10 million gallons of crude oil. The cause of the accident is still under investigation. Third-party liability coverage for both ships is written by the Norwegian protection and indemnity club Assuranceforeningen Gard. The tanker was on route from Estonia to Gothenburg, Sweden, when the collision occurred. Details of its hull insurance were not available. The Tern, registered in Cyprus, was carrying a cargo of sugar from Cuba to Latvia. It has hull coverage with the Norwegian Hull Club of Bergen, Norway.

BRIEFLY NOTED Insurance rating service A.M. Best Co. has placed under review with developing implications the A+ financial strength rating of **the reinsurance operations of Zurich Financial Services Group Inc.** Those operations are Zurich Reinsurance North America Group, Zurich Reinsurance North America Inc. and Zurich Re (Cologne). The review follows ZFS' recent announcement that it plans to exit the reinsurance business, spinning off its reinsurance operations as a publicly traded global company. Best said that the A+ financial strength rating of ZFS itself remains unaffected....The National Assn. of Insurance Commissioners has awarded second-round accreditation to the **Arkansas Department of Insurance,** bringing to 46 the number of state insurance departments with such credentials....Arch Capital Group Ltd. will pay $36 million for privately held **Altus Holdings Ltd.,** a Cayman Islands-based provider of rent-a-captive and other alternative risk transfer services. Altus owns U.S.-domiciled First American Insurance Co., which provides fronting and other services; and Alternative Re, a Bermuda-based rent-a-captive. Greenwich, Conn.-based Arch Capital was one of Altus' original investors, along with Trident Fund L.P. and an investment unit of Marsh & McLennan Cos. Inc....The **Alliance of Community Health Plans** has named Jack Ebeler its president and chief executive officer. Previously, he served as senior vp and director of the health care group at the Robert Wood Johnson Foundation. Mr. Ebeler succeeds Daniel Wolfson...**ACE Ltd.** has changed its symbol on the New York Stock Exchange to ACE from ACL. BI

To get breaking news as it occurs, visit Business Insurance's free online Updates at www.businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

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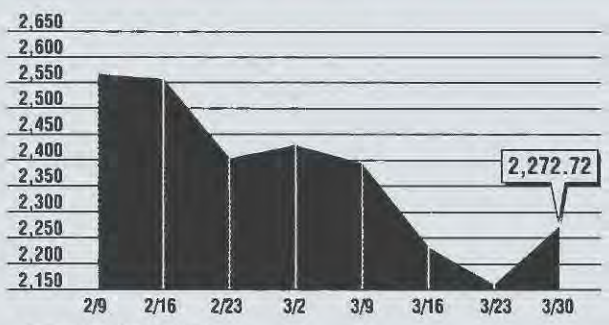
BI Industry Stock Report

MARCH 26, 2001, THROUGH MARCH 30, 2001

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	35.50	4.50	3.65	42.31	20.94	4480
Brown & Brown	NYS	34.05	3.31	-2.71	39.92	15.90	269
Clark Bardes Holdings	NDQ	8.50	-6.85	-16.05	17.88	7.25	31
E.W. Blanch Holdings Inc.	NYS	7.95	-9.45	-54.41	56.94	7.70	454
Gallagher Arthur J. & Co.	NYS	27.70	1.80	-12.93	34.25	11.53	1517
Hilb, Rogal & Hamilton	NYS	35.00	0.55	-12.23	42.13	26.56	156
Kaye Group Inc.	NDQ	13.13	2.44	69.35	13.25	5.00	222
Marsh & McLennan	NYS	95.03	5.38	-18.78	135.69	70.50	4276
BROKERS	AVERAGE		0.14	-5.80			
INSURERS/REINSURERS							
ACE Ltd.	NYS	37.12	11.47	-12.53	43.94	14.06	5422
Accel International Corp.	NDQ	0.16	-5.88	-46.11	1.00	0.10	20
Acceptance Insurance Cos.	NYS	4.08	3.29	-22.29	6.94	3.75	108
AEGON N.V.	NYS	29.24	3.84	-29.44	43.00	25.92	622
AFLAC Inc.	NYS	27.54	7.79	-23.70	37.47	16.78	8068
Allmerica Financial Corp.	NYS	51.89	7.61	-28.43	74.25	35.06	1280
Allstate Corp.	NYS	41.94	6.96	-3.72	44.75	17.19	9679
Ambac Financial Group	NYS	63.43	10.12	8.78	63.43	25.91	4628
American Financial Group	NYS	24.10	4.78	-9.27	29.00	18.69	410
American General	NYS	38.25	6.90	-6.13	41.72	22.81	8918
American Intl Group	NYS	80.50	6.69	-18.33	103.75	52.38	17770
American Safety Insurance	NYS	8.82	1.97	44.00	9.10	3.25	14
Argonaut Group	NDQ	15.88	-0.39	-24.40	21.25	13.50	74
AXA-UAP Group	NYS	54.75	5.65	-23.76	81.50	49.16	979
Baldwin & Lyons Inc.	NDQ	21.56	0.58	-7.26	28.75	15.25	16
Berkley W.R. Corp.	NDQ	45.06	-2.57	-4.50	48.75	14.00	1436
Berkshire Hathaway Inc.	NYS	65450.00	-0.83	-7.82	74600.00	49600.00	1
Capitol Transamerica Corp.	NAS	13.50	0.47	8.54	14.44	10.00	16
Chubb Corp.	NYS	72.44	8.93	-16.25	90.25	43.25	3841
CIGNA Corp.	NYS	107.36	4.22	-18.85	136.75	60.75	3404
Cincinnati Financial Corp.	NYS	37.94	5.38	-4.11	43.31	26.19	1138
Citigroup	NYS	44.98	4.97	-11.91	59.13	35.81	62745
CNA Financial Corp.	NYS	35.01	3.58	-9.65	41.94	24.56	497
CNA Surety	NYS	13.28	1.30	-6.81	14.94	10.38	179
EMC Insurance Group Inc.	NDQ	11.75	2.17	0.00	13.13	6.81	96
ESG Re Ltd.	NDQ	2.63	1.20	42.37	5.50	1.72	14
Enhance Financial Services	NYS	13.45	0.00	-12.87	17.00	8.63	0
Everest Reinsurance	NYS	66.53	8.50	-7.11	74.75	23.63	1026
Fremont General Corp.	NYS	3.88	22.78	37.96	7.56	1.50	886
Gainsco Inc.	NYS	1.80	-13.46	-31.43	6.38	1.40	446
Harleysville Group	NDQ	22.19	-5.59	-24.15	30.63	12.00	299
HSB Group Inc.	NYS	38.75	0.00	0.00	40.63	21.50	0
HCC Insurance Holdings	NYS	26.45	7.09	-1.81	27.19	10.94	1696
ING Groep N.V.	NYS	65.08	8.56	-18.78	83.94	46.81	586
IPC Holdings Ltd.	NDQ	22.38	11.53	6.56	24.50	11.25	125
Hartford Financial Services	NYS	59.00	3.51	-16.46	80.00	29.38	4827
John Hancock Financial Services	NYS	38.45	8.74	2.19	38.45	13.44	5629
LaSalle Re Holdings Ltd.	NYS	18.88	0.00	0.00	19.38	10.88	0
Lincoln National	NYS	42.47	6.31	-10.24	56.38	22.63	3068
MAIC Holdings Inc.	NYS	12.30	-5.02	-26.29	21.13	10.00	127
Markel Corp.	NYS	187.00	1.36	3.31	190.00	111.50	200
MBIA Insurance Group	NYS	60.68	6.37	8.64	81.10	36.50	2312
Meadowbrook Insur. Group	NYS	3.40	-0.58	-58.15	8.38	3.40	4
MetLife	NYS	30.05	9.27	-14.14	36.63	14.25	6715
Mutual Risk Mgmt. Ltd.	NYS	7.25	5.84	-52.26	23.75	6.02	1826
Navigators Group	NDQ	13.44	-2.27	0.94	14.38	8.63	41
NYMagic Inc.	NYS	18.05	-0.82	-4.37	19.25	12.25	0
Ohio Casualty Corp.	NDQ	9.41	5.24	-5.94	17.88	6.13	684
Old Republic Int'l	NYS	28.40	5.15	-11.25	32.06	10.63	2109
Partner Re Ltd.	NYS	49.27	4.65	-19.23	62.50	30.00	812
Penn-America Group Inc.	NYS	10.45	12.97	37.05	10.45	6.88	23
PMA Capital Corp.	NDQ	17.38	-1.77	0.72	19.13	15.19	24
Philadelphia Cons. Holding	NDQ	27.63	0.45	-10.53	31.92	14.13	92
PXRE Corp.	NYS	16.40	-1.20	-2.81	20.10	12.50	70
ReliaStar Financial Corp.	NYS	53.94	0.00	0.00	53.94	23.75	0
RenaissanceRe Holdings Ltd.	NYS	70.01	8.71	-10.60	84.19	35.88	893
RLI Corp.	NYS	40.84	0.12	-8.61	46.16	26.25	29
St. Paul Cos.	NYS	44.05	9.03	-8.90	57.00	21.31	7518
SCOR	NYS	42.40	3.41	-5.62	53.75	38.38	24
SAFECO Corp.	NDQ	28.19	8.41	-14.26	35.88	18.00	3206
SCPIE Holdings Inc.	NYS	20.30	-1.50	-14.07	34.63	18.31	NA
Seibels Bruce Group	NDQ	1.78	-5.01	216.62	2.25	0.53	71
Selective Ins. Group	NDQ	23.22	2.62	-4.25	26.94	14.88	152
Tokio Marine & Fire	NDQ	50.25	3.88	-11.84	61.00	45.25	124
Torchmark Corp.	NYS	38.83	7.62	1.02	41.19	18.75	1830
Transatlantic Holdings	NYS	102.51	4.34	-3.18	107.06	68.75	52
Trenwick Group Inc.	NYS	19.73	-1.25	-20.48	27.13	12.00	694
Unico American Corp.	NDQ	5.63	-3.23	-4.26	7.75	4.50	2
United Fire & Casualty	NDQ	20.38	3.16	3.16	25.00	15.50	13
Unitrin	NDQ	36.38	4.11	-10.46	41.94	27.19	423
UNUM Corp.	NYS	29.22	0.06	8.73	30.44	11.94	3524
Vesta Insurance Co.	NYS	6.65	2.31	3.36	8.39	4.13	124
XL Capital Ltd.	NYS	76.07	8.59	-12.94	89.25	40.63	3239
Zenith National Ins.	NYS	23.60	-4.45	-19.66	30.70	20.00	33
INSURERS/REINSURERS	AVERAGE		3.52	-5.53			

HEALTH MAINTENANCE ORGANIZATIONS		Price	Weekly % change	Year to date %change	Year to date High	Year to date Low	Vol.(000)
Aetna Inc.	NYS	35.92	0.48	-12.52	42.69	32.94	2946
Health Net Inc.	NYS	20.61	7.79	-21.30	26.94	7.63	1353
Humana Inc.	NYS	10.48	-0.19	-31.28	15.81	4.75	3407
Oxford Health Plans	NDQ	26.75	4.39	-32.28	42.75	13.50	5322
Pacificare Health Sys.	NDQ	24.88	0.51	65.83	72.31	9.81	2807
Sierra Health Services	NYS	4.56	18.44	20.00	6.70	2.44	352
United HealthGroup	NYS	59.26	8.73	-3.45	64.38	23.19	8214
Wellpoint Health Networks	NYS	95.31	4.97	-17.30	121.50	56.94	2840
HMOs	AVERAGE		6.38	-2.82			
ALL COMPANIES			3.35	-4.72			

BI Insurance Index



Base=100 on Dec. 29, 1978

Top advancing issues: Fremont General Corp., Sierra Health Services, Penn-America Group Inc. Leading decliners: Gainsco Inc., E.W. Blanch Holdings, Clarke Bardes Holdings. Most active issue: Citigroup. The *BI* Index increased 5.2%; the Dow Jones 30 Industrials rose 3.9%; the S&P 500 went up 1.8% and the NYSE Composite increased 3.1%. Average P/E: Brokers, 20.1; Insurers/reinsurers, 31.2; and HMOs, 16.2.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

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